STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205011	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barron Center	1145 Brighton Ave Portland, ME 04102

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included but is not limited to, the attending physician, a registered nurse, a Certified Nurses Aid (CNA) with responsibility for the resident, a member of nutrition services and to the extent possible participation of the resident and/or his/her representative after each assessment for 6 of 21 reviewed for care planning. (Resident #6, #3, #5, #91, #99 and #8).1. On 8/18/25 at 10:59 a.m., during an interview, with Resident #6 and his/her representative, Resident #6 stated he/she is not aware of the meetings and I've never been invited. The resident representative stated the IDT's have We do it on the phone and it's been without [Resident #6].Review of Resident #6's medical record, the surveyor noted IDT meetings held on 2/21/25 and 12/19/24. The medical record lacked evidence that the resident was invited and/or participated in his/her IDT meetings, and the meetings lacked the participation of the attending physician, a Certified Nurses Aid (CNA) with responsibility for the resident, and a member of nutrition services.On 8/20/25 at 10:17 a.m., during an interview with both the Director of Social Services and the Licensed Social Worker #1, the Director of Social Services stated, all residents and family receive a letter inviting them to the IDT meetings. At this time the surveyor requested copies of the letters inviting Resident #6 to his/her IDT's on 2/21/25 and 12/19/24.On 8/20/25 at 1:39 p.m., the LSW #1 provided the surveyor with resident #6's invitation letters for the above IDT dates. Review of the IDT invitation letter for the scheduled 12/19/24 meeting was handwritten with the date of the meeting being on Wednesday 12/18/25.On 8/20/25 at 1:49 p.m., during an interview with the Administrator, the Surveyor questioned the vitality/integrity of the letter as it was signed with the IDT date of 12/18/25 (future date) and was supposed to be for the 12/19/24 IDT meeting. The surveyor questioned if the letter was created today.On 8/20/25 at 2:14 p.m., during an interview with 3 surveyors present, LSW #1 confirmed the IDT invitation letter with the date of 12/18/25 for the IDT which occurred on 12/19/24, was created today, stating, That was on me, I didn't invite her to this meeting. I did sign this today.On 8/20/25 at 2:37 p.m., during an interview with the Administrator, the Surveyor discussed the LSW#1 falsification of Resident #6's medical record relating to the IDT invitation letter for the meeting which was held on 12/19/24. 2. Review of Resident #3's medical record, the surveyor noted an IDT meeting held on 3/19/25, with only the participation of the social worker and a member of nutrition services. Further review showed no evidence that an IDT meeting occurred after the Quarterly Minimum Data Sets (MDS) 3.0 dated 12/4/24 and the significant Change MDS dated [DATE]. 3. Review of Resident #5's medical record, the surveyor noted an IDT meeting held on 7/9/25, with only the participation of the social worker and a member of nutrition services. 4. Review of Resident #91's medical record, the surveyor noted an IDT meeting held on 7/9/25 and 10/23/24, with only the participation of the social worker and a member of nutrition services 5. Review of Resident #99's medical record, the surveyor noted an IDT meeting held on 11/13/24, with only the participation of the social worker and a member of nutrition services. On 8/20/25 at 10:17 a.m., during an interview the above was confirmed with both the Director of Social Services and the Licensed Social Worker #1.