STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495398	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of care regarding wound documentation for one of thirteen residents in the survey sample (Resident #6). The findings include: Facility staff failed to document an assessment for Resident #6's wound that included measurements, appearance, description, and/or status of a wound. Resident #6 (R6) was admitted to the facility with diagnoses that included femur fracture, peripheral vascular disease, diabetes, end stage renal disease, anemia, coronary artery disease, cancer, congestive heart failure, and cerebrovascular accident (stroke). The minimum data set (MDS) dated [DATE] assessed R6 as cognitively intact. R6's closed clinical record documented a care concern form dated 11/23/24 listing that the resident was assessed with a new skin impairment. The form categorized the wound as other and documented unstageable to right lower leg. A nursing note dated 11/23/24 documented, .Resident noted to have a diabetic ulcer to RLE [right lower extremity]. New treatment order is in place. MD and RP [responsible party] notified. A skilled nursing note dated 11/24/24 documented the resident had impaired skin/wound with note to refer to skin/wound notes and/or treatment record. R6's treatment administration record documented a physician's order with start date of 11/24/24 stating, Cleanse wound to right lower extremity with NS [normal saline], pat dry, and apply medihoney and cover with dry dressing one time a day for Wound care . R6's clinical record documented no descriptive assessment of the right lower leg wound other than unstageable and diabetic ulcer. The clinical record included no wound measurements, shape, appearance, color, presence of drainage, pain status, or condition of surrounding skin. On 1/13/25 at 2:26 p.m., the director of nursing (DON) was interviewed about R6's right leg wound assessment. The DON stated nurses were expected to document skin impairments in the clinical record and include descriptions such as size, appearance, location, and color. On 1/13/25 at 3:00 p.m., the DON stated she reviewed the clinical record and did not find a description of the wound other than the location on the right lower leg and diabetic ulcer. The DON stated again it was an expectation for nurses to describe the appearance, condition and status of wounds. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Documentation of Wound Treatments (revised 12/29/23) documented, .The following elements are documented as part of a complete wound assessment .Type of wound (pressure injury, surgical, etc.) and anatomical location .degree of skin loss if non-pressure (partial or full thickness) . Measurements: height, width, depth .Description of wound characteristics .Color of the wound bed .Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) .Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) .Presence, amount, and characteristics of wound drainage/exudate .Presence or absence of odor .Presence or absence of pain . These findings were reviewed with the administrator, director of nursing and regional consultant during a meeting on 1/13/25 at 3:50 p.m. with no further information presented prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to perform timely neurological assessments following an unwitnessed fall for one of thirteen residents in the survey sample (Resident #10). The findings include: Resident #10 had no neurological checks initiated immediately following an unwitnessed fall to assess for possible head injury. Resident #10 (R10) was admitted to the facility with diagnoses that included metabolic encephalopathy, depression, dementia with severe agitation, cognitive communication deficit and hypertension. The minimum data set (MDS) dated [DATE] assessed with severely impaired cognitive skills. R10's closed clinical record also documented a nursing note dated 7/8/24 at 11:45 p.m. stating, .resident has been aggressive and agitated all shift . rounded on her q [every] 30 mins [minutes] due to her trying to get out of bed. while in room she was sitting on side of bed with feet on floor and put herself on fall mat . A post-fall assessment dated [DATE] documented the resident's vital signs and listed no change of consciousness, no pain, no changes in mobility and no injuries as a result of the fall. A nursing note written by the director of nursing (DON) dated 7/9/24 at 7:31 a.m. documented, .Upon further investigation, resident fall was unwitnessed. Neuro checks initiated I reassessed resident. No c/o [complaints of] pain PERRLA [pupils equal, round and reactive to light and accommodation] 3 MM [millimeters] bilaterally .Residents speech is clear and confused, this is baseline . R10 had additional neurological assessments documented on 7/9/24 at 8:35 a.m. and on 7/11/24 at 12:31 p.m. R10's clinical record documented no neurological checks immediately following R10's fall on evening of 7/8/24. Two neurological checks were documented on 7/9/24 at 7:31 a.m. and 8:35 a.m. No checks were documented on 7/10/24 and one check was completed on 7/11/24. The clinical record documented skilled nursing notes, vital signs, and nurse practitioner visits in the days following the 7/8/24 fall with no injuries or complications noted. On 1/14/25 at 9:10 a.m., the DON was interviewed about R10's fall on 7/8/24 and neurological assessments. The DON stated licensed practical nurse (LPN) #3, caring for R10 on the evening of 7/8/24, notified her that the resident fell . The DON stated on the morning of 7/9/24, she reviewed the circumstances of R10's fall and found that the fall was not witnessed by staff members and that neurological checks had not been initiated. The DON stated R10 had significant cognitive impairments and was not able to accurately report what happened. The DON stated neurological assessments should have been initiated immediately following the fall to assess for any possible head injury. On 1/15/24 at 7:55 a.m., the DON stated she recalled initiating a neuro sheet on 7/9/24 when she discovered the fall as unwitnessed. The DON stated that she reviewed R10's clinical record and did not find the neuro check sheet or any further neurological assessments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Neurological Evaluation (revised 12/28/23) documented, .A neurological evaluation will be completed by the licensed nurse to assist in detecting early signs of neurological injury related to an incident or accident .If an incident/accident occurs which involves potential or actual trauma to the patient's head, a 'Neurological Evaluation' form is to be initiated. If a fall is reported in which there are no witness's [witnesses], the patient is to be evaluated for potential complications associated with a possible head injury related to the fall by a Licensed Nurse, utilizing the 'Neurological Evaluation' form .Frequency guidance as indicated below .Every 15 minutes times 4, then .Every 30 minutes times 4, then .Every 1-hour times 4, then . Every 4 hours for 24 hours, then Every shift for 24 hours .All neurological findings must be recorded in the EHR [electronic health record] documentation including all evaluations and the nurse's notes to describe the patient's condition . This finding was reviewed with the administrator, DON, and regional consultant during meetings on 1/14/25 at 11:20 a.m. and on 1/15/25 at 9:20 a.m. with no further information presented prior to the end of the survey.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure one of thirteen residents in the survey sample was free from a significant medication error (Resident #8). The findings include: Resident #8 was administered one dose of oxycodone 30 mg (milligrams) extended-release when the physician's order required an immediate release 20 mg dose. Resident #8 (R8) was admitted to the facility with diagnoses that included diabetes with peripheral angiopathy, below knee amputation, anemia and hypertension. The minimum data set (MDS) dated [DATE] assessed R8 as cognitively intact. R8's closed clinical record documented a physician's order dated 4/22/24 for oxycodone 20 mg every 4 hours as needed for pain (prn). The clinical record documented a physician's order dated 5/17/24 for oxycodone 30 mg extended-release with instructions for one tablet every 12 hours for pain management. R8's medication administration record (MAR) documented licensed practical nurse (LPN) #3 administered the resident oxycodone 20 mg on 6/10/24 at 3:40 p.m. for pain rated 8 out of 10 (scale with 0 = no pain, 10 = worst pain). R8's narcotic count sheets for the oxycodones documented inaccurate drug counts at the end of the 6/10/24 evening shift, alerting staff to an error. A medication error report dated 6/11/24 documented LPN #3 administered an oxycodone 30 mg extended-release tablet instead of the ordered 20 mg immediate release tablet for the 3:40 p.m. prn dose 6/10/24. The medication error report documented notification to the physician concerning the error and monitoring of R8's vital signs with alertness noted and no adverse effects as a result of the error. On 1/14/25 at 9:10 a.m., the director of nursing (DON) was interviewed about the incorrect oxycodone dose administered to R8. The DON stated R8 had orders for oxycodone 30 mg (extended-release) scheduled for every 12 hours and an order for oxycodone 20 mg