STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495432	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vierra Falls Church	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of facility policies, the facility failed to ensure equipment used in the kitchen was clean when not in use; failed to ensure food stored in the kitchen's dry food storage, walk-in freezer, and refrigerator in the cooking area were dated with opened date and not expired; failed to ensure temperature of foods added to the steam table were checked before serving; and failed to ensure staff did not touch food and plate surfaces with their (gloved) hands while they were placing food on plates. These failures had the potential to increase the prevalence and spread of foodborne illness and infection for 138 residents. Findings include: 1. During the initial inspection of the facility's kitchen on 04/20/26 at 8:30 AM an accumulation of a dark substance was observed on the inside of the can opener device. In a concurrent interview with [NAME] 1, she observed the can opener device and when asked if it was dirty and needed to be cleaned, she said, Yes. During the initial inspection of the kitchen's refrigerator on 04/20/26 at 8:35 AM in the cooking area by the steam table, revealed an opened and undated 16-ounce container of Roasted Chicken Base. In a concurrent interview with [NAME] 1, she confirmed it was open and when asked if the date opened was marked on the container, [NAME] 1 stated, No. When asked if the date opened was supposed to be marked on the container, [NAME] 1 stated, Yes. During the initial inspection of the kitchen's dry storage on 04/20/26 at 9:03 AM, a box of individually wrapped soft baked cookies was observed opened and one third full. There was no open date on the box or individual cookie packaging. There were three 5-pound boxes of Krusteaz Homestyle Cornbread mix with no opened date on the boxes or the opened packaging they were in. During the initial inspection of the kitchen's walk-in freezer on 04/20/26 at 9:07 AM, an open package of food was observed with no open date marked on it and the label was unreadable. Follow-up observation of the kitchen's dry storage with the Dietary Manager (DM) on 04/20/26 at 9:24 AM revealed a 6-pound can of Red Peppers with an unreadable stamped date. In a concurrent interview with the DM, when asked if she could read the stamped date on the can of Red Peppers, she stated, No. When asked if the can was supposed to be marked with the date, the DM stated, Yes. During a follow-up observation of the kitchen's walk-in freezer on 04/20/26 at 9:25 AM, the DM observed the opened package of food and confirmed there was no open date marked on it. When asked what it was, the DM stated Vegetables and when asked if it should be marked with the date it was opened, the DM stated, Yes. During follow-up observation of the kitchen's dry storage on 04/23/26 at 3:00 PM, the DM observed the box of individually wrapped soft cookies and the three 5-pound boxes of Krusteaz Homestyle (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cornbread Mix and confirmed there were no date when opened on them. 2. During observation of the kitchen staff's preparation of lunch trays on 04/22/26 from 11:15 AM to 12:30 PM, the following findings were observed: At 11:58 AM [NAME] 1 placed a new tray of meat sauce on the steam table and without checking the temperature, [NAME] 1 placed the meat sauce on residents' plates. [NAME] 1 also placed broccoli on the steam table at 12:07 PM, 12:12 PM, and 12:17 PM and without checking the broccoli temperature, she placed it on residents' plates. At 11:36 AM [NAME] 1 touched the spaghetti hanging off the side of two plates with her gloved hand and lifted it to the plate surfaces, then she touched the scoops and the ledge/shelf of the steam table and then touched spaghetti on another plate at 11:38 AM. [NAME] 1 touched the spaghetti hanging off the sides of plates with her gloved hand a total of 12 times during tray line (at 11:36 AM, 11:38 AM, and 11:46 AM on two plates, 11:47 AM on two plates, 12:18 PM on two plates and at 12:22 PM on two plates). [NAME] 1 also touched the surface of plates with the same gloved hands placing the palm of her hand on the surface of the plates four times (at 11:48 AM, 11:49 AM on two plates, and at 11:55 AM). Interview with [NAME] 1 and the DM immediately after tray line on 4/22/26 at 12:30 PM, when asked if [NAME] 1 should have touched the spaghetti with her gloved hand, the DM stated, No, she should have used the utensil. When asked if [NAME] 1 should have touched the surface of the plates, the DM stated, No. When asked if they were supposed to check the temperature of the meat sauce and broccoli after placing them on the steam table and before serving them to residents, the DM stated, I didn't know we were supposed to do that. Review of the facility's policy titled, Food Safety Requirements, revised 08/12/22 revealed, . Policy . It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety . l. Food safety practices shall be followed throughout the facility's entire food handling process. Thisprocess begins when food is received from the vendor and ends with delivery of the food to theresident. 