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, record reviews and facility policy review, the facility failed to maintain a sanitary environment for 2 of 3 residents reviewed for respiratory care. (Resident #6 & #64) The facility's policy Oxygen Use and Storage, dated 10/20/21, indicates that: A sanitary environment must be maintained to prevent the transmission of disease and infection. Oxygen tubing must be discarded and changed every two weeks, labeled with the date and staff initials. Nasal cannulas must be discarded and changed weekly, labeled with the date and staff initials. Staff changing the tubing or cannula must document the change on the Treatment Administration Record (TAR). On 8/18/25 at 11:52 a.m. Resident #64 was observed receiving oxygen via nasal cannula through an oxygen concentrator. The oxygen tubing was dated 7/17/25, and per facility policy, should have been changed on 8/31/25. (18 days past due for replacement) The nasal cannula had no label, no date of change, and no staff initials as required by facility policy. At this time, the surveyor confirmed the finding with Registered Nurse (RN) #6, who verified that the tubing was past due for replacement and the nasal cannula had not been labeled. Review of Resident #64's Treatment Administration Record (TAR) revealed no documentation of tubing or cannula changes per policy. On 8/18/25 at 3:00 p.m., the surveyor discussed this finding with the Administrator. 1. On 8/19/25 at 2:09 p.m., the surveyor observed Certified Nurses Aid (CNA) #3 and CNA #4 perform personal hygiene on Resident #6. During this process, the resident's oxygen nasal cannula tubing with the nasal prongs lying on the floor under the bed. After the personal hygiene was completed and the resident was made comfortable in the bed, CNA #4 picked up the nasal cannula off the floor and placed it on the resident's face. The surveyor immediately intervened and discussed the nasal cannula being on the floor and lack of maintaining a sanitary environment to prevent transmission of disease or infection. CNA#4 stated, it was still attached to the Oxygen concentrator. At this time, the Surveyor requested the resident receive a new nasal cannula tubing. On 8/19/25 at 2:20 p.m., the above observation was discussed with the Administrator.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to adequately date and properly dispose of open medications according to manufacturer specifications and failed to ensure expired medications were removed from the supply available for use on 3 of 4 units observed (2 South, 2 North and 3 South).1. On 8/18/25 at 12:09 p.m., during review of 2 South Medication room with the Registered Nurse (RN) #1, the following was observed: one unopened, available for use, bottle of Naproxen Sodium with exp date of 5/2025. The refrigerator contained 2 opened and undated vials of Lantus insulin with manufactures directions of, Throw away any medicine that remains 28 days after first use and one opened and undated Basaglar insulin KwikPen with manufactures directions of, throw away the Pen you are using after 28 days, even if it still has insulin in it. At this time, the expired and unlabeled medications were confirmed with RN#1. 2. On 8/19/25 at 8:06 a.m., during review of 3 South Certified Nurses Aid - Medication Technician (CNA-M) #1 cart the surveyor observed one bingo card of Zofran 4mg with 27 tabs remaining with the expiration date of 5/13/25 and another bingo card of Zofran 4mg with 22 tabs remaining with the expiration date of 5/29/25. At this time, CNA-M#1 confirmed the meds were expired and removed them form the cart. 3. On 8/19/25 at 8:42 a.m., during review of the 2 North Medication room and the 2 North Nurse Medication cart with RN#4, the following was observed:The medication room contained one unopened, available for use, bottle of Calcium 600 with Vitamin D with expiration date of 7/2025 and the refrigerator contained an opened vial of Tuberculin Purified Protein Derivative labeled with the open date of 7/17/25 with manufactures directions of Once entered, vial should be discarded after 30 days.The Nurse Medication cart contained an opened and undated Basaglar insulin KwikPen with manufactures directions of, throw away the Pen you are using after 28 days, even if it still has insulin in it. At this time, RN#4 confirmed the expired and unlabeled medications.

