

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Vierra Falls Church		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Powhatan Street Falls Church, VA 22043	
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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 26 residents in the survey sample, Residents #6, #7, #2, #4 and #18. The findings include: 1. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to A) complete pressure injury (1) treatment per the physicians order and B) obtain labs per the physicians order on 3/23/2026. A) On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 1/19/2026, the resident was assessed as having one Stage II pressure injury and one Stage IV pressure injury, both of which were present on admission. The comprehensive care plan for R6 documented in part, [Name of R6] has pressure ulcer presents with a stage IV R hip and stage 2 sacrum pressure injury. And is at further risk for skin breakdown r/t (related to) Immobility, decreased mobility, comorbidities, incontinence of stool. 2/26-Has chronic hip wound, stage IV. Pt is refusing turning /off loading and proper wound care. Has declined wound vac (2). Bone is exposed. 3/17 - Mid Scalp & Resolved. Date Initiated: 01/26/2026 . Under Interventions it documented in part, Administer treatments as ordered and monitor for effectiveness. Date Initiated: 01/26/2026. The physician orders for R6 documented in part, - RIGHT HIP: Cleanse with normal saline, pat dry apply vashe moistened gauze pads to the area and let it sit for 10mins, rinse with normal saline, pat dry gently tuck Aquacel Ag rope in wound bed and undermining and cover with Drawtex absorbent dressing and cover with bordered foam. every 24 hours as needed for If wound vac stops working AND every day shift. Order Date: 02/25/2026 . The progress notes documented in part, - 3/22/2026 9:12 PM Note Text : During the shift the wound vac was beeping. Resident wound vac therapy was changed to wet to dry dressing due to unavailability of wound vac canister. - 3/23/2026 3:00 PM Note Text : Resident's wound vac noted not working per previous nurse. Wound (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vac not in use; wet to dry dressing applied. - 3/24/2026 11:50 AM Note Text : Wet to dry dressing completed to stage 4 wound to right hip. - 3/24/2026 1:39 PM Note Text : New wound vac cannister delivered to facility. Previous wet to dry dressing removed. Wound vac applied to resident's wound on right hip per order. Dressing intact with appropriate seal noted. No signs of leakage observed. Resident tolerated dressing change. On 7/9/2026 at 7:44 AM, an interview was conducted with the MDS coordinator who stated that the purpose of the care plan was to address the patient's needs and care and it should be followed. On 7/9/2026 at 8:23 AM, an interview was conducted with licensed practical nurse (LPN) #1 who stated that she worked with R6 when they were at the facility. She stated that R6 had a pressure injury that was followed by the outpatient wound clinic and had a wound vac in place. She stated that there were times when R6 would refuse the wound vac and they would put a wet to dry dressing in place and when the wound vac was not working they used a wet to dry dressing. LPN #1 stated that a wet to dry dressing was wetting gauze with normal saline and placing that on the wound and then covering it with dry gauze and then a foam dressing. B) The comprehensive care plan for R6 documented in part, FALL: [Name of R6] is at risk for falls r/t (related to) Other low back pain, Chronic Systolic (Congestive) heart failure, Gait/balance problems. [Name of R6] had an actual fall and at risk for further falls. Date Initiated: 01/13/2026 . Under Interventions it documented in part, .Continue to monitor residents and labs ordered. Date Initiated: 03/23/2026. The physician orders for R6 documented in part, - CBC (complete blood count),CMP (comprehensive metabolic panel), UA C&S (urinalysis culture and sensitivity) one time only for 1 Day. Order Date: 03/23/2026. The progress notes documented in part, - 3/23/2026 7:03 AM Note Text: Today, in this morning, the lab person didn't come to East, so writer placed a call to the lab center and spoke to the staff, [Name of staff]. She stated she didn't know when the lab person was going to come but anyway the lab person was going to come to this facility. waiting to come. The progress notes failed to evidence any further follow up regarding the labs or the labwork being obtained prior to R6 being sent to the emergency room on 3/25/2026. Review of the clinical record failed to evidence the CBC and CMP being collected or resulted prior to R6 being sent to the emergency room on 3/25/2026. On 7/9/2026 at 7:44 AM, an interview was conducted with the MDS coordinator who stated that the purpose of the care plan was to address the patient's needs and care and it should be followed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/2026 at 7:48 AM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that the lab came in between 3:00-5:00 AM Monday through Friday and Sundays. She stated that stat labs were completed on Saturdays as needed and if a lab was not completed as ordered they contacted the lab for them to come in that day to draw them. On 7/9/2026 at 8:04 AM, an interview was conducted with LPN #4 who stated that on 3/23/2026 the lab did not come to the unit to draw the ordered labs. She stated that she had called the lab manager who said that someone was coming in later that day to draw the labs. LPN #4 stated that she had put the progress note in and reported off to the day shift nurse and thought that the lab had come in after she went home from her shift. thing in my notes. On 7/9/2026 at 8:23 AM, an interview was completed with LPN #1 who stated that the lab came in daily to draw ordered labs. She stated that routine labs were drawn Monday through Friday and if needed labs could be entered as stat and were drawn within one to two hours. LPN #1 stated that the results went directly into the medical record. On 7/9/2026 at 8:59 AM, an interview was conducted with registered nurse (RN) #1 who stated that the lab came in every day except the weekends for routine labs. She stated that if a lab was not drawn on the day it was supposed to be done, they contacted the lab to have them come back to draw it and it would be done within a four hour window. The facility policy Comprehensive Care Plans revised 1/30/2024 documented in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment . On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure sores are sores on your skin. They're caused by being in a bed or wheelchair nearly all the time. Sometimes they're called bedsores or pressure ulcers . Stage 1. During this stage, the area of the sore looks red. It may feel warm to the touch. It may burn, hurt, or itch. The pressure sore may look blue or purple in people who have dark skin. Stage 2. During this stage, the area is more damaged. The sore may be open. It may look like a cut or blister. The skin around the sore may be discolored. The sore is painful. Stage 3. During this stage, the sore will have a crater-like look. This is due to increased damage below the surface. This makes the wound deeper. Stage 4. This is the most serious stage. Skin and tissue are severely damaged. The sore becomes a large wound. Infection is possible. You're likely able to see muscle, bones, tendons, and joints . This information was obtained from the website: Pressure Sores Family Doctor (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/2026 at 8:23 AM, an interview was completed with LPN #1 who stated that the lab came in daily to draw ordered labs. She stated that routine labs were drawn Monday through Friday and if needed labs could be entered as stat and were drawn within one to two hours. LPN #1 stated that the results went directly into the medical record. On 7/9/2026 at 8:59 AM, an interview was conducted with registered nurse (RN) #1 who stated that the lab came in every day except the weekends for routine labs. She stated that if a lab was not drawn on the day it was supposed to be done, they contacted the lab to have them come back to draw it and it would be done within a four hour window. On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. 3. For Resident #2 (R2), the facility staff failed to implement the comprehensive care plan. R2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: infection following a procedure; other surgical site, presence of right artificial knee joint, aftercare following joint replacement, osteoarthritis and depression. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/1/2024, the resident was coded as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The comprehensive care plan dated, 10/6/2024, documented in part, Focus: (R2) has right TKA (total knee arthroscopy) surgical wound infection s/p (status post) I%D (incision and drainage). Interventions: Administer antibiotic as per MD (medical doctor) orders. The physician order dated, 9/28/2024 documented, Vancomycin HCL (hydrochloride) Intravenous Solution 500MG/100ML; Use 500 ml (milliliters) two times a day for Wound infection for 6 weeks. The September 2024 MAR (medication administration record) documented the above order. The Medication Administration Audit Report documented on 9/29/2024, the 9:00 a.m. dose was documented as administered at 11:36 a.m. The Medication Administration Audit Report documented on 9/30/2026, the 9:00 a.m. dose was documented as administered at 1:12 p.m. The October 2024 MAR documented the above order. The Medication Administration Audit Report documented on 10/1/2024, the 9:00 a.m. dose was documented as administered at 11:56 a.m. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Audit Report documented on 10/3/2024, the 9:00 a.m. dose was documented as administered at 11:51 a.m. The physician order dated, 10/3/2024, documented, Vancomycin HCL (hydrochloride) Intravenous Solution 500MG/100ML (milligrams per milliliters); Use 500 mg (milligram) intravenously two times a day for wound infection until 11/9/2026 timing change to 0600 (6:00 a.m.) and 1800 (6:00 p.m.). The October 2024 MAR documented the above order. On the following dates and times there was a blank at the time of administration: 10/14/2024 at 6:00 a.m.; 10/17/2024 at 6:00 a.m. and 10/24/2024 at 6:00 a.m. The physician order dated 9/28/2024 documented, Cefepime HCL Intravenous Solution Reconstituted 2 GM (grams); Use 2 gram intravenously three times a day for Wound Infection for 6 weeks. The September 2024 MAR documented the above order. The Medication Administration Audit Report documented on 9/30/2024 the 8:00 a.m. dose was documented as given at 10:22 a.m. and the 12:00 p.m. dose was documented as administered at 3:25 p.m. The October 2024 MAR documented the above order: The Medication Administration Audit Report documented the following: 10/14/2024 the 2:00 p.m. dose was administered at 4:59 p.m. 10/15/2024, the 2:00 p.m. dose was administered at 4:25 p.m. 10/26/2024, the 2:00 p.m. dose was administered at 11:01 a.m. 10/31/2024, the 2:00 p.m. doe was administered at 4:54 p.m. The November 2024MAR documented the above order: The Medication Administration Audit Report documented the following: 11/3/2024, the 2:00 p.m. dose was administered at 3:35 p.m. 11/4/2024, the 2:00 p.m. dose was administered at 9:32 p.m. 11/5/2024, the 2:00 p.m. dose was administered at 3:36 p.m. 11/6/2024, the 2:00 P.M. dose was administered at 3:31 p.m. On 7/9/2026 at 7:44 AM, an interview was conducted with the MDS coordinator who stated that the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	purpose of the care plan was to address the patient's needs and care and it should be followed. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit. 4. For Resident #4, the facility staff failed to implement the comprehensive care plan. Resident #4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: diabetes, aftercare following joint replacement surgery, diabetes, and anemia. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, the resident was coded as scoring an 11 out of 15 on the BIMS (brief interview for mental status score, indicating the resident was moderately impaired for making cognitive daily decisions. The comprehensive care plan dated, 9/1/2025, documented in part, NURSING CARE NEEDS. Interventions: Labs/radiology tests as ordered by the physician or as needed. The physician order dated, 9/5/2025 documented, CBC and BMP (basic metabolic panel) (2) every night shift every Wed (Wednesday) and Sun (Sunday) for routine labs (laboratory tests). The start date was documented as 9/7/2025 and end date of 10/3/2025. Review of the clinical record failed to evidence that these physician order lab tests were completed. On 7/9/2026 at 7:44 AM, an interview was conducted with the MDS coordinator who stated that the purpose of the care plan was to address the patient's needs and care and it should be followed. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit. 5. For Resident #18, the facility staff failed to implement the comprehensive care plan. R18 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: benign prostatic hypertrophy (1), bladder cancer and urinary tract infection. The MDS (minimum data set) assessment, and admission assessment, with an assessment reference date of 6/18/2026, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section H &ndash; Bladder and Bowel, the resident was coded as having an indwelling catheter. In Section O &ndash; Special Treatments, Procedures and Programs, the resident was coded as having a Midline IV (intravenous) access. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated, 6/15/2026, documented in part, Focus: MIDLINE: (R18) has a midline r/t (related to) ABT (antibiotic)/IV/ midline of the upper arm the catheter. Interventions: Weekly measure the arm circumference 3 inches above the insertion site and the length of the catheter from the insertion site to the tip of the catheter and document. If swelling to the arm or migration of the catheter is noted, notify the MD (medical doctor). The physician order dated 6/17/2026, documented, Observe Midline insertion site and surrounding areas. Monitor IV site for infiltration, bruising, pain IV infiltration, s/s (signs and symptoms) of infection. Review of the TAR (treatment administration record) failed to evidence any documentation of the measuring of the arm circumference or catheter length. On 7/9/2026 at 7:44 AM, an interview was conducted with the MDS coordinator who stated that the purpose of the care plan was to address the patient's needs and care and it should be followed. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to administer medications per the physician orders for one of 26 residents in the survey sample, Residents #2. The findings include: 1a. For Resident #2 (R2), the facility staff failed to administer Vancomycin (1) per the physician orders. R2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: infection following a procedure; other surgical site, presence of right artificial knee joint, aftercare following joint replacement, osteoarthritis and depression. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/1/2024, the resident was coded as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The physician order dated, 9/28/2024 documented, Vancomycin HCL (hydrochloride) Intravenous Solution 500MG/100ML; Use 500 ml (milliliters) two times a day for Wound infection for 6 weeks. The September 2024 MAR (medication administration record) documented the above order. The Medication Administration Audit Report documented on 9/29/2024, the 9:00 a.m. dose was documented as administered at 11:36 a.m. The Medication Administration Audit Report documented on 9/30/2026, the 9:00 a.m. dose was documented as administered at 1:12 p.m. The October 2024 MAR documented the above order. The Medication Administration Audit Report documented on 10/1/2024, the 9:00 a.m. dose was documented as administered at 11:56 a.m. The Medication Administration Audit Report documented on 10/3/2024, the 9:00 a.m. dose was documented as administered at 11:51 a.m. The physician order dated, 10/3/2024, documented, Vancomycin HCL (hydrochloride) Intravenous Solution 500MG/100ML (milligrams per milliliters); Use 500 mg (milligram) intravenously two times a day for wound infection until 11/9/2026 timing change to 0600 (6:00 a.m.) and 1800 (6:00 p.m.). The October 2024 MAR documented the above order. On the following dates and times there was a blank at the time of administration: 10/14/2024 at 6:00 a.m.; 10/17/2024 at 6:00 a.m. and 10/24/2024 at 6:00 a.m. An interview was conducted with RN (registered nurse) #1, a unit manager, on 7/8/2026 at 10:43 a.m. RN #1 stated the nurse evidence that they've given medication/treatment by documenting it on the MAR. Medications are administered within an hour before or an hour after the scheduled time. 1b. The physician order dated 9/28/2024 documented, Cefepime HCL Intravenous Solution Reconstituted 2 GM (grams); Use 2 gram intravenously three times a day for Wound Infection for 6 weeks. The September 2024 MAR documented the above order. The Medication Administration Audit Report documented on 9/30/2024 the 8:00 a.m. dose was documented as given at 10:22 a.m. and the 12:00 p.m. dose was documented as administered at 3:25 p.m. The October 2024 MAR documented the above order. The Medication Administration Audit Report documented the following: 10/14/2024 the 2:00 p.m. dose was administered at 4:59 p.m. 10/15/2024, the 2:00 p.m. dose was administered at 4:25 p.m. 10/26/2024, the 2:00 p.m. dose was administered at 11:01 a.m. 10/31/2024, the 2:00 p.m. dose was administered at 4:54 p.m. The November 2024 MAR documented the above order. The Medication Administration Audit Report documented the following: 11/3/2024, the 2:00 p.m. dose was administered at 3:35 p.m. 11/4/2024, the 2:00 p.m. dose was administered at 9:32 p.m. 11/5/2024, the 2:00 p.m. dose was administered at 3:36 p.m. 11/6/2024, the 2:00 P.M. dose was administered at 3:31 p.m. The comprehensive care plan dated, 10/6/2024, documented in part, Focus: (R2) has right TKA (total knee arthroscopy) surgical wound infection s/p (status post) I% D (incision and drainage). Interventions: Administer antibiotic as per MD (medical doctor) orders. An interview was conducted with RN (registered nurse) #1, a unit manager, on 7/8/2026 at 10:43 a.m. RN #1 stated the nurse (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence that they've given medication/treatment by documenting it on the MAR. Medications are administered within an hour before or an hour after the scheduled time. The facility policy, Medication/Treatment Administration documented in part, 11.d. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide foot care for one of 26 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to provide treatment for the resident's right great toe wound from 2/7/26 through 2/19/26. A review of R9's clinical record revealed a podiatry note dated 2/6/26 that documented, Assessment/Plan1.) Painful R (right) great toe-superficial wound to lateral border secondary to ingrown toenail-partial slant back performed for relief-I cleansed site with soap and water, pat dry, applied bacitracin and covered with bandaid-I discussed with wound nurse (name of facility wound nurse) who says she will add the patient to her list. Further review of R9's clinical record failed to reveal any further treatment of R9's right great toe until a physician's order dated 2/18/26 documented to cleanse the right great toe with wound cleanser, pat dry, apply silver alginate (a wound dressing) and cover with a bordered dressing every day and every 24 hours as needed. A consulting wound care nurse practitioner note dated 2/19/26 documented, Location: Right great toe. Primary Etiology: Abrasion. Stage/Severity: Partial Thickness. Size: 0.5 cm (centimeters) x 0.5 cm x 0.1 cm. Calculated area is 0.25 sq cm (square centimeters). The former facility wound nurse was not available for interview. On 7/8/26 at 7:58 a.m., an interview was conducted with RN (Registered Nurse #1). RN #1 stated that if the podiatrist reports a foot wound that he provided treatment for, the nurse should immediately report this to the physician and the wound care nurse practitioner then they will tell the nurse if the current treatment should be continued or they will initiate a new treatment. RN #1 stated nurses evidence wound treatments are provided by signing them off on the treatment administration record. On 7/9/26 at 2:41 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Wound Treatment Management documented, 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. No further information was presented prior to exit.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for indwelling urinary catheters for three of 26 residents in the survey sample, Residents #17, #9, and #18. The findings include: 1. For Resident #17 (R17), the facility staff failed to cleanse the resident's nephrostomy (1) tube sites, failed to change nephrostomy tube dressings per physician's orders, and failed to empty nephrostomy tube bags per physician's orders. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/26, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R17's clinical record failed to reveal a physician's order and failed to reveal documentation that the resident's left and right nephrostomy tube sites were cleansed (except for a nurse's note dated 5/12/26 that documented the right tube was cleansed). A review of R17's physician's orders revealed the following orders: -3/16/26-change dressings to both nephrostomy tubes, apply split gauze every day shift. -3/16/26-empty left nephrostomy tube/bag every shift and as needed. -3/16/26-empty right nephrostomy tube/bag every shift and as needed. Further review of R17's clinical record failed to reveal the above treatments were provided (as evidenced by blank spaces on the TARs [treatment administration records]): -R17's dressing changes to both nephrostomy tubes were not provided on 6/14/26 and 6/29/26. -R17's left nephrostomy tube/bag was not emptied on 5/3/26 during the night shift, 5/30/26 during the night shift, 6/14/26 during the day shift and night shift, 6/19/26 during the night shift, and 6/22/26 during the night shift. -R17's right nephrostomy tube/bag was not emptied on 5/3/26 during the night shift, 5/30/26 during the night shift, 6/9/26 during the day shift, 6/13/26 during the night shift, 6/14/26 during the day shift and night shift, 6/19/26 during the night shift, and 6/22/26 during the night shift. On 7/7/26 at 9:14 a.m., an interview was conducted with R17. R17 stated staff only empties her nephrostomy bags when she tells them to. R17 stated she wasn't sure if staff always cleanses her nephrostomy tube sites or changes the dressings. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/26 at 10:37 a.m., an interview was conducted with RN (Registered Nurse) #1. RN #1 stated care for nephrostomy tubes/sites should include cleansing the sites with normal saline, collecting drainage every shift, and daily dressing changes. RN #1 stated nurses should follow physician's orders for nephrostomy care and nurses evidence the treatments are done by signing them off on the TAR. On 7/9/26 at 2:41 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Nephrostomy and Cystostomy Tube Care and Maintenance documented, Residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. No further information was presented prior to exit. Reference: (1) A percutaneous nephrostomy is the placement of a small, flexible tube (catheter) through your skin into your kidney to drain your urine. It is inserted through your back or flank. This information was obtained from the website: https://medlineplus.gov/ency/article/007375.htm 2. For Resident #9 (R9), the facility staff failed to provide physician ordered urinary catheter (1) treatments on multiple dates in January 2026 and March 2026. A review of R9's clinical record revealed the following physician's orders: -1/12/26-check catheter anchor for placement and function every shift. If misplaced or malfunctioned, replace with new anchor. -1/12/26-indwelling urinary Foley catheter 16 French with a 10 cubic centimeter balloon. Check for placement and function every shift. -1/12/26-urinary catheter care every shift; cleanse with soap and water or cleansing cloth. Further review of R9's clinical record failed to reveal the above treatments were provided (as evidenced by blank spaces on the TARs [treatment administration records]): -R9's catheter anchor was not checked for placement and function on 1/24/26 during the night shift, and 3/9/26 during the evening shift. -R9's indwelling urinary Foley catheter was not checked for placement and function on 1/13/26 during the evening shift, 1/19/26 during the evening shift, 1/24/26 during the night shift, 1/26/26 during the evening shift, and 1/29/26 during the evening shift. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-R9's urinary catheter care with soap and water or a cleansing cloth was not provided on 1/24/26 during the night shift, and 3/9/26 during the evening shift. On 7/8/26 at 7:58 a.m., an interview was conducted with RN (Registered Nurse) #1. RN #1 stated urinary catheter treatments should be provided per physician's orders and nurses evidence urinary catheter treatments are provided by signing them off on the treatment administration record. On 7/9/26 at 2:41 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Catheter Care documented, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care .1. Catheter care will be performed every shift and as needed by nursing personnel. No further information was presented prior to exit. Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm 3. For Resident #18, the facility staff failed to provide indwelling catheter care and measure urinary output. Resident #18 (R18) was admitted to the facility on [DATE], with diagnoses that included but were not limited to: benign prostatic hypertrophy (1) and bladder cancer. The MDS (minimum data set) assessment, and admission assessment, with an assessment reference date of 6/18/2026, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section H &ndash; Bladder and Bowel, the resident was coded as having an indwelling catheter. The physician order dated, 6/13/2026, documented, Urinary Catheter: Indwelling urinary output, every shift. Check for placement and function. Urinary Catheter: urinary catheter care every shift cleanse with soap and water or cleansing cloth. The June 2026 Treatment Administration Record (TAR) documented the above orders. On 6/15/2026, night shift; 6/19/2026, evening shift; and 6/20/2026, there were blanks on the TAR where the urine output should be documented. On 6/19/2026 and 6/20/2026 for the evening shift, there were blanks where the catheter care was to be documented. The July 2026, TAR documented the above orders. On 7/3/2026 there were blanks for the evening shift for both urinary output and indwelling catheter care. The comprehensive care plan dated 6/15/2026 documented in part, Focus: URINARY CATHETER: (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(R18) has indwelling catheter r/t (related to) retention. Interventions: Monitor and document intake and output as per facility policy. On 7/8/26 at 7:58 a.m., an interview was conducted with RN (Registered Nurse) #1. RN #1 stated urinary catheter treatments should be provided per physician's orders and nurses evidence urinary catheter treatments are provided by signing them off on the treatment administration record. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit. 1. Benign Prostatic Hypertrophy - An enlarged prostate is when your prostate gland becomes larger than normal. It's also called benign prostatic hyperplasia or BPH for short. Benign means not cancer. And hyperplasia means too much cell growth. This information was obtained from the following website: https://medlineplus.gov/enlargedprostatebph.html.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and store food in a sanitary manner in one of one kitchen. The findings include: On 7/7/2026 at 8:30 AM, an observation was made of the facility kitchen with the dietary manager. Observation of the walk-in refrigerator revealed a baking sheet approximately 18x13 inches on the second shelf of a four shelf wire rack. The baking sheet contained cooked bacon and sausage and was observed to be uncovered. The dietary manager stated that the bacon and sausage was in the walk-in refrigerator to cool, and they had been told to leave it uncovered by the local health department. Continued observation of the kitchen area revealed an approximately two gallon plastic container filled with water and sliced meat which was identified as pork by the dietary manager. The meat was observed to not have temperature monitoring or running water into the container. At that time the dietary manager used a thermometer and checked the temperature which read 72 degrees. The dietary manager stated that the water should have been running over the meat while thawing it. On 7/9/2026 at 9:33 AM, an interview was conducted with the dietary manager who stated that if cooling something in the refrigerator then it should be covered to not contaminate it or anything else. She stated that when thawing meat in water it should be submerged in cold water and the water should be running because they did not want bacteria growing on the food. The facility policy Food Safety Requirements revised 8/12/2022 documented in part, .