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 . e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food . Practices to maintain safe refrigerated storage include . iv. Labeling, dating, and monitoring refrigerated food. Including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) /discarded; and . 6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to . c. Staff shall wash hands prior to handling clean dishes and shall handle them by outside surfaces or touch only the handles of utensils . 7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects . b. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli, paper, and spatulas . Review of the facility's policy titled, Record of Food Temperatures revised 08/12/22 revealed, Policy . It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled . 7. When holding hot foods for service, food temperature should be measured when placing it on the steam table line.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, interviews and policy review, the facility failed to ensure the trash dumpsters were not overfilled and were covered for three of three dumpsters and failed to ensure dumpsters had drain plugs for two of three dumpsters. These failures had the potential to attract rodents and insects and affect all residents in the facility.Findings include:During the initial kitchen inspection on 04/20/26 at 9:15 AM, three trash dumpsters outside the back door of the kitchen were observed with lids open and trash piled higher than the top of the dumpster. Two of the dumpsters did not have drain plugs, creating an opening at the bottom edges for rodents and insects to enter. During an interview with Dietary Aide (DA)1 on 04/20/26 at 9:15 AM, he observed all three dumpsters had open lids and trash piled higher than the top of the dumpsters and two of them did not have drain plugs. DA1 stated, I didn't know. During an interview with the Dietary Manager (DM) on 04/22/26 at 12:32 PM, she observed the dumpsters and all three of them had open lids, and two of the three did not have drain plugs. She confirmed the findings and stated, I didn't know. Review of the facility's policy titled, Disposal of Garbage and Refuse revised 08/12/22 revealed, Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids. doors, or covers. Containers and dumpsters shall be kept covered when not being loaded.Storage areas, enclosures, and receptacles for refuse shall be maintained in good repair and cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to offer advanced directive information for one of five residents (Resident (R)13) reviewed for advanced directives in the sample of 31. The failure to discuss advanced directive information with the residents and resident representatives could potentially affect their ability to make informed decisions about their care. Findings include:Review of R13's electronic medical record (EMR) admission Record under the Profile tab identified that R13 was admitted to the facility on [DATE]. Review of R13's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/30/25 with a Brief Interview Mental Status (BIMS) score of seven out of 15 indicated R13's cognition was significantly impaired. Review of R13's undated SOCIAL SERVICES HISTORY & INITIAL ASSESSMENT indicated, Titled Advanced Care Planning.Does the patient have Advanced Directive.the answer was No.If No, was information about advanced directives offered.information not offered. Interview on 04/21/26 at 3:34PM, the Administrator reviewed the document and stated, No family could be found. the resident was not in a state to sign, and we did not offer her the advanced directives information. Review of the facility's policy titled SS024: Residents' Rights Regarding Treatment and Advanced Directives dated 08/15/2022 indicated, Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advanced directive.Policy Explanation and Compliance Guidelines. 2. The facility will provide the resident or the resident's representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and to formulate an advanced directive.