every four hours as needed for pain associated with a recent amputation. The DON stated on 6/10/24 at 3:40 p.m., LPN #3 pulled the pharmacy supply card for the scheduled 30 mg dose instead of the card with the 20 mg prn dose for administration to R8's request for pain medication. The DON stated nurses noted the error when the narcotic counts did not match at the end of the shift. The DON stated R8 verified that she was administered an oxycodone dose on 6/10/24 at 3:40 p.m. The DON stated the narcotic counts indicated LPN #3 pulled the 30 mg dose instead of the 20 mg dose that was ordered. The DON stated LPN #3 stated she thought she was pulling the 20 mg dose but pulled the 30 mg tablet instead. The DON stated R8 reported no issues from the incorrect dose and had no changes in condition as a result of the error. LPN #3, who administered the incorrect dose of oxycodone to R8, was not available for interview, as she no longer worked at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Medication Administration (effective 6/21/17) documented, .Medications will be administered by legally-authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice . This policy documented the procedure for medication administration as, .Open the medication administration book/eMAR to the appropriate resident and note the first medication to administer .Read the label comparing to the MAR [medication administration record] before preparing the medication .Pour the correct number of tablets or capsules into the medication cup .Explain to the resident the type of medication to be administered .Administer medication and remain with resident while medication is swallowed . The Nursing 2022 Drug Handbook on page1124 describes oxycodone as a schedule II opioid analgesic used for the treatment of moderate to severe pain. Page 1126 of this reference documents that oxycodone carries multiple black box warnings including, Serious, life-threatening, or fatal respiratory depression may occur with use of extended-release oxycodone. Monitor patient for respiratory depression, especially during initiation of therapy and after a dosage increase .Oxycodone extended-release tablets are indicated for the management of moderate to severe pain, when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. They aren't intended for use as as-needed analgesics . (1) This finding was reviewed with the administrator, director of nursing, and regional consultant during a meeting on 1/13/25 at 3:50 p.m. with no further information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to properly store a controlled medication for one of thirteen residents in the survey sample (Resident #7) The findings include: Resident #7 (R7) was admitted to the facility with diagnoses that included chronic kidney disease, atherosclerotic heart disease, hypertension, benign prostatic hyperplasia, and gout. The minimum data set (MDS) dated [DATE] assessed R7 as cognitively intact. R7's closed clinical record documented a physician's order dated 6/9/24 for the medication Tramadol 50 mg (milligrams) with instructions to give two tablets every 6 hours as needed for pain management. Review of a medication error report sheet dated 6/14/24 documented that on 6/13/24, licensed practical nurse (LPN) #3 signed out one tablet of Tramadol for R7. The report documented LPN #3 did not administer the medication to R7 and left the medicine unsecured in the medication cart. The controlled drug count sheet for R7's Tramadol documented LPN #3 signed out one tablet of Tramadol on 6/13/24 at 9:00 p.m. R7's medication administration record (MAR) documented no administration of the 9:00 p.m. dose of Tramadol. R7's MAR documented the only dose administered on 6/13/24 was at 12:16 p. m. On 1/14/25 at 9:10 a.m., the director of nursing (DON) was interviewed about R7's Tramadol left in the medication cart. The DON stated the then assistant director of nursing found the Tramadol in a medicine cup in the cart on the morning of 6/14/25. The DON stated the cup was labelled with R7's name attached to the cup but was not stored in the narcotic lock box. The DON stated the Tramadol count sheet documented LPN #3 signed out one tablet of Tramadol on 6/13/24 at 9:00 p.m. but no dose was given to the resident. The DON stated LPN #3 reported that R7 was asleep when she went to administer the Tramadol, so she placed the Tramadol in the cart and forgot to go back and give the medication. The DON stated Tramadol was a controlled medication and facility protocol required this medication to be kept in the cart lock box and counted at each shift change. The DON stated if the medication was not given, it should have been discarded per policy. The DON stated all controlled medications were supposed to be stored in the designated lock box. The facility's policy titled Medication Storage (effective 7/23/19) documented, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations and those of the supplier . Schedule II medications and other drugs subject to abuse are stored in a separate, permanently affixed area and under double lock. Schedule III-IV medication may be stored along with non-controlled drugs, but may be under more strict storage controls at the Facility's discretion or as required by state regulations . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Medication Administration (effective 6/21/17) documented, .Once removed from the package or container, unused doses should be destroyed following facility policy and documenting the destruction according to facility policy . The Nursing 2022 Drug Handbook on page 1462 describes Tramadol as a schedule IV-controlled analgesic used for the management of moderate to severe chronic pain. Page 1464 of this reference documents Tramadol has a black box warning stating, Tramadol exposes patients to the risk of addiction, abuse, and misuse, which can lead to overdose and death . (1) This finding was reviewed with the administrator, DON, and regional consultant during a meeting on 1/14/25 at 11:20 a.m. and on 1/15/25 at 9:20 a.m. with no further information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for two of thirteen residents in the survey sample (Residents #8 and #10). The findings include: 1. There was no documentation in Resident #8's clinical record that the resident was administered an incorrect dose of the medication oxycodone. R8's closed clinical record documented a physician's order dated 4/22/24 for oxycodone 20 mg every 4 hours as needed for pain (prn). The clinical record documented a physician's order dated 5/17/24 for oxycodone 30 mg extended-release with instructions for one tablet every 12 hours for pain management. R8's medication administration record (MAR) documented administration of oxycodone 20 mg on 6/10/24 at 3:40 p.m. for pain rated 8 out of 10 (scale with 0 = no pain, 10 = worst pain). A medication error report dated 6/11/24 documented LPN #3 administered an oxycodone 30 mg extended-release tablet instead of the ordered 20 mg immediate-release tablet for the 3:40 p.m. dose on 6/10/24. R8's narcotic count sheets for the oxycodones documented inaccurate drug counts at the end of the 6/10/24 shift alerting staff to the error. The error report documented notification to R8's physician concerning the error. R8's clinical record made no mention of the 6/10/24 medication error. R8's record documented ongoing monitoring following the medication error that included vital signs, oxygen saturations, physician assessments and daily nursing assessments that evidenced no negative outcome from the error but made no mention that the resident had received a 30 mg dose instead of the ordered 20 mg dose on 6/10/24. On 1/15/24 at 8:20 a.m., the director of nursing (DON) was interviewed about R8's record including no mention of the medication error. The DON stated she thought she entered a note about the error. The DON stated she reviewed the record and did not locate any mention of the error. The DON stated, I recorded everything on the med error sheet. This finding was reviewed with the administrator, DON, and regional consultant during a meeting on 1/15/25 at 9:20 a.m. 2. Inaccurate documentation was entered in R10's clinical record regarding the circumstances of a fall. Resident #10 (R10) was admitted to the facility with diagnoses that included metabolic encephalopathy, depression, dementia with severe agitation, cognitive communication deficit, and hypertension. The minimum data set (MDS) dated [DATE] assessed with severely impaired cognitive skills. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's closed clinical record documented a nursing note written by licensed practical nurse (LPN) #3 dated 7/8/24 at 11:45 p.m. stating, .resident has been aggressive and agitated all shift .rounded on her q [every] 30 mins [minutes] due to her trying to get out of bed. while in room she was sitting on side of bed with feet on floor and put herself on fall mat . (SIC) A post-fall assessment dated [DATE] documented R10's vital signs and listed no change of consciousness, no pain, no changes in mobility, and no injuries as a result of the fall. LPN #3 entered a post fall evaluation dated 7/8/24 at 11:47 p.m. again documenting that R10's fall was witnessed, with the resident noted sitting on the bedside and putting herself on the floor. A nursing note written by the director of nursing (DON) dated 7/9/24 