STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215001	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, document review it was determined that the facility failed to have an effective process in place to ensure a resident's personal property was kept safe and available to the residents. This was evident for 1 (Resident# 83) of 7 Residents reviewed for food during a survey. The findings include: On 6/23/25 at 8:48 AM Resident # 83, a long-term resident of the facility, reported that the food served in the facility is hard to chew and his family often brings in food form home for him/her to eat. On 6/24/25 at 7:20 AM an observation was made of Resident #83s family members speaking with the long-term care unit 1 secretary (Staff #10). Resident #83s family member reported to the secretary that s/he brought food in for Resident #83 on 6/23/25. However, s/he just looked in the unit refreshment refrigerator and the food was not there. 06/24/25 08:00 AM the corporate dietician provided the facility's policy titled Food from Home Policy. On 6/24/25, a review of the Food form Home Policy revealed that all food items that are brought in by the family must be labeled with content and date and if not consumed within 3 days will be thrown away by the facility. On 6/24/25 at 12:18 PM the Regional Director of the food service (Staff #2)) was interviewed. During the interview she reported that the kitchen is responsible for cleaning out the refrigerators every morning and discarding any expired food. On 6/24/25 at 12:59 PM The Regional Certified Dietary Manager (Staff #3) was interviewed. During the interview he reported that he cleaned out the refrigerator in the long-term care unit every morning this week and he removed all items without an expiration date. He reported that he looked for 2 dates the date it is placed in the refrigerator and the expiration date. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 1:31 PM a nurse on long term care 1 (Staff #4) was interviewed. She reported that the door to the room that houses the refrigerator that contains residents' food brought from home is locked. When a resident or resident brings in food the nursing staff makes sure the food is properly labeled prior to the resident placing it in the refrigerator. Nurse #4 reported that one of the label requirements is the date the food is placed in the refrigerator. Nurse #4 reported that the food is thrown out 3 days after that date. She confirm that the food is not required to be labeled with an expiration date. 06/27/25 04:43 PM 4:37 PM the above concern that the food form home policy is not consistently followed by staff was discussed with the administrator and Director of nursing. No additional information was provided prior to the end of the survey.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. Based on observations, record review and interviews, it was determined that the facility failed to provide reasonable accommodations to maintain residents' independence by failing to ensure access to call lights and lighting controls. This was found to be evident for one (Resident #40) out of ten residents reviewed for activities of daily living; and 10 out of 10 rooms observed for location of lighting controls.The findings include: 1. On 6/26/25 at approximately 12:11 PM, the surveyor observed Resident #40 out of bed and seated in their wheelchair on the right side of their bed. The surveyor noted that the resident's call bell was tied to the left side bed rail and was out of the resident's reach. The surveyor then asked a Nursing Assistant (GNA #17) to enter the room and assess the placement of the call bell. GNA #17 confirmed that the call bell was out of reach and repositioned it closer to the resident.On 6/27/25 at 1:55 PM, the surveyor observed Resident #40 out of bed and seated in their wheelchair on the right side of the bed. Once again, the surveyor noted that the call bell was tied to the left side bed rail and was out of reach. The surveyor asked the Nurse Unit Manager (UM #8) to come to the resident's room. UM #8 confirmed that the call bell was out of reach and moved it within the resident's reach. The surveyor expressed concern that this was the second instance in which the call bell had been observed tied to the bed and inaccessible to the resident. UM #8 acknowledged the concern and stated that she would remind staff to ensure the resident is provided access to their call bell whenever s/he is out of bed.On 6/30/25 at 8:43 AM, the surveyor met with the Nursing Home Administrator (NHA) to express concern that Resident #40 had been placed in their wheelchair at bedside without their call bell within reach on two occasions during the past week. The NHA confirmed that the expectation is for the call bell to be accessible to the resident at all times.