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, interview, policy review, the facility failed to ensure one of one resident (Resident (R) 9) and their resident representative (RR) reviewed for emergency hospital transfer out of a survey sample of 31 residents, was provided with a written transfer/discharge notice which contained the appeal process. This failure had the potential to affect the resident and their RR by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for the resident transferred to the hospital. Findings include:Review of R9's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 03/27/26. Review of R9's EMR admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/26 indicated a 'Brief Interview for Mental Status (BIMS) score of zero out of 15 which revealed the resident was severely cognitively impaired. Review of R9's EMR SBAR [Situation, Background, Assessment, Recommendation] for Providers dated 04/08/26 located under the Prog (Progress) Note tab indicated that the resident sustained a change in her condition in which the resident was found with copious amounts of pus from her gastrostomy tube (G-tube) site. Both the medical provider and the RR were notified of the condition of the resident. The medical provider ordered that the resident be transported immediately to the emergency room for evaluation and treatment. Review of R9's EMR revealed no evidence that the resident and/or her RR were provided with a written emergency transfer notice which included the appeal rights to the transfer/discharge. During an interview with the Administrator on 04/23/26 at 4:40 PM, he stated that he was unaware of the requirement for a transfer/discharge notice along with the appeal requirements. Review of the facility's policy titled Transfer and discharge date d 01/17/25 indicated, . It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include.the following at the time it is provided. An explanation of the right to appeal the transfer or discharge to the State.The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. Information on how to obtain an appeal form.Information on obtaining assistance in completing and submitting the appeal hearing request.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to revise the comprehensive care plan to include comfort care for one of 31 sample residents (Resident (R) 110) reviewed for care plans. The failure had the potential to affect the resident's medical, nursing, mental, and psychosocial needs not met causing an adverse reaction related to unnecessary cares given. Findings include: Review of R110's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/20/25 and located in the electronic medical record (EMR) under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) unable to perform which indicated the resident had severe cognitive impairment. The MDS revealed the resident was admitted on [DATE] with diagnoses to include hypertensive heart disease, hypertensive chronic kidney disease stage four, and palliative care. Review of R110's EMR comprehensive care plan located under the Care Plan tab with an initiated date of 03/14/25 did not include comfort care for R110. During an interview on 04/21/26 at 11:00 AM, Licensed Practical Nurse (LPN)2 stated that a resident receiving comfort care should be included on the care plan to help communicate the care needed for that resident. During an interview on 04/21/25 at 12:40 PM, the MDS Coordinator (MDSC) stated that comfort care should be included on the care plan so that staff know the needs of the resident. During an interview on 04/21/26 at 4:15 PM, the Director of Nursing (DON) confirmed that after reviewing R110's care plan, that comfort measures were not listed as care needs. The DON stated the care plan lets all nursing staff know how to properly take care of a resident. The DON stated that not including comfort care, could lead to staff providing cares that may cause unnecessary cares being provided. Review of the facility's policy titled, Comprehensive Care Plans indicated, .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 residents comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, document review and policy review, the facility failed to ensure showers were provided for two (Resident (R)22 and (R)161 of two residents reviewed in the sample of 31 residents. Specifically, R22 and R161's records lacked documentation of showers being provided according to the facility's shower schedule.Findings included1. During an interview on 04/20/26 11:24 AM, family member (FM) 1stated that resident is supposed to get two showers a week but last week the second week of his stay he did not get one shower. She said his shower days are on Monday and Thursdays in the morning. She said now it is Monday again and she will see if he gets one today. During an interview on 04/21/26 at 10:30 AM, R22 and FM1 stated that yesterday (Monday) no one came and asked him about a shower or if he wanted to have a shower. So, he missed his third shower in a row. FM1 stated that R22 may be going home on Thursday and maybe he could have a shower before he went home. During an interview on 04/22/26 at 2:05 PM, R22 stated that he still had not had a shower. Review of R22's admission Record in the EMR under the Profile tab indicated the resident was admitted on [DATE] with diagnoses of arthritis of left knee and hip, muscle weakness, and lack of coordination. Review of R22's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/04/26 and located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognitive impairment. The MDS revealed under preferences