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety . Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following . b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. c. Preparation of food, including thawing, cooking, cooling, holding and reheating . On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to assess a resident for medication self-administration for one of 26 residents in the survey sample, Resident #17. The findings include: For Resident #17 (R17), the facility staff failed to assess the resident to ensure it was safe for the resident to keep Blu Emu (a topical pain reliever) (1) at the bedside. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/26, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 7/7/26 at 9:14 a.m., R17 was observed lying in bed. A plastic jar of Blu Emu (approximately 1/4 empty) was observed on R17's bedside table. R17 stated she had the Blu Emu in her room for some time and kept the cream at the bedside so her sister can assist her with applying it. A review of R17's clinical record failed to reveal a physician's order for Blu Emu and failed to reveal a medication self-administration assessment. On 7/7/26 at 9:26 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated that if a resident wishes to keep a medication at the bedside, the nurses should let the nurse practitioner or physician know and complete a medication self-administration evaluation. LPN #2 stated she administered medications to R17 earlier that morning, but the resident had a lot of stuff on the overbed table, and she did not see the Blu Emu. On 7/9/26 at 2:41 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Resident Self-Administration of Medication documented, It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. No further information was presented prior to exit. Reference:(1) Blu Emu is a topical pain reliever containing emu oil, trolamine salicylate, aloe vera, MSM (methylsulfonylmethane), and glucosamine. This information was obtained from the website: https://www.blue-emu.com/		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to notify the medical provider and the responsible party of changes in condition for one of 26 residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to notify the medical provider and responsible party (RP) of change in condition on 4/20/2026. On the most recent MDS (minimum data set) assessment, discharge assessment with a reference date of 4/24/2026, the resident was assessed as having a PEG (1) (percutaneous endoscopic gastrostomy) tube and receives 51% or more of calories from enteral feeding. The resident's BIMS (brief interview for mental status) score was assessed at 15, indicating he was intact for making daily decisions. The resident's diagnoses included but are not limited to malignant neoplasm of mouth (1), dysphagia (2), difficulty in walking, hypertension (3). -A review of a late entry noted entered by LPN #7, on 4/21/2026 at 00:10 (12:10 AM), documents: Fall Details: Fall was not witnessed. Fall occurred in the Resident's room. Resident was attempting to self-toilet at time of the fall. The reason for the fall was not evident. Contributing Factors: Recent change in environment: Yes. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Medication Changes: Recent change to Resident's medications: No. Medication review note: Resident is a new admit Vitals: T 97.6 - 4/21/2026 00:05 Route: Forehead (non-contact) BP 133/69 - 4/21/2026 00:05 Position: Lying I (left)/arm P 76 - 4/21/2026 00:05 Pulse Type: Regular Pain: Indicators of pain: None. Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal. No skin issues identified. Skin note: No new injuries other than those present during admission Physical Findings: Change in diagnosis status: No. Recent diagnosis of stroke (4), TIA (5) (transient ischemic attack) or arrhythmia (6): No. Decrease in fluid intake: No. Change in blood glucose levels: No. Change in blood pressure: No. Further review of the clinical record failed to evidence the medical provider was notified of the fall on 4/20/2026. On 7/8/2026 at 8:25 AM, an interview was conducted with LPN #7. When asked what is the process to follow after a resident has fallen? LPN #7 stated inform the supervisor, assess the patient, get help to transfer the patient, if the patient hit their head, neurological checks should be done, or if there is weakness neurological checks are done; the doctor and family members should be notified. LPN #7 also stated that a fall assessment should be completed and the fall should be documented in the progress notes in risk management. LPN #7 stated that R8 fell on 4/20/2026. When asked what is the process to ensure residents call bells are answered while breaks are taken, LPN #7, stated they let the aides know a break is about to be taken and then they notify their colleague nurse so that their colleague can back them up. LPN #7 further stated they work as a team. On 7/8/2026 at 2:45 PM, an interview was conducted with the Director of Nursing (DON). When asked if they remembered R8's fall, they stated they did not. When asked for the process that should be followed after a resident falls, they stated, the nurse will go into the resident's room with a CNA to assess the resident for any injuries, transfer the resident to the bed, call the doctor or nurse practitioner (NP) on call and the RP; and then investigate what happened; check the resident for neurological changes; pain; complete a skin assessment and complete a change of condition. DON further stated that the nurse on the next shift will continue to monitor the resident. On 7/8/2026 at 4:15 PM, an interview was conducted with LPN #8, who stated that they did not remember R8's fall. When asked what is the process to follow after a resident has fallen, LPN #8 stated that the protocol is to check on the resident, get the resident up, notify the MD and the family. LPN #8 stated they have a fall protocol in the risk (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management section in the electronic records that the complete. A review of the facility's NURP-031: Fall Prevention Program policy, revised 1/29/2024, stated in part, when any resident experience a fall, the facility will notify the physician and family. 5/13/2026 at 10:10 AM, the Administrator and Director of Nursing were made aware of the concern for R8. No further information was provided prior to exit. Reference:1. Malignant neoplasm- A malignant neoplasm is the medical term for cancer. It is an abnormal mass of tissue created by cells that grow uncontrollably. https://jamanetwork.com/journals/jamaoncology/article-abstract/27686342. Dysphagia- Dysphagia means you cannot swallow well. https://www.enthealth.org/conditions/dysphagia/3. Hypertension- Hypertension, or high blood pressure, means the force of blood pushing against your artery walls is consistently too high. It forces your heart to work harder and, over time, damages blood vessels, potentially leading to serious health risks like heart attacks, stroke, and kidney disease. https://my.clevelandclinic.org/health/diseases/4314-hypertension-high-blood-pressure4. Stroke- A stroke happens when there is a loss of blood flow to part of the brain. Your brain cells cannot get the oxygen and nutrients they need from blood, and they start to die within a few minutes. This can cause lasting brain damage, long-term disability, or even death. https://medlineplus.gov/stroke.html5. TIA- A transient ischemic attack (TIA) is a stroke that lasts only a few minutes. It happens when the blood supply to part of the brain is briefly blocked. Symptoms of a TIA are like other stroke symptoms, but do not last as long. https://medlineplus.gov/transientischemicattack.html6. Arrhythmia- An arrhythmia is a problem with the rate or rhythm of your heartbeat. Your heart beats too quickly, too slowly, or with an irregular pattern. Changes in the electrical signals that control your heartbeat cause arrhythmias. https://medlineplus.gov/arrhythmia.html		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff interview, and facility document review, the facility staff failed to promptly and fully resolve a grievance for one of 26 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to address the resident representative's grievance regarding the phone and podiatry appointment. A grievance summary dated 3/23/26 documented, Grievance Details: Patient's son reported various concerns about her phone, podiatry appointment, and nursing care. Summary of Investigation: Documentation from staff indicates that pt. (patient) refuses all bowel regiment [sic] medications and requests an enema, but then will refuse the enema. Pt. also declines daily to get out of bed. Summary of Findings: Documentation from staff indicates that pt. refuses all bowel regiment [sic] medications and requests an enema, but then will refuse the enema. Pt. also declines daily to get out of bed. Summary of Actions Taken: Nurses will inform NP (Nurse Practitioner) to replace enemas to other laxatives that resident would be amenable to take. The summary documented a resolved date of 3/31/26 and documented the grievance was resolved by the former Director of Nursing. Further review of the summary failed to reveal concerns regarding R9's phone or podiatry appointment were addressed. On 7/8/26 at 2:05 p.m., an interview was conducted with the Director of Social Services (also the Grievance Official). The Director of Social Services stated grievances are entered into the computer system by her, the Administrator, or the Director of Nursing then depending on the nature of the grievance, other department heads are added and are responsible for investigating and resolving the grievances. The Director of Social Services stated the goal was to resolve a grievance within 48 to 72 hours, but this was dependent on the nature of the grievance. The Director of Social Services reviewed the above grievance summary. The Director of Social Services stated the former Director of Nursing resolved the grievance although it did not document concerns regarding the phone and podiatry appointment were addressed. On 7/9/26 at 2:41 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Resident and Family Grievances documented, 10.d.ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. 'Prompt efforts' include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. No further information was presented prior to exit.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to develop a complete baseline care plan for one of 26 residents, Resident #8. The findings include: For Resident #8 (R8) the facility staff failed to complete the baseline care plan for PEG (1) (percutaneous endoscopic gastrostomy) tube care. On the most recent MDS (minimum data set) assessment, discharge assessment with a reference date of 4/24/2026, the resident was assessed as having a PEG (1) (percutaneous endoscopic gastrostomy) tube and receives 51% or more of calories from enteral feeding. The resident's BIMS (brief interview for mental status) score was assessed at 15, indicating he was intact for making daily decisions. The resident's diagnoses included but are not limited to malignant neoplasm of mouth (2), dysphagia (3), difficulty in walking, hypertension (4). -The physician's orders for R8 documented in part Enteral Tube Site Care: everyday shift cleanse site with soap and water, pat dry and place dry dressing around site. -A review of the initial base line care plan dated 4/20/2026 failed to evidence the initiation of a care plan focus/goal/interventions for R8's PEG tube. On 7/8/2026 at 2:25PM, an interview was conducted with the DON (Director of Nursing), who stated that the Unit Manager is responsible for developing a baseline care plan and the DON, ADON (Assistant Director of Nursing) and supervisors have an input in the development of the care plan. The DON stated that if the resident is admitted in the evening, they will complete a basic care plan addressing nursing needs and then review it in the morning and update it. When asked what is included in the base line care plan, the DON stated fall assessment, skin observations, medical device, nursing needs, nutrition, and fluid restrictions. When asked should enteral feeding be included the DON stated it should be included. On 7/9/2026 at 7:35 AM, an interview was conducted with MDS Coordinator, who stated that initially nursing initiates the care plan on admission and then IDT (inter-disciplinary team) will make any changes such as falls, skin tears and bruises. MDS Coordinator further stated that MDS will revise the care plan on day seven and they have 14 days to add any additional information that needs to be added. MDS Coordinator further stated that on admission a baseline care plan is completed by nursing and covers the immediate needs and MDS will complete a comprehensive care plan. When asked if enteral feeding and PEG care should be included the MDS Coordinator stated yes, anything pertaining to the resident should be on the care plan. On 7/9/2026 at 9:30 AM, an interview was conducted with the RN #1 Unit Manager, who stated that the supervisor initiates a baseline care plan on admission and sometimes the care plan requires changes and MDS makes those changes. RN #1 Unit Manager stated that enteral feeding and care of a PEG tube should be included in the baseline care plan. Review of the facility's policy MDS-004: Baseline Care Plan, revised 8/11/2022, documented in part: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality of care. the baseline care plan will include the minimum healthcare information necessary to properly care for a resident. On 7/9/2026 at 2:38 PM, the Administrator and Director of Nursing were notified of the findings. No further information was provided prior to exit. Reference: 1. PEG Tube- A PEG tube stands for Percutaneous Endoscopic Gastrostomy tube. It is a flexible feeding tube placed through the abdominal wall directly into the stomach. This allows nutrition, fluids, and medications to be delivered while completely bypassing the mouth and esophagus. https://southlakegastro.com/understanding-percutaneous-endoscopic-gastrostomy/ 2. Malignant (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neoplasm- A malignant neoplasm is the medical term for cancer. It is an abnormal mass of tissue created by cells that grow uncontrollably. https://jamanetwork.com/journals/jamaoncology/article-abstract/27686343 . Dysphagia- Dysphagia means you cannot swallow well. https://www.enthealth.org/conditions/dysphagia/4 . Hypertension- Hypertension, or high blood pressure, means the force of blood pushing against your artery walls is consistently too high. It forces your heart to work harder and, over time, damages blood vessels, potentially leading to serious health risks like heart attacks, stroke, and kidney disease. https://my.clevelandclinic.org/health/diseases/4314-hypertension-high-blood-pressure		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for medication administration for one of four residents observed during the medication administration observation, Resident #25. The findings include: For Resident #25 (R25), the facility staff crushed Toprol XL extended release (1) during the medication administration observation on 7/7/2026. On 7/7/2026 at approximately 9:18 AM, an observation was made of licensed practical nurse (LPN) #3 preparing medications for R25. LPN #3 was observed to remove a Metoprolol succinate ER (extended release) 50 mg (milligram) tablet from the packaging and proceeded to crush the medication along with other scheduled medications for R25. LPN #3 stated that R25 was unable to swallow the pills whole and required all the medications to be crushed and taken in applesauce. The physician orders for R25 documented in part, - Toprol XL Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN (hypertension). Order Date: 06/22/2026.- Crushable Medications May Be Crushed. Order Date: 06/20/2026. The comprehensive care plan for R25 documented in part, Special Instructions: MEDS CRUSHED IN APPLESAUCE/PUDDING. On 7/9/2026 at 8:59 AM, an interview was conducted with licensed practical nurse (LPN) #5 who stated that if a resident could not swallow their medication whole there was normally a note in the medical record saying to crush the medications. She stated that if it was an extended release medication it should not be crushed and the nurse would contact the nurse practitioner to change it to something that could be crushed or a liquid. LPN #5 stated that this was done because the extended release medications were made to work slowly and if they were crushed they did not work that way. On 7/9/2026 at 10:26 AM an interview was conducted with the pharmacist who stated that Toprol XL extended release should not be crushed because it was designed to be released over 24 hours and if it was crushed it defeated the purpose. He stated that if the resident could not swallow the medication whole the physician should change it to another medication that could be crushed. The facility policy Medication/Treatment Administration revised 5/30/2023 documented in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . Administer medication as ordered in accordance with manufacturer specifications . Crush medications as ordered. Do not crush medications with do not crush instructions . On 7/9/2026 at 2:14 PM, the Administrator and Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Toprol XL- Metoprolol comes as a tablet, an extended-release (long-acting) tablet, and an extended-release capsule to take by mouth. Take the regular tablet once or twice a day with meals or immediately after meals. Take the extended-release tablet and extended-release capsule once a day. To help you remember to take metoprolol, take it around the same time(s) every day. Take metoprolol exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. The extended-release tablet may be split. Swallow the whole or half extended-release tablets whole; do not chew or crush them . This information was obtained from the website: Metoprolol: MedlinePlus Drug Information		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide pressure injury treatment per the physician's order for one of 26 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to provide pressure injury (1) treatment per the physicians order when the wound vac (2) was not functioning on 3/22/2026-2/23/2026. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 1/19/2026, the resident was assessed as having one Stage II pressure injury and one Stage IV pressure injury, both of which were present on admission. The comprehensive care plan for R6 documented in part, [Name of R6] has pressure ulcer presents with a stage IV R hip and stage 2 sacrum pressure injury. And is at further risk for skin breakdown r/t (related to) Immobility, decreased mobility, comorbidities, incontinence of stool. 2/26-Has chronic hip wound, stage IV. Pt is refusing turning /off loading and proper wound care. Has declined wound vac. Bone is exposed. 