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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. Based on medical record review and interview it was determined that the facility failed to ensure health care advance directives were discussed with a resident. This was found to be evident for 1 (Resident #79) out of three residents reviewed for advance directives. The findings include: Resident #79 has resided at the facility for several years and is certified as having adequate decision making capacity. Review of an Advanced Directive admission assessment form revealed the following: An advanced directive allows you to decide who you want to make health care decisions for you if you are unable to do so yourself. You can also use it to say what kinds of treatments you do or don't want, especially the treatments often used in a medical emergency or near the end of a persons life. Review of the Advance Directive admission form for Resident #79 revealed that staff documented in February 2023 that an Advanced Directive was currently in place. Further review of the medical record revealed a Social Service Assessment, dated 3/26/24, that documented in the section titled: Health Care Decision Making, that the resident had an Advance Directive document and that it was on file. On 6/25/25 further review of the medical record failed to reveal an Advance Directive in either the electronic medical record or the paper chart. On 6/25/25 at 11:39 AM the Social Service Designee (SSD Staff #23) reported that Advance Directives are used to help a resident maintain their wishes when they can no longer make decisions. She went on to report that she asks about them on intake and often has to explain the difference between MOLST (Maryland Orders for Life Sustaining Treatment) and Advance Directives. If a resident does not have an Advance Directive the SSD indicated she would offer to assist them with establishing one. In regard to Resident #79, SSD #23 reported the resident might be one of the residents that the family brought in the wrong paperwork and indicated she would look into it. Surveyor informed the SSD that the Social Service note from March 2024 indicated an Advance Directive was on file but none was found. On 6/25/25 at approximately 12:30 PM the SSD # 23 provided Durable Power of Attorney paperwork and reported that it was found in the electronic health record. Review of the Power of Attorney paperwork provided by the SSD revealed it did not address health care. Further review of the electronic health record revealed this document was uploaded in March 2024. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 2:15 PM interview with the SSD #23 confirmed that the resident is currently capable to make his/her own health care decisions. SSD reported : I think [s/he] is the one I'm trying to hunt down the right one [Advance Directive paperwork]. SSD confirmed there is no documentation to support that the family was informed the document provided was not related to health care. Surveyor reviewed the concern that previous Social Service documentation indicated an Advance Directive was on file but it is not.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 2. An observation on 6/24/25 at 6:58 AM revealed that Resident #48's room had dark debris, dried food particles, and dried sticky fluid on the floor. The Resident's Representative was present and said, The floor has been like this for at least 2 weeks. In an interview on 6/24/25 at 9:21 AM in Resident #48's room, staff #36, a housekeeping technician, confirmed the concerns and stated that Residents' rooms were to be swept, mopped, and wiped down daily. During a subsequent interview with staff #37, the director of environmental services, in Resident #48's room, he confirmed that there were dark stains, debris, and dried sticky fluid on the floor. Staff then added that the Resident's room looked dirty and would be taken care of after the surveyor's intervention. Based on observations, record review and interviews, it was determined that the facility failed to ensure a clean, comfortable, and home-like environment for residents. This was found to be evident for one (Resident #62) of 10 residents reviewed for activities of daily living and one (Resident #48) identified during an environmental observation. The findings include: 1. Resident #62 has a history of stroke, which requires him/her to depend on staff for total care. S/He has a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/23/25 at 7:55 AM, the surveyor interviewed Resident #62, who complained that the facility had not changed their bed linens and stated that they are typically only changed every couple of weeks. The surveyor observed visible stains on the sheets and a significant amount of dried, flaking skin that appeared to have come from the resident's feet. The pillowcase appeared dingy and soiled, and the bedding was disheveled. On 6/25/25 at 12:30 PM, the surveyor spoke with Resident #62, who reported that their sheets had still not been changed. The surveyor observed that the bed linens remained in the same disarray as the previous day, with the addition of new stains and crumbs present in the bed. On 6/25/25 at 1:00 PM, the surveyor interviewed the Director of Nursing (DON) and inquired about the facility's typical schedule for changing bed linens. The DON stated that sheets are generally changed on shower days and whenever they become soiled. Resident #62's care plan indicates that s/he is scheduled to receive showers twice weekly. On 6/25/25 at 1:31 PM, the surveyor interviewed Geriatric Nursing Assistant (GNA #17), who confirmed that linens should be changed when the resident is showered and whenever they become soiled. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #62, who stated that their sheets had still not been changed. The surveyor observed a stale sweat-like odor, and the sheets contained skin debris, food particles, and stains. On 6/26/25 at 9:16 AM, the surveyor observed Resident #62 in bed with the same dirty sheets and a urine-soaked incontinence pad sliding out from beneath the resident's backside. The sheets smelled of urine and sweat. On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The surveyor expressed concerns that Resident #62 had not had their sheets changed since the surveyors entered the facility on 6/23/25, and that the resident reported typically having to wait at least two weeks for a new set of sheets. The surveyor reported observing soiled sheets with stains, food debris, and a soiled incontinence brief in the resident's bed that morning. The NHA stated she would ensure the linens are changed promptly. On 6/26/25 at 2:18 PM, the surveyor observed that Resident #62's bed linens had been changed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined that the facility failed to implement their grievance policy when a resident alleged their property was missing. This was evident for 1 (Resident #102), of 3 residents reviewed for personal property during the recertification survey. The findings include: On 6/24/25 at 8:56 AM an interview was conducted with Resident #102 who reported that when they were admitted to the facility they brought their wheelchair with leg rests. The resident further explained that the leg rests of their personal wheelchair had been missing for approximately one month and that the physical therapist (Staff #11) had tried to find them. In the meantime, the facility provided other leg rests to the resident. 06/24/25 at 2:35 PM an interview was conducted with unit nurse (Staff #16) regarding Resident #102's wheelchair and leg rests. She said that she was aware of the resident's concern that their personal wheelchair leg rests were missing and the Physical Therapist (Staff #11) was looking for them. When asked if there was anything in writing about the missing wheelchair, she said she she did not know. On 6/24/25 at 3:30 PM an interview with Staff #11 was conducted. He said that Resident #102 had told him about the missing leg rests and that he had been looking for them but had not found them yet. When asked about the process for missing property, Staff #11 said his process was to report any concerns to the nursing department. On 6/24/25 at 3:46 PM the Director of Rehabilitation (Staff #5) was interviewed. He explained that the normal process for missing property was to initiate the grievance process, and that this was done by the person who first learned about the concern. Staff #5 acknowledged that the facility failed to initiate a grievance for Resident #102's missing wheelchair leg rests.

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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 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. Based upon record review and pertinent staff interviews, it was determined that facility failed to ensure that incidents of alleged abuse were thoroughly investigated and reported to the state agency in a timely manner. This was evident for 1 (Resident #125) of 13 residents reviewed for abuse during the survey. The findings include: 1) Resident #125 was admitted into the facility in early 2022. A quick look into the resident's medical record indicated severely impaired mental cognition. A review of the intake information related to MD00192139 was conducted on 6/27/25 at 12:48 PM. The review indicated that Resident #125's family member alleged that another resident may have been inappropriately touching the resident. On 6/27/25 at 1:43 PM, a review of the investigation packet for MD00192139 revealed that the initial report was sent on 5/5/23 at 5:36 PM by the Director of Nursing (DON). The initial report noted the time and date of the incident as 5/5/23 at 4 PM. However, a statement by a nurse (Staff #20) reporting the allegation was signed and dated 5/3/23. The DON was interviewed about the allegation on 6/27/25 at 3:10 PM. During the interview, the DON reported that Resident #125's family member reported the allegation to Staff #20, who then reported it to her. The DON indicated that she investigated and reported the concern immediately. However, the date on the initial report was 2 days after Staff #20 made her statement. The DON acknowledged the concern.