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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 observations, interviews, and record review, the facility failed to maintain a safe and sanitary environment for food preparation and storage. Specifically, the facility did not consistently maintain temperature logs for kitchen equipment and food storage areas, failed to monitor tray line temperatures, neglected to check for outdated supplies in unit kitchenettes, and did not ensure cleanliness of food preparation equipment. Main Kitchen Refrigerator/Freezer Logs:On 8/18/2025 at 9:15 a.m., during the initial visit to the Kitchen, with the Director of Dietary Services, a surveyor observed no ongoing documentation of refrigerator/freezer temperatures in the main kitchen. The only record provided was a single sheet with the last entry dated 5/5/2025. The Director of Food Services confirmed the absence of current documentation.Dish Machine Temperature Logs:On 8/18/2025 at 11:00 a.m., document review revealed that dish machine temperatures were not consistently recorded. Of 129 days reviewed, 37 days lacked documentation, including dates spanning April through August 2025.Tray Line Temperature Checks:On 8/18/2025 at 11:30 a.m., review of 14 weeks of tray line temperature audits showed 4 sheets without dates and 110 meals out of 294 lacked temperature documentation.Unclean Food Preparation Equipment:On 8/19/2025 at 10:15 a.m., during the return visit to the Kitchen, with Director of Dietary Services and Food Production Manager, the meat slicer was observed with dried debris. The large floor mixer and countertop mixer were covered in dust and debris. Staff confirmed the equipment had been used recently, indicating inadequate cleaning practices.Unit Refrigerator/Freezer Temperature Logs:On 8/21/2025 between 7:00 a.m. and 8:15 a.m., surveyors reviewed temperature logs across multiple units:Third Floor Day Room: 180 of 336 opportunities not documented for both refrigerator and freezer.Second Floor Day Room: No documentation for May-August; 336 missed opportunities.2 North & 2 South Kitchenettes: 235 and 233 missed opportunities respectively.Zolov Unit: 76 missed fridge checks and 74 missed freezer checks out of 242 opportunities.Outdated Supply Checks in Unit Kitchenettes:On 8/21/2025 at 9:00 a.m., documentation showed:3rd Floor: 11 of 20 days not checked.2nd Floor: 9 of 20 days not checked.Zolov Unit: 1 of 20 days not checked.Administrator Confirmation:On 8/21/2025 at 9:25 a.m., the facility Administrator confirmed all findings during an interview

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility policy, observations, interviews and record reviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to the use of Personal Protective Equipment (PPE) for residents on Enhanced Barrier Precautions (EBP) (Resident #118 and #6) for 1 of the 4 days of survey. (8/19/25)The facilities Infection Control: Standard and Transmission-Based Precautions & Enhanced Barrier Precautions policy and procedure last updated on 10/2023 states under Enhanced Barrier Precautions that targeted gown and gloves use during high contact resident care activities: dressing, bathing, showering providing hygiene, changing linens, toileting or care r/t wound care. For both active and colonized MDRO. When a resident has an indwelling medical device, i.e. Foley catheters, feeding tubes. - EBP when caring for the device (high contact activity). 1. On 8/19/25 at 8:30 a.m., Resident #118's bedroom was posted with Enhanced Barrier Precautions sign and a yellow bag hanging on the door containing gloves and a tub of purple top Sani cleaner wipes. The door was open and the surveyor observed 2 Registered Nurse (RN) managers, RN#5 and RN#6 at the residents bedside wearing only gloves. RN#6 had the residents the gastrostomy tube (G-tube) connected to a syringe and appeared to be cleansing around the tube site and holding the syringe. RN #5 stepped away from the beside to the dresser where she obtained a gauze pad and brought it over to the resident. At that time RN#6 observed the surveyor watching and closed the door. The surveyor immediately knocked on the door, entered the room, introducing herself. Both of the RN's were wearing only gloves. At this time, the surveyor intervened questioning the lack of proper PPE which included a gown while providing care to the residents G-tube, with no response from either RN, the surveyor exited the room.At 8:36 a.m., during an interview with RN#4, who was at the nurse's medication cart adjacent to resident #118's room. The surveyor asked RN#4 what she would wear for PPE while caring for Resident #118 and the G-tube site. RN#4 stated gloves. She then stated the nurse managers are in with the resident because he/she dislodged his/her tube. The surveyor asked again what PPE would be used while caring for his/her G-tube, while showing the RN#4 the EBP posted on door. RN#4 stated, I never understood that and [He/she] is not on precautions, [he's/she's] not on any precautions. The surveyor explained R#118 had an indwelling device (G-Tube) that is why the EBP is posted. At that time RN#4 paused then stated she would also use a gown in addition to gloves for care. At 8:39 a.m., RN#5 exited R#118's room and approached the