3/17 - Mid Scalp - Resolved. Date Initiated: 01/26/2026 . Under Interventions it documented in part, Administer treatments as ordered and monitor for effectiveness. Date Initiated: 01/26/2026. The physician orders for R6 documented in part, RIGHT HIP: Cleanse with normal saline, pat dry apply vashe moistened gauze pads to the area and let it sit for 10mins, rinse with normal saline, pat dry gently tuck Aquacel Ag rope in wound bed and undermining and cover with Drawtex absorbent dressing and cover with bordered foam. every 24 hours as needed for If wound vac stops working AND every day shift. Order Date: 02/25/2026 . The physician orders failed to evidence an order for use of a wet to dry dressing when the wound vac was not working. The progress notes documented in part, - 3/22/2026 9:12 PM Note Text : During the shift the wound vac was beeping. Resident wound vac therapy was changed to wet to dry dressing due to unavailability of wound vac canister. - 3/23/2026 3:00 PM Note Text : Resident's wound vac noted not working per previous nurse. Wound vac not in use; wet to dry dressing applied. - 3/24/2026 11:50 AM Note Text : Wet to dry dressing completed to stage 4 wound to right hip. - 3/24/2026 1:39 PM Note Text : New wound vac cannister delivered to facility. Previous wet to dry dressing removed. Wound vac applied to resident's wound on right hip per order. Dressing intact with appropriate seal noted. No signs of leakage observed. Resident tolerated dressing change. On 7/9/2026 at 8:23 AM, an interview was conducted with licensed practical nurse (LPN) #1 who stated that she worked with R6 when they were at the facility. She stated that R6 had a pressure injury that was followed by the outpatient wound clinic and had a wound vac in place. She stated that there were times when R6 would refuse the wound vac and they would put a wet to dry dressing in place and when the wound vac was not working they used a wet to dry dressing. LPN #1 stated that a wet to dry dressing was wetting gauze with normal saline and placing that on the wound and then covering it with dry gauze and then a foam dressing. The facility policy Pressure Injury Prevention and Management revised 6/12/2024 documented in part, . This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries . On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) Pressure sores are sores on your skin. They're caused by being in a bed or wheelchair nearly all the time. Sometimes they're called bedsores or pressure ulcers . Stage 1. During this stage, the area of the sore looks red. It may feel warm to the touch. It may burn, hurt, or itch. The pressure sore may look blue or purple in people who have dark skin. Stage 2. During this stage, the area is more damaged. The sore may be open. It may look like a (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cut or blister. The skin around the sore may be discolored. The sore is painful. Stage 3. During this stage, the sore will have a crater-like look. This is due to increased damage below the surface. This makes the wound deeper. Stage 4. This is the most serious stage. Skin and tissue are severely damaged. The sore becomes a large wound. Infection is possible. You're likely able to see muscle, bones, tendons, and joints . This information was obtained from the website: Pressure Sores Family Doctor(2) To help some surgical wounds heal, you may have a wound VAC (vacuum-assisted closure) dressing. It increases blood flow in the wound and helps with healing. This is a negative pressure (vacuum) dressing. There is a vacuum pump, a foam piece cut to fit the wound, and a vacuum tube. A clear dressing is taped on top. The dressing and the foam piece are changed every 2 to 3 days. It may take days, weeks, or even months for the wound to be clean, clear of infection, and finally heal . This information was obtained from the website: Surgical wound infection - treatment: MedlinePlus Medical Encyclopedia		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to administer scheduled enteral feeding for one of 26 residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to evidence the administration of scheduled enteral feeding. On the most recent MDS (minimum data set) assessment, discharge assessment with a reference date of 4/24/2026, the resident was assessed as having a PEG (1) (percutaneous endoscopic gastrostomy) tube and receives 51% or more of calories from enteral feeding. The resident's BIMS (brief interview for mental status) score was assessed at 15, indicating he was intact for making daily decisions. The resident's diagnoses included but are not limited to malignant neoplasm of mouth (2), dysphagia (3), difficulty in walking, hypertension (4). -The physician's order for R8 documented in part Enteral Feed Order two times a day Nutren 2.0 via pump @ 60ml (milliliters)/hr (hour) x20 hrs (hours) START infusion 1200 and continue until 1200mL. Automatic flush to run concurrent with feeding @ 50ml/hr x20 hrs via pump until 1000mL STOP TIME 0800. -The April MAR (medication administration record) failed to evidence by means of a blank box on the MAR, that R8's enteral feeding was administered on 4/23/2026 at 16:00 (4:00PM). -The Dietician's note on 4/21/2026, documents in part, Note: Nutritional Intervention: Nutrition Support Nutren 2.0 via pump @ 60ml/hr x20 hrs START infusion 1200 and continue until 1200mL. Automatic flush to run concurrent with feeding @ 50ml/hr x20 hrs via pump until 1000mL STOP TIME 0800 TV: 1200mL, 2400kcal, 106g protein, 828mL of FW (filtered water), 120% RDIs (recommended daily intakes), TFWF (total food and water fluid): 1828mL. On 7/7/2026 at 2:55 PM, an interview was conducted with LPN #6. When asked they stated that central supply takes care of stocking enteral food and they stock the supply/medication room every day. When asked if there are times, they do not have enteral feeding in stock, they stated normally it is in stock unless it is something they don't normally administer but they can check downstairs if it is not in stock in the supply/medication room. LPN #6 stated that for new admissions they secure the needed enteral feeding by first checking the supply/medication room, and if none is there, then they will check downstairs where they keep a larger supply. If it is not in either place, then they will call the MD for a substitution. On 7/8/2026 at 8:25 AM, an interview was conducted with LPN #7. They stated that enteral feeding is kept in the medical supply room and it is always stock and they never have a problem with it not being stocked however if they would ever not have what is order the appropriate step would be to call the doctor and let him/she know what is available, for a substitution until they receive the ordered feeding. On 7/8/2026 at 9:50 AM, an interview was conducted with Central Supply Coordinator. When asked how they decide what supplies to order, they stated it is determined by the census, and the census is checked daily, and this applies to enteral feeding. The Central Supply Coordinator stated that they have three units. Enteral feeding is kept in the main unit for Main, South and East. [NAME] has their own supply room and keeps their enteral feeding there. The Central Supply Coordinator stated there is also a storage supply downstairs that they keep additional supplies should the unit run out. When asked the Central Supply Coordinator stated they order supplies every two weeks and if their normal supplier does not have the supplies they need, they will call their representative who will get the supplies from a different vendor. An interview was conducted with RN (registered nurse) #1, a unit manager, on 7/8/2026 at 10:43 a.m. RN #1 stated the nurse evidence that they've given medication/treatment by documenting it on the MAR. Medications are administered within an hour before or an hour after the scheduled time. On 7/8/2026 at 2:24 PM, an interview was (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the Dietician who stated that the R8 was admitted to the facility on a bolus and they changed R8's order to Nutren for higher calories and weight gain. The Dietician stated that they are not aware of the facility ever having any shortages of enteral feeding or syringes.No policy was provided.On 7/9/2026 at 2:38 PM, the Administrator and Director of Nursing were notified of the findings.No further information was provided prior to exit. Reference:PEG tube- A PEG tube stands for Percutaneous Endoscopic Gastrostomy tube. It is a flexible feeding tube placed through the abdominal wall directly into the stomach. This allows nutrition, fluids, and medications to be delivered while completely bypassing the mouth and esophagus. https://southlakegastro.com/understanding-percutaneous-endoscopic-gastrostomy/ Malignant neoplasm- A malignant neoplasm is the medical term for cancer. It is an abnormal mass of tissue created by cells that grow uncontrollably. https://jamanetwork.com/journals/jamaoncology/article-abstract/2768634Dysphagia- Dysphagia means you cannot swallow well. https://www.enthealth.org/conditions/dysphagia/Hypertension- Hypertension, or high blood pressure, means the force of blood pushing against your artery walls is consistently too high. It forces your heart to work harder and, over time, damages blood vessels, potentially leading to serious health risks like heart attacks, stroke, and kidney disease. https://my.clevelandclinic.org/health/diseases/4314-hypertension-high-blood-pressure		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to provide care and services for a PICC line for two of 26 residents in the survey sample, Residents #18 and #19. The findings include: 1. For Resident #18 (R18), the facility staff to assess a PICC (1) line for placement. R18 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: benign prostatic hypertrophy (1), bladder cancer and urinary tract infection. The MDS (minimum data set) assessment, and admission assessment, with an assessment reference date of 6/18/2026, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section H &ndash; Bladder and Bowel, the resident was coded as having an indwelling catheter. In Section O &ndash; Special Treatments, Procedures and