at 7:31 a.m. documented, .Upon further investigation, resident fall was unwitnessed. Neuro checks initiated . The facility's investigation of R10's fall of 7/8/24 documented other staff members caring for R10 at the time of the fall reported the resident's fall was not witnessed as the resident was found in the floor. A written statement from CNA #2 dated 7/11/24 documented, .We heard something, while we were at the nursing station .I said, what is that When [other two CNAs] went to the room, [CNA #1] peeked her head out and said shes [R10] on the floor. When I went in both fall mats were on the floor and patient was sitting on the floor mat .It wasn't a witnessed fall .we all were at the nurses station . (sic) On 1/14/24 at 9:10 a.m., the director of nursing (DON) was interviewed about inaccurate documentation regarding the circumstances of R10's fall on 7/8/24. The DON stated on the morning of 7/9/24, a CNA called and reported that LPN #3 had listed R10's fall as witnessed when it was unwitnessed. The DON stated upon investigation, CNA #2 and LPN #5 reported that the resident was found in the floor and the incident was not witnessed as documented by LPN #3. The DON stated LPN #3 had indicated she was listing the fall as witnessed because she had not initiated neurological checks as required for unwitnessed falls. The DON stated the fall note and post fall document entered by LPN #3 inaccurately documented the circumstances of the fall and indicated the fall was witnessed when it was not witnessed. LPN #3 was not available for interview, as she no longer worked at the facility. This finding was reviewed with the administrator, DON, and regional consultant during a meeting on 1/14/25 at 11:20 a.m. and on 1/15/25 at 9:20 a.m. with no further information presented prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 21875 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control practices during a medication pass observation on one of three units (200 hall). The findings include: On 1/14/25 at 8:00 a.m., a medication pass observation was conducted with licensed practical nurse (LPN) #6 administering medications to Resident #5 (R5). Among the medications administered was a docusate sodium gel cap 100 mg (milligrams). When removing the capsule from the pharmacy packaging, LPN #6 dropped the capsule in the floor. LPN #6 put on gloves, picked up the capsule, placed it in a medicine cup, and stated since the capsule was gel, he would rinse it off with water. LPN #6 took the gel cap to the sink in R5's room, quickly rinsed the capsule with running water, drained remaining water from the cup, and proceeded to administer the docusate sodium gel cap to R5. When questioned, LPN #6 stated that he rinsed the gel cap because there were no over-the counter medications on the cart and the water would not hurt the gel covering. R5's clinical record documented a physician's order dated 12/26/24 for docusate sodium 100 mg capsule twice per day for constipation. On 1/14/25 at 9:35 a.m., the director of nursing (DON) was interviewed about the medication pass observation with LPN #6. The DON stated it was unacceptable to rinse a medication or administer a contaminated medicine to a resident. The DON stated a back-up supply was available in case medicines were dropped and/or contaminated. The DON stated the nurse should have discarded the medication and obtained a new capsule from the back-up supply. On 1/15/25 at 8:05 a.m., the consultant registered pharmacist (other staff #3) was interviewed about the rinsed docusate sodium gel cap. The pharmacist stated anything dropped on the floor should be discarded and not administered due to infection concerns. The pharmacist stated quickly rinsing the gel cap with water, with the capsule integrity maintained, would not deter the efficacy of the medicine. The pharmacist stated the docusate sodium gel caps were not enteric coated and had no delayed release coating. The pharmacist stated dropping/rinsing a capsule was obviously an infection control concern. On 1/15/25 at 7:55 a.m., the DON stated she discussed the medication pass observation with LPN #6. The DON stated that LPN #6 had said he thought it was okay to rinse the docusate sodium capsule because it was gel coated. The DON stated dropping a medicine in the floor and rinsing a medication were infection control issues. The facility's policy titled Medication Storage (effective 7/23/19) documented, .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495398	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator, DON, and regional consultant during a meeting on 1/15/25 at 9:20 a.m. with no further information presented prior to the end of the survey.