surveyor stating, both her and RN#6 were not providing care on the tube. At this time, the surveyor discussed what was observed, including G-tube care and asked what PPE should be worn during G-tube care. RN#5 stated, should've worn gowns.At 8:42 a.m., the surveyor observed RN #4, bring a gown into to RN#6 who was still in Resident#118's room. 2. On 8/19/25 at 2:09 p.m., Resident #6's room was posted with Enhanced Barrier Precautions sign and a yellow bag hanging on the door containing gloves and gowns. At this time, the surveyor observed Certified Nurses Aid (CNA) #3 and CNA #4 wearing only gloves, perform personal hygiene including peri care on Resident #6 who has a diagnosis of neurogenic bladder requiring a suprapubic catheter and a history of Extended-Spectrum Beta-Lactamase (ESBL), a Multidrug-Resistant Organism (MDRO), in the urine. On 8/19/25 at 2:15 p.m., during an interview, CNA #4 confirmed she provided catheter care. The surveyor asked why neither of them were a gown, CNA#4 stated, I was under the impression we only wear it when we are emptying the foley bag, The posted EBP on both Resident #118 and #6's room stated the following instructions: Enhanced Barrier Precautions. Providers and staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities. Providing hygiene, changing briefs or assisting with toileting, Device care or use: .urinary catheter, feeding tube . On 8/19/25 at 2:20 p.m., the above observation was discussed with the Administrator.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility's policy, record review, and interviews, the facility failed to investigate an allegation of potential misappropriation of a resident's loss of personal property, and failed to ensure that the facility's investigation was sent to the State Agency within 5 business days of the incident for 1 of 6 intake investigations reviewed during an annual survey.A review of the facility's policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, Section G. Reporting and Response, stated All allegations of abuse or neglect will be reported to the Administrator or designee at the time the allegation is made. The facility will: Immediately report all alleged violations to the administrator.Take all necessary actions as a result of the investigation, which may include, but are not limited to the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent future occurrences. Procedure. Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator or designee. b. The Administrator or designee will involve key leadership personnel as necessary to assist with reporting, investigation and follow-up. External Reporting: Report the results of all investigations to the Administrator or designee and to other officials in accordance with State law, and follow-up report to the State Survey Agency within 5 working days of the incident. The Administrator or designee will inform the resident or resident's representative of the report of an incident and that the investigation is being conducted. On 4/8/25, the Division of Licensing and Certification received the facility's report that Resident #30 (R30) was missing 2 cell phones, a [NAME] case containing the resident's identification, Medicare card and a small amount of cash. A copy of an email, dated 4/8/25, sent to the social worker from R30's son stated he/she has never lost these items before and is usually mindful of where they are, because he/she uses them regularly every day for entertainment and contacting family. I believe on possible theory that was mentioned to us was that maybe these items fell into the trash can, which he/she keeps beneath the bedside tray. Although, this is possible, it feels unlikely, especially that all three items would fall into the trash and go unnoticed. A follow-up email, dated 4/8/25 from the social worker to R30's son stated when the items were discovered missing, staff searched trash, the resident's room, and notified the kitchen and laundry departments. The social worker notified the local police department via an online crime report. On 4/10/258, the police department replied and stated the report had been rejected because We do not complete police reports for missing or lost property. A review of R30's medical record noted a personal effects inventory, dated 2/5/25, which included an android phone with green wallet case, and an IPhone with charger and cord. On 8/19/25 at 2:20 p.m., in an interview with a surveyor, the facility's Social Services Director stated she was not able to locate evidence that an investigation had been completed, or that a 5-day report was sent to the State Agency on this incident. On 8/20/25 at 2:00 p.m., in an interview with a surveyor, the facility's Administrator stated the incident had never been reported to her. At this time, the facility's Director of Nursing stated she had no knowledge of the incident either and that it had not been discussed at morning staff meetings.