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility investigative material, medical record review and interview with resident representatives along with facility staff, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 4 (Resident #17, 121, 125, 118) of 13 residents reviewed for abuse during a survey. The findings include: 1. On 6/24/25 at 7:05 AM review of intake #MD00218372 revealed concerns regarding the care of Resident #17, a long-term resident of the facility. The intake included concerns that a staff member stuck Resident #17. On 6/25/25 the facility provided a self-report investigation regarding the above concern. 6/25/25 at 9:30 AM review of the facility self-report revealed a statement from Resident #17 that was taken by the Unit Manager (Staff # 8) on 5/22/25. Review of Resident #17 statement revealed that s/he reported that the staff feeding her/him the previous night kept hitting her/his nose when the staff was pulling the spoon out of her/his mouth. The resident stated that s/he told her to stop but the Aide did not stop. The resident reported s/he spit out the food and the Aide smacked her upside the head. The resident motioned to the right temple area when asked where s/he was hit. On 6/25/25 The police were notified regarding the above allegation of abuse. Review of the police report, recorded on 5/21/2025 at 6 PM, revealed the following statement, It should be noted that (Resident #17) had visible redness at the corner of (her/his) right eye and complained of eye pain. I photographed the area to document the possible injury. On 6/25/25, the review of Resident #17's medical record (prior to the allegation of abuse) from 5/19/25 to 5/21/25 failed to reveal documentation regarding any discoloration to Resident #17s eye. On 6/25/25 Review of Resident #17's medical record revealed a late entry note dated 5/22/2025 at 9:00 AM titled Change in Condition Late Entry. Further review of this note revealed the change in condition included a small red discoloration noted to the right corner of the right eye. Further review of the medical record failed to reveal a follow-up change in condition form regarding the right eye discoloration. On 6/26/25 at 5:53 PM the Director of Nursing (DON) was interviewed. During the interview she reported that a follow-up change in condition should be completed within 72 hours of the initial change in condition documentation. She confirmed that residents medical record did not contain a follow up change in condition nor was the resident asked why she was rubbing her eye. On 6/26/25 at 5:56 PM The above concerns were discussed with the DON, that there was a lack of thorough investigation into the resident possible injury following an allegation of abuse. No additional information was provided prior to the end of the survey. 2. A review of the facility reported incident #MD00211311 revealed that a local hospital emergency department contacted the facility to report that Resident #121 had been pushed at the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's investigation file revealed that in addition to the self-report to the state agency, it contained 3 pages of documents that appeared to be medical records. These documents lacked the name of the patient or the healthcare facility. One of the pages contained a nurses note dated 10/28/24 17:00 [5:00 PM] which stated pt [patient] arrives to ED [emergency department] c/o [complaint of] 20/10 [pain score which rated patient said pain level 20 on scale of 0-20] R [right] leg pain. Pt. has significant bruising to the leg without any deformities. Pt also has bruising to the L [left] cheek and blood coming from her mouth. Pt stated she was pushed at [NAME] Lake. Pt is alert and oriented x 4 upon assessment repeatedly asking for a pain shot. Further review of the facility's investigation file revealed a typed statement with the Nursing Home Administrator's handwritten name and signature, that was dated 10/28/24. The paragraph stated that she received a call from [police officer name] stating he had met with the resident and spouse at the emergency room. The spouse told the police officer that Resident #121 was allegedly pushed by someone about 2 months prior at another facility, and they felt that the resident's bruises were from that alleged incident. Further review of the facility's investigation file failed to reveal any investigation of Resident #121's care at the facility or investigation notes. There were no witness statements, no staff or resident interviews, and no evidence that the resident facility medical records were reviewed. Although the facility's self-report contained a police report number, no report was found in the file. On 6/27/25 at approximately 4:10 PM an interview was conducted with the Nursing Home Administrator (NHA) to review the lack of evidence that the facility investigated the resident's allegation that he/she was pushed. The NHA acknowledged that she heard the surveyor's concern but had no response. No further evidence was provided by the end of the survey. 