Programs, the resident was coded as having a Midline IV (intravenous) access. The physician order dated 6/17/2026, documented, Observe Midline insertion site and surrounding areas. Monitor IV site for infiltration, bruising, pain IV infiltration, s/s (signs and symptoms) of infection. The comprehensive care plan dated, 6/15/2026, documented in part, Focus: MIDLINE: (R18) has a midline r/t (related to) ABT (antibiotic)/IV/ midline of the upper arm the catheter. Interventions: Weekly measure the arm circumference 3 inches above the insertion site and the length of the catheter form the insertion site to the tip of the catheter and document. If swelling to the arm or migration of the catheter is noted, notify the MD (medical doctor). Review of the TAR (treatment administration record) failed to evidence any documentation of the measuring of the arm circumference or catheter length. An interview was conducted with LPN (licensed practical nurse) #9 on 7/9/2026 at 8:25 a.m. LPN #9 described the process of administering medications through a PICC line. LPN #9 stated that during the weekly dressing change of the PICC line, the nurse looks for redness and swelling and make sure the line is intact. When asked if she measures the PICC line or the circumference of the arm above the line, LPN #9 stated she has never measured it, she just looks at it. The care plan above was shared with LPN #9. She stated that she has never seen that before. The facility policy, Care and maintenance of Central Venous Catheter, failed to evidence any documentation related to measuring the length of the catheter. Catheter assessment: External catheter length (in cm from insertion site to first hub): compare to documented insertion length; document any change. Patency: flushed easily; blood return present or absent (document if absent). Lumens used and functional.External length monitoring is the primary (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside tool for detecting catheter migration. If external length has decreased (catheter advanced in), tip may now be in RA &mdash; requires imaging. If external length increased (catheter withdrawn out), tip may be too proximal for central infusions. (2) The Administrator and Director of Nursing were made aware of the above concern on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit. (1) A peripherally inserted central catheter (PICC) is a long, thin tube that goes into your body through a vein in your upper arm. The end of this catheter goes into a large vein near your heart. Your health care provider has determined that you need a PICC. The information below tells you what to expect when the PICC is inserted . This information was obtained from the website: Peripherally inserted central catheter - insertion: MedlinePlus Medical Encyclopedia (2) This information was obtained from the following website: https://clinical-database.com/vascular-access/guides/picc-lines/picc-care-maintenance/ 2. For Resident #19 (R19), the facility staff failed to measure arm circumference and length of catheter ports of a PICC (peripherally inserted central catheter) (1) following professional standards of practice. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 6/5/2026, the resident was assessed as receiving IV (intravenous) medications while a resident. The physician orders documented orders to change the dressing to the PICC line site weekly and as needed, change the needless caps weekly and as needed and assess the site for infiltration, bruising, swelling, pain, and signs or symptoms of infection every shift. The orders failed to evidence an order to measure the length of the exposed IV catheter ports or measure the circumference of the arm the PICC line was located in. The comprehensive care plan for R19 documented in part, PICC LINE: The resident has a PICC line r/t (related to) ABT/IV (antibiotic/intravenous) for leg infection. Date Initiated: 06/18/2026. On 7/9/2026 at 8:25 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that PICC line dressings were changed weekly and the site was assessed for swelling to make sure the line was intact. She stated that they did not measure the PICC line catheter ports or the arm and only observed the site. On 7/9/2026 at 9:20 AM, an interview was conducted with registered nurse (RN) #1 who stated that there were batch orders put in place when a resident came in with a PICC line. She stated that they followed the SASH protocol (2), changed the PICC line dressing weekly and assessed the PICC line (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	site for infiltration and any redness when starting the medication. RN #1 stated that they did not measure the circumference of the arm or measure the length of the catheter ports unless there was an order in place to do so. On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) A peripherally inserted central catheter (PICC) is a long, thin tube that goes into your body through a vein in your upper arm. The end of this catheter goes into a large vein near your heart. Your health care provider has determined that you need a PICC. The information below tells you what to expect when the PICC is inserted . This information was obtained from the website: Peripherally inserted central catheter - insertion: MedlinePlus Medical Encyclopedia (2) The SASH Protocol: SASH (Saline-Administer-Saline-Heparin) or SASSaline-only variant (SAS) is the standard PICC flushing protocol . This information was obtained from the website: PICC Line Care and Maintenance: Dressing Changes, Flushing, and Removal The Clinical Database		

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NAME OF PROVIDER OR SUPPLIER Vierra Falls Church		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Powhatan Street Falls Church, VA 22043	
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to administer pain medications as ordered for one of 26 residents. The findings include: For Resident #8 (R8), the facility staff failed to evidence the administration of pain medication as scheduled and failed to evidence administering pain medication on time. On the most recent MDS (minimum data set) assessment, discharge assessment with a reference date of 4/24/2026, the resident was assessed as having a PEG (1) (percutaneous endoscopic gastrostomy) tube and receives 51% or more of calories from enteral feeding. The resident's BIMS (brief interview for mental status) score was assessed at 15, indicating he was intact for making daily decisions. The resident's diagnoses included but are not limited to malignant neoplasm of mouth (2), dysphagia (3), difficulty in walking, hypertension (4).-The physician's order for R8 documented in part Pregabalin Oral Capsule 150 mg, Give 1 capsule via G-tube two times a day for squamous cell carcinoma of oral cavity. Start Date-4/21/2026 900 (9:00 AM); D/C (discontinue) date 4/21/2026 13:08 (1:08 PM).-The physician's order for R8 documented in part Lyrica Oral Solution 20 mg/ml (Pregabalin), Give 8.5 ml via G-tube every morning and at bedtime for neuropathic pain. Start Date 4/21/2026 2000 (8:00 PM); D/C date 4/24/2026 1222 (12:22 PM).-The physician's order for R8 documented in part Acetaminophen Oral Liquid 650 mg/20.3ml via G-tube three times a day for pain. Start Date 4/21/2026 2000 (8:00 PM); D/C date 4/24/2026 1222 (12:22 PM).-The April MAR (medication administration record) failed to evidence by means of a #9 (coded to see progress note) in the box on the MAR, that R8's medication was not administered on 4/21/2026 at 9:00AM. The progress note, was reviewed and documented in part, pain medications have not been delivered from pharmacy.-The April Medication Admin Audit Report, documented in part, that R8's Lyrica Oral Solution 20 mg/ml and Acetaminophen Oral Liquid 650 mg/20.3ml were not administered on 4/23/2026 at 8:00AM as ordered but administered, three and a half hours later at 11:32AM. On 7/7/2026 at 2:55 PM, an interview was conducted with LPN #6, who stated that if a medication is not available, they check the limited lock box first which is an extension of Omnicare. If it is not in stock, they will call third eye or the MD on call. On 7/8/2026 at 2:45 PM, an interview was conducted with the DON, who stated pain medication should be administered immediately as prescribed and if it is given late, the nurse should document that it was given late. The DON further stated that the expectation is that staff document as they administer a medication and if a pain medication is scheduled it can be administered one hour before and no later than an hour after the ordered time. On 7/9/2026 at 8:45 AM, an interview was conducted with LPN #1, When asked what is the expectation for administering pain medication, LPN #1 stated pain medication should be given at the scheduled time but it can be given one hour before the scheduled time or if a nurse is behind no later than one hour after the scheduled time. LPN #1 further stated if the medication is late, a note should be written in the progress note and a notation should be made in the MAR. When shown the MAR with a 9 in it, she stated this mean there is a nurses' note in the progress notes about the medication. A review of the facility's policy NURM-026: Medication/Treatment Administration, revised on 5/30/2023, documented in part, that medications should be administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. On 7/9/2026 at 2:38 PM, the Administrator and Director of Nursing were notified of the findings. No further information was provided prior to exit. Reference: PEG tube- A PEG tube stands for Percutaneous Endoscopic Gastrostomy tube. It is a flexible feeding tube placed through the abdominal wall directly into the stomach. This allows nutrition, fluids, and medications to be delivered while completely bypassing the mouth