for customary routine and activities that it was very important to the resident to choose between a shower or a sponge bath and that R22 was dependent on staff for shower and bathing. Review of R22's Care Plan revised 04/07/26, located in the EMR under the Care Plan tab revealed R22 needs assistance for Activities of Daily Living (ADLs) due to impaired mobility/cognition/communication. Interventions included: Date initiated 04/7/26 honor R22's ADL preference. Date initiated 03/30/26 Bathing/Showering R22 requires dependent assistance by (1) staff with bathing/showering twice/week and as necessary. Review of facility's Shower Assignment Certified Nurse Aide (CNA) located in the CNA binder on the nursing unit station, indicated that R22's bed number was to get a shower on Mondays and Thursdays on the day shift. During an interview on 4/21/26 at 1:45 PM, CNA2 stated that she gives showers according to the listing schedule in the CNA book at the nurse's station. CNA2 said after she completes the shower she documents it in the EMR under the Task tab, so it is recorded in the record. During an interview on 4/21/26 at 1:55 PM, Licensed Practical Nurse (LPN)1 stated that showers are assigned to each resident according to the bed assignment. The assignment grid or chart is in the CNA book. LPN1 stated if the resident refuses a shower the CNA will let her know. LPN1 stated after the shower is completed the CNA charts in the EMR that the shower was completed and how much assistance the resident needed. Review of the Plan of Care (POC) response history indicated that R22 should have received a shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/13/26, 04/16/26 and 04/20/26. Review of R22'sPOC document revealed CNA3 gave R22 a shower on 04/16/26 on the evening shift about 9:17 PM. Further review showed that on 04/13/26 and 04/20/26, CNAs documented that the shower was non-applicable (N/A). Review of CNA tasks for showering and bathing show revealed that CNA4 documented that she gave R22 a bed bath on 04/16/26 at 10:06 AM. During an interview on 04/23/26 at 11:52 AM, CNA4 stated that she had not given R22 a shower or a bed bath on 04/16/26 as documented at 10:06 AM. CNA4 stated she must have charted on the wrong resident. Review of R22's EMR Task tab for Shower and bathing shows the following: On 4/13/26 CNA5 documented at 10:06 AM that she gave R22 a bed bath. On 4/14/26 CNA5 documented at 5:18 PM R22 was given a shower. On 4/16/26 CNA4 documented at 10:06 AM that R22 was given a bed bath. On 4/17/26 CNA7 documented at 2:59 PM that R22 was given a shower. On 4/18/26 CNA7 documented at 8:14 PM that R22 was given a tub bath. On 4/20/26 CNA8 documented at 1:28 AM that R22 was given a shower. O 4/20/26 CNA9 documented at 2:14 PM that R22 was given a bed bath. During an interview on 04/22/26 at 11:30 AM, Assistant Director of Nursing (ADON) stated she would investigate each of the CNAs' documentation and acknowledge that the facility does not have a tub bath. 2. Review of R161's EMR admission Record located under the Profile tab indicated that the facility admitted the resident on 09/19/24 with a diagnosis of muscle weakness. Review of R161's EMR admission MDS with an ARD of 09/25/24 indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated that the resident required partial to moderate assistance with bathing, such as showers/baths. Review of R161's EMR Care Plan located under the Care Plan tab to provide the resident with a sponge bath if a full shower/bath could not be tolerated by the resident. Review of a document provided by the facility for R161 titled Documentation Survey Report for the month of 10/24 indicated that the resident received either a shower/bath or sponge bath on 10/01/24. A request was made to the Administrator for all bathing/shower records during R161's stay which would have included 09/24. No additional shower/bath records were provided by the end of the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey. During an interview on 04/22/26 at 12:20 PM, Director of Nursing (DON) stated that all residents were to be given two showers per week according to the schedule in the CNA book. DON stated it would be his expectation that the CNA would do the showers as directed by the schedule and document correctly. Review of the facility's policy titled Resident Shower dated 01/29/24 indicated, . It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided with showers as per request or as per facility schedule protocols and based upon resident safety.