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 4 sampled residents reviewed for new admissions (Resident #5).Resident #5 was admitted on [DATE] with a diagnosis of cerebrovascular accident with right arm flaccid paralysis, type 2 diabetes mellitus, lung mass, fracture of right humerus with delayed healing, dysphagia and recurrent fall. Review of the clinical record lacked evidence of a baseline care plan was completed within 48 hours to include the instructions necessary to properly care for Resident #5's immediate health and safety needs for the above concerns. The care plan was initiated on 7/3/25, 3 days after admission. On 8/20/25 at 12:31 p.m., during an interview, the above was discussed with the Director of Nursing.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record reviews and interviews, the facility failed to ensure that a comprehensive plan of care was developed in the area of Multidrug-Resistant Organism (MDRO) and Preadmission Screening and Resident Review (PASRR) for 2 of 23 residents reviewed for comprehensive care plans. (Resident #6 and #9)1. On 8/18/25 and 8/19/25 observations of Resident 6's bedroom door with an Enhanced Barrier Precautions (EBP) sign posted on the door. The clinical record indicated he/she was re-admitted to the facility in April 2025 with a diagnosis of neurogenic bladder requiring a suprapubic catheter and a history of Extended-Spectrum Beta-Lactamase (ESBL), an MDRO, in the urine. The current care plan, last updated on 6/3/25, lacked evidence of goals and interventions relating to the use of EBP precautions and history of ESBL in the urine. 2. Resident #9's clinical record was reviewed and included a Level II PASRR, dated 1/22/19 which indicated the resident was eligible for services due to diagnosis of Alzheimer's disease, major mental psychotic disorder and deaf and mute since childhood. As of 8/20/25, Resident #9's care plan lacked evidence of goals and interventions in the area of PASRR. On 8/20/25 at 12:31 p.m., during an interview, the Director of Nursing confirmed both Resident #6 and 9's care plans lacked the above required information.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to develop a Coronavirus (COVID-19) policy and procedure for COVID-19 vaccination, and failed to offer an updated 2024-2025 COVID-19 vaccination for 1 of 5 residents reviewed for immunizations (Resident #80).1. A review of the facility's policies and procedures for infection control lacked evidence of a COVID-19 policy and procedure regarding immunizations.On 8/20/25 at 11:00 a.m., in an interview with a surveyor, the Director of Nursing, confirmed she was unable to find a current policy and procedure regarding COVID-19 vaccinations.2. Clinical record review indicated R80, was admitted in March, 2025, and is currently [AGE] years old. R80's last documented COVID-19 vaccination was on 11/3/22. There was no evidence R80 had received, been offered, or refused the COVID-19 vaccination.A review of the CDC website, COVID-19, last revised 6/6/25, Stay Up to Date with COVID-19 Vaccines | CDC, indicated that CDC recommends the 2024-2025 updated COVID-19 vaccines are especially important if one has never received a COVID-19 vaccine, are aged 65 years and older, at high risk for severe COVID-19, living in a long-term care facility. The adult immunization recommendations state, Previously vaccinated before 2024-25 vaccine with: 1 or more doses Moderna or Pfizer-BioNTech: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 dose Novavax: 1 dose 2024-25 Novavax 3-8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. 2 or more doses Novavax: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 or more doses [NAME]: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. For adults [AGE] years of age and older, Previously vaccinated before 2024-25 vaccine: follow recommendations above for previously vaccinated persons ages 19-64 years and administer dose 2 of 2024-25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).On 8/20/25 at 11:00 am, the Director of Nursing confirmed the clinical record did not indicate staff had offered R80 a COVID-19 vaccination upon admission.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that the Minimum Data Sets (MDS) 3.0 were coded accurately in the area of Active Diagnosis and Preadmission Screening and Resident Review (PASRR) for 2 of 21 sampled (Resident #6 and #9).1. On 8/18/25 and 8/19/25, Resident 6's bedroom door was observed to have an Enhanced Barrier Precautions sign posted on the door. Review of the clinical record indicated the resident was re-admitted to the facility in April 2025 with a diagnosis of neurogenic bladder requiring a suprapubic catheter and a history of Extended-Spectrum Beta-Lactamase (ESBL), a Multidrug-Resistant Organism (MDRO), in the urine. Review of the Quarterly MDS dated [DATE], the Significant Change MDS dated [DATE] and the most recent Quarterly MDS dated [DATE] indicates, under Active Diagnosis section I1700 stated that the resident #6 did not have a Multidrug-Resistant Organism. 2. On 8/20/25, Resident #9's clinical record was reviewed and included a Level II PASRR, dated 1/22/19 which indicated the resident was eligible for services due to diagnosis of Alzheimer's disease, major mental psychotic disorder and deaf and mute since childhood. Review of the Quarterly MDS's dated 7/31/24, 10/25/24, 1/24/25, 7/17/25 and the Annual MDS dated [DATE] under section S0510 PASRR lacked evidence of a PASRR level II being completed. On 8/20/25 at 12:31 p.m., during an interview, the Director of Nursing confirmed both Resident #6 and 9's MDS's were coded incorrectly.