3) Resident #125 was admitted into the facility in early 2022. A quick look into the resident's medical record indicated severely impaired mental cognition. A facility reported incident (FRI) related to MD00192139 alleged that Resident #125 was inappropriately touched by another resident of the facility. The facility's investigation for the FRI mentioned above was reviewed on 6/27/25 at 1:43 PM. The review revealed the final report submitted by the Director of Nursing (DON) on 5/9/23. The final report noted that the allegation of sexual abuse was unsubstantiated because Resident #125 had no injuries based on the provider assessment and staff that were interviewed had not observed any inappropriate touching. Further review of the investigation revealed the social services director interviewed 3 residents and had no concerns. However, the interview documentation was not dated, 4 other residents were also interviewed but the documentation failed to reveal who conducted the interview and was not dated as well. One documentation for staff interview was filed with the investigation that indicated the staff (Staff #21) had not witnessed anything. This document was dated 5/12/23. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 6/27/25 at 3:10 PM. During the interview, the concern was discussed that resident interviews were not dated, 4 of the 7 residents interviewed failed to indicate who conducted the interview, and the 1 staff interview documented was dated 3 days after the final report was submitted. The DON confirmed that the resident interviews were not dated and 4/7 did not indicate who conducted the interviews. Furthermore, the DON indicated that she must have interviewed Staff #21 over the phone, and she may have written her statement when she came back to work. However, there was no other documentation to indicate that Staff #21 was interviewed prior to the completion of the facility's investigation or other staff interviews conducted. The DON verbalized understanding and acknowledged the concern. 4. Resident #118 has a medical history of cerebral infarction (stroke), resulting in hemiplegia and paralysis on the right side, along with polyneuropathy, which causes numbness, pain, and muscle weakness. The resident has a BIMS (Brief Interview for Mental Status) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/27/25 at 3:26 PM, the surveyor reviewed a facility-reported incident (MD00190346), which read as follows: The resident [Resident #118] stated that a staff member came in to provide care and was rough and appeared to be rushing. The resident reported that when the staff member turned them, they placed all their weight on the resident's leg/knee area. The resident's BIMS score is 15. A head-to-toe assessment was completed, with no bruising, swelling, or redness noted. The staff member was suspended pending investigation. Investigation is pending. On 6/29/25 at 7:30 PM, the surveyor reviewed the resident's progress notes, which documented the following: * 3/19/23 at 1:20 PM, Change in Condition Note: Right knee swollen, bruise to right outer knee, unable to bend knee without difficulty. * 3/19/23 at 1:53 PM, General Nurse's Note: Physician notified for x-ray; change in condition noted to have occurred during the 11-7 shift. * 3/19/23 at 9:53 PM, Change in Condition: Ongoing swelling and bruising of the right knee. * 3/21/23 at 10:36 PM, Change in Condition: Bruising continues with less swelling. * 3/23/23 at 2:18 PM, Care Plan Progress Note: New order for Tylenol for five days due to increased leg pain. The facility's investigation packet related to this allegation contained the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* A self-report form completed by former Licensed Nursing Home Administrator (LNHA #32). The form inconsistently listed the time of the allegation as both 11-7a and 11-7p and left the alleged perpetrator section blank. It also indicated law enforcement was contacted but omitted the date, time, case number, and officer's name. * A statement from GNA #33, which read in part (quoted exactly): At 5:45 AM I immediately went to his room to answer the call light and ask to be change, [their] bed was very wet so I told [them] I'm going to bed sheet to change the whole bed why changing [them]. All I did was to ask [them] to move side to side and fasting pad because patient move in bed. S/He always ask you to roll [him/her] that is in so much pain. Only time I touch the patient was to ask [them] to roll so I cloud [NAME] the sheet under [them] and fasting [their] pad. There was no documentation indicating whether GNA #33 was the staff member against whom the allegation was made, nor was there evidence of follow-up to clarify her involvement. The statement she provided contained multiple grammatical and spelling errors, which made it challenging to clearly interpret her account of the events. * Resident #118 statement dated 3/19/23 at 6:00 PM was taken by an unidentified staff member (#34), listed only by first name and last initial, with no title included. The resident reported that the nursing assistant was rough and rushed, resulting in injury to his right knee. There was no evidence of follow-up questions to determine the identity of the alleged perpetrator or