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to follow the facility's policy to obtain the admission weight and then weekly weights for additional four weeks for one resident (Resident (R) 4) out of seven residents reviewed for nutrition out of a sample of 31. In addition, R4's weight was not obtained after the admission weight and prior to Registered Dietitian (RD)1 assessment of R4's nutritional needs in regard to the enteral tube feeding. The failure to obtain an initial baseline weights for residents could cause the facility to not accurately determine weight loss or gain during the resident's stay. Findings include:Review of R4's electronic medical record (EMR) titled admission Record indicated the resident was admitted on [DATE] with the following diagnoses of dysphagia (difficulty swallowing, often caused by neurological disorders, Parkinson's, diabetes, and pneumonia. Review of R4's EMR titled Weights located under the Wts. (Weights) & Vitals tab failed to contain evidence that the resident was weighed each week for four weeks after admission. Review of R4's EMR admission Minimum Data Set with an Assessment Reference Date (ARD) of 04/10/26 indicated the resident's Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating moderate cognitive impairment. The MDS indicated R4's weight of 105 pounds on admission and had a swallowing disorder that required him to be fed entirely by feeding tube. Review of R4's EMR Progress Notes located under the Prog (Progress) Notes tab dated 04/14/26 revealed that Registered Dietitian (RD)2 identified on admission that resident was at risk for malnutrition related to being dependent on enteral feeding for total nutrition support, dysphagia, and low body mass index (BMI). RD2 recommends R4's weight to be done per facility protocol. Review of R4's EMR Care Plan located under the Care Plan tab dated 04/14/26 identified that the resident was at risk for malnutrition related to nothing by mouth (NPO) justification for tube feeding related to dysphagia, and Parkinson's. Interventions include the following:Monitor/record/report to MD as needed signs and symptoms of malnutrition: significant weight loss: 3 lbs. in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Weight per facility protocol and/or interdisciplinary team recommendation. Review of R4's EMR Nutrition/Dietary Note progress note located under the Prog (Progress) Notes tab dated 04/20/26 indicate R4's current body weight: 104.8 pounds, BMI: underweight. RD1 recommendation to increase feeding to meet estimated needs. (no updated weight since admission 20 days before). During an interview on 04/21/26 at 2:10 PM RD 1 stated that R4 entered the facility with a tube feeding and was weighed on admission.RD1 stated that she was unaware of the facility's policy for weights and how often they were done. She stated that she was not the dietitian that did his original nutritional assessment, but she was the dietician that made a note on 4/20/26. RD1acknowledged that she had not obtained another weight for the resident before she had done her assessment. RD1 states she had not noticed that he had not been weighed in 16 days. After review of the facility weight policy and admission weight were to be done once a week for four weeks, RD1 acknowledged that the resident should have been weight on 04/12/26 and 04/19/26. During an interview on 04/22/26 at 10:29 AM, Licensed Practical Nurse (LPN)5 stated that all new admission are weighed daily for three days then weekly for four weeks. LPN5 stated she knows who (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs to be weighed. LPN5 stated that she does get a list of all the resident who need to be weighed that day from the Director of Nursing (DON), so that she can makes sure the Certified Nurse Aide (CNA) who is assigned gets the weight. LPN5 could not explain why R4 had not been weighed since admission. During an interview on 04/23/2026 2:56 PM the DON stated his expectation is the weights will be done according to facility policy. DON acknowledged that the weights for R4 had not been done per facility policy. He missed two weeks of being weighed and it is important for the care of the resident. Review of a facility's policy titled Weight Monitoring dated 01/29/24 indicated, . weight can be a useful indicator of nutritional status.Weight Can be a useful indica creator of nutritional status. Significant unintended changes in weight (loss or gain) Or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 5. A weight monitoring schedule will be developed upon admission for all residents. Newly admitted residents-monitor weights weekly for four weeks. Residents with weight loss monitor weekly weights. If clinically indicated monitor weights daily as ordered by physician or nurse practitioner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, review of the facility's policy and the manufacturer's service manual for the oxygen (O2) concentrators, the facility failed to ensure O2 concentrators were maintained in accordance with manufacturers' specifications for two of two residents (Resident (R) 38 and R87) reviewed for oxygen use. This failure had the potential to contribute to increased shortness of breath and respiratory infections for R38 and R87. Findings include: On 04/20/2026 at 10:32 AM, R38 was observed in his room receiving oxygen via nasal canula Observation of the O2 concentrator in R38's room