and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	esophagus. https://southlakegastro.com/understanding-percutaneous-endoscopic-gastrostomy/ Malignant neoplasm- A malignant neoplasm is the medical term for cancer. It is an abnormal mass of tissue created by cells that grow uncontrollably. https://jamanetwork.com/journals/jamaoncology/article-abstract/2768634 Dysphagia- Dysphagia means you cannot swallow well. https://www.enthealth.org/conditions/dysphagia/ Hypertension- Hypertension, or high blood pressure, means the force of blood pushing against your artery walls is consistently too high. It forces your heart to work harder and, over time, damages blood vessels, potentially leading to serious health risks like heart attacks, stroke, and kidney disease. https://my.clevelandclinic.org/health/diseases/4314-hypertension-high-blood-pressure		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to obtain laboratory tests per the physician orders for three of 26 residents in the survey sample, Residents #4, #6 and #7. The findings include: 1. For Resident #4 (R4), the facility staff failed to obtain physician ordered laboratory tests, a complete blood count (CBC) (1). Resident #4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: diabetes, aftercare following joint replacement surgery, diabetes, and anemia. On the most recent MDS (minimum data set) assessment, a Medicare five-day assessment, the resident was coded as scoring an 11 out of 15 on the BIMS (brief interview for mental status score, indicating the resident was moderately impaired for making cognitive daily decisions. The physician order dated, 9/5/2025 documented, CBC and BMP (basic metabolic panel) (2) every night shift every Wed (Wednesday) and Sun (Sunday) for routine labs (laboratory tests). The start date was documented as 9/7/2025 and end date of 10/3/2025. Review of the clinical record failed to evidence that these physician order lab tests were completed. The comprehensive care plan dated, 9/1/2025, documented in part, NURSING CARE NEEDS. Interventions: Labs/radiology tests as ordered by the physician or as needed. On 7/9/2026 at 8:23 AM, an interview was completed with LPN #1 who stated that the lab came in daily to draw ordered labs. She stated that routine labs were drawn Monday through Friday and if needed labs could be entered as stat and were drawn within one to two hours. LPN #1 stated that the results went directly into the medical record. An interview was conducted on 7/9/2026 at approximately 10:30 a.m. with the attending physician for R4. He reviewed the clinical record and stated the lab tests were not done per his order. Stating the resident should have had blood drawn 9/8/2025 and 9/11/2025. The facility policy, Laboratory Services and Reporting documented in part, Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. The Administrator and Director of Nursing were made aware of the above findings on 7/9/2026 at approximately 4:30 p.m. No further information was provided prior to exit. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A complete blood count (CBC) test measures the following: The number of white blood cells (WBC count). The number of red blood cells (RBC count). The number of platelets. The total amount of hemoglobin in the blood. The fraction of the blood composed of red blood cells (hematocrit). This was obtained from the following website: https://medlineplus.gov/ency/article/003642.htm. 2. A basic metabolic panel (BMP) measures eight different substances in your blood. It provides important information about your body's fluid balance, your metabolism (the process your body uses to make energy from food you eat), and how well your kidneys are working. This test is often used to check your general health. This information was obtained from the following website: https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/. 2. For Resident #6 (R6), the facility staff failed to obtain labs per the physicians order on 3/23/2026. The comprehensive care plan for R6 documented in part, FALL: [Name of R6] is at risk for falls r/t (related to) Other low back pain, Chronic Systolic (Congestive) heart failure, Gait/balance problems. [Name of R6] had an actual fall and at risk for further falls. Date Initiated: 01/13/2026 . Under Interventions it documented in part, .Continue to monitor residents and labs ordered. Date Initiated: 03/23/2026. The physician orders for R6 documented in part, CBC (complete blood count),CMP (comprehensive metabolic panel), UA C&S (urinalysis culture and sensitivity) one time only for 1 Day. Order Date: 03/23/2026. The progress notes documented in part, - 3/23/2026 7:03 AM Note Text: Today, in this morning, the lab person didn't come to East, so writer placed a call to the lab center and spoke to the staff, [Name of staff]. She stated she didn't know when the lab person was going to come but anyway the lab person was going to come to this facility. waiting to come. The progress notes failed to evidence any further follow up regarding the labs or the lab work being obtained prior to R6 being sent to the emergency room on 3/25/2026. Review of the clinical record failed to evidence the CBC and CMP being collected or resulted prior to R6 being sent to the emergency room on 3/25/2026. On 7/9/2026 at 7:48 AM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that the lab came in between 3:00-5:00 AM Monday through Friday and Sundays. She stated that stat labs were completed on Saturdays as needed and if a lab was not completed as ordered they contacted the lab for them to come in that day to draw them. On 7/9/2026 at 8:04 AM, an interview was conducted with LPN #4 who stated that on 3/23/2026 the lab did not come to the unit to draw the ordered labs. She stated that she had called the lab manager who said that someone was coming in later that day to draw the labs. LPN #4 stated that she had put the progress note in and reported off to the day shift nurse and thought that the lab had come in after (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she went home from her shift. thing in my notes. On 7/9/2026 at 8:23 AM, an interview was completed with LPN #1 who stated that the lab came in daily to draw ordered labs. She stated that routine labs were drawn Monday through Friday and if needed labs could be entered as stat and were drawn within one to two hours. LPN #1 stated that the results went directly into the medical record. On 7/9/2026 at 8:59 AM, an interview was conducted with registered nurse (RN) #1 who stated that the lab came in every day except the weekends for routine labs. She stated that if a lab was not drawn on the day it was supposed to be done, they contacted the lab to have them come back to draw it and it would be done within a four hour window. On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit. 3. For Resident #7 (R7), the facility staff failed to obtain labs per the physicians order on 3/23/2026. The comprehensive care plan for R7 documented in part, Nursing Care Needs: [Name of R7] has clinical care needs r/t (related to) Traumatic Subdural Hemorrhage with loss of consciousness status unknown . Date Initiated: 03/19/2026 . Under Interventions it documented in part, .Labs/radiology tests as ordered by the physician or as needed. Date Initiated: 03/19/2026 . The physician orders for R7 documented in part, CBC (complete blood count), BMP (basic metabolic panel) every night shift every Wed, sun for SAH (subarachnoid hemorrhage) . Order Date: 03/19/2026. The progress notes documented in part, - 3/23/2026 6:23 AM Note Text: Today, in this morning, the lab person didn't come to East, so writer placed a call to the lab center and spoke to the staff, [Name of staff]. She stated she didn't know when the lab person was going to come but anyway the lab person was going to come to this facility. waiting to come. The progress notes failed to evidence any further follow up regarding the labs or the lab work being obtained prior to R7 being sent to the emergency room on 3/24/2026. Review of the clinical record failed to evidence the CBC and BMP being collected or resulted prior to R7 being sent to the emergency room on 3/24/2026. On 7/9/2026 at 7:48 AM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that the lab came in between 3:00-5:00 AM Monday through Friday and Sundays. She stated that stat labs were completed on Saturdays as needed and if a lab was not completed as ordered they contacted the lab for them to come in that day to draw them. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2026 at 8:04 AM, an interview was conducted with LPN #4 who stated that on 3/23/2026 the lab did not come to the unit to draw the ordered labs. She stated that she had called the lab manager who said that someone was coming in later that day to draw the labs. LPN #4 stated that she had put the progress note in and reported off to the day shift nurse and thought that the lab had come in after she went home from her shift. thing in my notes. On 7/9/2026 at 8:23 AM, an interview was completed with LPN #1 who stated that the lab came in daily to draw ordered labs. She stated that routine labs were drawn Monday through Friday and if needed labs could be entered as stat and were drawn within one to two hours. LPN #1 stated that the results went directly into the medical record. On 7/9/2026 at 8:59 AM, an interview was conducted with registered nurse (RN) #1 who stated that the lab came in every day except the weekends for routine labs. She stated that if a lab was not drawn on the day it was supposed to be done, they contacted the lab to have them come back to draw it and it would be done within a four hour window. On 7/9/2026 at 2:14 PM, the Administrator and the Interim Director of Nursing were made aware of the concern. No further information was provided prior to exit.		