revealed a build-up of grey debris on the external surface of the filter. On 04/20/26 at 10:50 AM, R87 was observed lying in bed in her room and the O2 concentrator had a solid layer of grey debris across the entire external surface of the filter. Interview with Licensed Practical Nurse (LPN) 3 on 04/20/26 at 12:12 PM, he observed the O2 concentrator filters in R38's room and in R87's room and confirmed there was a build-up of grey debris on the filters and there should not be. When asked who was responsible for maintenance of the O2 concentrator filters LPN3 stated, I do not know. Interview with the Director of Nursing (DON) on 04/23/26 at 11:30 AM, when asked who was responsible for cleaning the O2 concentrator filters, the DON stated, Maintenance. When asked if they had a schedule for cleaning them, he stated, They know. Review of the facility's policy titled, Oxygen Concentrators revised 07/20/2022 revealed, Care of the Concentrator . Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device . Only trained individuals, such as the Maintenance Director or supplier, shall service the device. Review of the undated Instructions for Use provided by the facility titled, Drive DeVilbiss 10-Liter Oxygen Concentrator Service Manual revealed, The air filter should be inspected periodically and cleaned as needed by the user . NOTE - Frequency of inspection and cleaning of filter may be dependent upon environmental conditions like dust and lint .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, interview and policy review, the facility failed to ensure that the provider responded to the consulting pharmacist's recommendation in a timely manner for one of five residents (Resident (R)11 reviewed for unnecessary medications in the sample of 31. The failure to provide evidence of the physician's rationale for continued use of the medications at the current doses had the potential to result in unnecessary medication use.Findings include:Review of R11's undated admission record located in the electronic medical record (EMR) under the Profile tab revealed admission date of 08/11/25 with diagnosis und the Diagnosis tab of schizophrenia unspecified. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/05/26 indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R11's cognition was intact. The MDS indicated no behavioral symptoms, no physical behavioral issues towards others, no verbal behaviors towards others, and no behavioral symptoms towards himself. Review of R11's EMR pharmacy review dated 02/18/26 under the Misc tab revealed the resident had an order for risperidone (antipsychotic medication] 3 mg [milligrams], mirtazapine [antidepressant medication] 7.5 mg at bedtime [HS], and fluoxetine [antidepressant medication] 40 mg every day [QD]. The document indicated the consulting pharmacist recommended, if clinically appropriate, consider a gradual dose reduction [GDR] perhaps considering discontinuing risperidone and mirtazapine and consider risperidone 2.5 mg at HS and mirtazapine 15 mgs at HS. The form did not indicate a response from the provider regarding the pharmacist's recommendation. During interview on 04/24/26 at 11:08AM, the consulting pharmacist stated that it was his practice that after a resident is admitted on psychotropic medications after six months to consider a GDR. During interview on 4/23/26 at 2:06 PM, the Director of Nursing (DON) explained that the pharmacist's recommendation goes to the unit managers who follow up with the provider. The DON confirmed there was no evidence in the EMR that the provider had responded to the consulting pharmacist's recommendation. During interview on 04 /24 /26 2:38 PM, physician (DR2) indicated that he would prefer the psychiatrist provider to get any recommendations with regard to psychiatric medications, but in this case the recommendation had been made to him.DR2 felt that the recommendation must have been rerouted in the wrong direction. Review on the facility's policy titled, pharmacy NU RM-33: medication regimen review dated 05/21/24 indicated, policy, the drug regime of each resident is reviewed at least monthly by a licensed pharmacist and includes a review of the resident medical chart. F. Facility staff shall act upon all recommendations according to procedures for addressing medication regime review irregularities. For urgent irregularities, the facility will be required to follow up on it immediately, or at a minimum within 24 to 48 hours of receiving the communication from the consultant pharmacist. For non-urgent irregularities, the facility will be required to follow up within 30 days of receiving the recommendation from the consulting pharmacist.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, interview and policy review, the facility failed to ensure accurate clinical documentation was entered into the resident's medical records for one of one resident (Resident (R)162) in the sample of 31 residents. Specifically, pictures of R162's wound were not posted in the resident's record (EMR). This failure had the potential to affect the quality of care for R162 and to assist with the resident's treatment plan.Findings include: Review of 162's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 04/02/25 with a diagnosis of an unstable burst fracture of the first lumbar vertebra. Review of R162's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25, located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated that the resident had an impairment on one side of her upper body but no impairment of her lower bilateral extremities. The MDS indicated the resident had a surgical wound. Review of R162's EMR titled Wound Assessment Report dated 04/03/25, located under the Misc tab indicated that the resident's back wound was full thickness surgical dehiscence. Review of R162's EMR titled Wound Assessment Report dated 04/08/25, located under the Misc tab indicated that the resident's back wound was stable. Review of R162's EMR titled Wound Assessment Report dated 04/18/25, located under the Misc tab indicated that NP2 noted that the resident's back wound was stable and indicated the surgical hardware was exposed. During an interview on 04/23/26 at 8:45 PM, NP1, who worked for a contracted wound management company, confirmed her visits with R162 on 04/03/25 and again on 04/08/25. During this interview, NP1 presented photographs of R162's back. The photographs clearly showed the improvement of R162's wound from the wound notes dated 04/03/25 and 04/08/25. The image from 04/18/25 showed a decline in the wound. NP1 described the wound from 04/03/25 and 04/08/25 with no signs of infection. NP1 stated the 04/18/25 image of the resident's back wound was worse than 04/08/25. NP1 stated that the area around the wound was red and the width of the wound had increased. NP1 stated she did not know why the images (pictures) were not incorporated into the resident's clinical records. During an interview on 04/23/26 at 1:06 PM, the Director of Nursing (DON) stated it was important to have a complete clinical records for a resident. The DON confirmed that R162's photographs of her wound were not uploaded to the clinical records. The DON stated by having the images this would provide critical information on the status of a resident and identify whether or not wound was healing. Review of a facility's policy titled Documentation in Medical Record dated 01/30/24 indicated .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.Documentation may be performed manually or as per the facility's specific electronic medical record software program.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, record review, facility policy review, document review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer two of five residents (Residents (R) 25 and R51) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. This practice had the potential to increase the risk for residents to contract pneumonia.Findings include:1. Review of a document provided by the facility titled Patient Vaccination View/Audit indicated R25 was overdue on receiving the pneumococcal vaccine as of 01/25/2000. Review of R25's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 03/23/23. Review of R25's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/26 located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which revealed the resident was moderately cognitively impairment. The assessment indicated that the resident's pneumococcal vaccine was not up to date. 2. Review of a document provided by the facility titled Patient Vaccination View/Audit indicated R51 received the Pneumococcal conjugate (PCV13) on 07/23/15. The document indicated that the resident received the pneumococcal polysaccharide (PPSV23) on 10/18/16. Review of R51's EMR titled admission Record located under the Profile tab indicated that the facility admitted the resident on 10/29/24. Review of R51's EMR titled quarterly MDS with an ARD of 03/23/26 located under the MDS tab indicated the resident had a BIMS score of three out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated that the resident's pneumococcal vaccine was not up to date. During an interview on 04/23/26 at 12:41 PM, with the Infection Preventionist (IP) and the Director of Nursing (DON), the DON stated that they were not familiar with the CDC's current recommendations for the pneumococcal vaccines. Review of the CDC website titled, PneumoRecs VaxAdvisor App (Application) for Vaccine Providers dated 01/09/25 indicated, . Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete.Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last does of PPSV23. Regardless of which vaccine is used . their pneumococcal series is complete . Review of the facility's policy titled Pneumococcal Vaccine dated 01/16/24 indicated, .It is our policy to offer residents and staff immunization against pneumococcal disease in accordancewith current CDC guidelines and recommendations.