whether other witnesses were interviewed. On 3/23/23 at 4:46 PM, the final investigation was submitted to the Office of Health Care Quality by LNHA #32. It failed to identify the alleged perpetrator or include a police report case number, date, time, or officer name. The conclusion read: The GNA (Geriatric Nursing Assistant) involved stated that the resident needed changed due to him being incontinent. She was assisting [them] in turning but never touched [their] knee, nor did she lean on the resident to turn [them]. Head to toe assessment was completed, no bruising, swelling, or redness was noted. X-ray was done as resident complained of pain to right knee. X-ray showed no fracture or any abnormalities to the right knee. Staff interviewed and other residents in GNA's group. No other residents stated they felt rushed by GNA or that GNA was rough with them. Unable to substantiate. On 6/30/25 at 8:31 AM, the surveyor interviewed the current Nursing Home Administrator (NHA) regarding the self-reported incident. After reviewing the facility's investigation, the NHA agreed that: * The identity of the accused staff member was unclear. * No evidence of police report or other staff/resident interviews was included in the investigation packet. * While the skin assessment showed no bruising, multiple clinical notes confirmed swelling and bruising to the resident's knee. The NHA acknowledged that the allegation was not thoroughly investigated.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory time frames to facilitate appropriate care planning and maintain current and accurate assessment records. This was evident for 1 (Resident #311) of 6 residents reviewed for accidents The findings include: The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. The admission MDS assessment is a comprehensive assessment for new Residents and, under some circumstances, returning residents. It must be completed by the end of day 14, considering the date of admission to the facility as day 1. The last day of the observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods. A review of Resident #311's medical record showed that the Resident was admitted to the facility on [DATE]. Continued review included an admission MDS assessment dated [DATE] for Resident #311. The MDS was due on 5/25/25. However, it was completed and signed in section V0200B2 on 5/29/25, day 18, after Resident #311's admission to the facility and four days late. In an interview on 6/30/25 at 8:00 AM, staff #13, MDS Coordinator, confirmed that Resident #311's admission MDS assessment was completed 4days late.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days for a resident admitted to hospice care. This was evident for 1 (Resident #17), of 1 resident reviewed for hospice during a survey The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected on the MDS drives Resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. The nursing home should complete a Significant Change in Status MDS assessment within 14 days when there's a major decline or improvement in a resident's status. On 6/23/25 at 12:50 AM a review of Resident #17's medical records revealed that the resident was first admitted to the facility on [DATE] On 6/23/25 at 12:53 a review of Resident #80's current attending provider's orders revealed an order for hospice with an effective date of 4/21/25. The continued review contained a Significant Change in Status MDS assessment dated [DATE] for Resident 17. The MDS assessment was completed and signed outside of the required time frame in sections Z0500B & V0200B2 on 5/7/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 4 (Resident #35, #311,#110,# 25) of 68 residents reviewed during the survey. The findings include: 1.The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A review of Resident #35's admission MDS assessment dated [DATE], revealed that in Section P, Question P0100 the resident used a limb restraint. On 6/23/25 at 9:58 AM an observation and interview were conducted at the resident's bedside with a family member present. No restraints were observed to be in use or present in the resident's room. When asked, Resident #35 and their family member both said there had never been any restraint used since admission to the facility. On 6/25/25 at 12:18 PM, in an interview with Unit Manager (Staff #15), she said that Resident #35 never used any restraint and that the facility was restraint-free. When Staff #15 was shown the MDS which was coded to for use of a limb restraint, she said that it was inaccurate and that she would talk to the MDS staff. On 6/30/25 at 7:14 AM, in an interview with the MDS Coordinator (Staff #13), she confirmed the MDS was coded in error. On 6/20/25 at 9:30 AM an interview with the Director of Nursing (DON) was conducted to review the survey findings. She acknowledged the deficiency. 2) A record review for Resident #311 on 6/24/25 at 7:43 AM showed that the Resident had a recent right hip surgery due to fracture. The review contained an occupational therapy (OT) evaluation and plan of treatment dated 5/13/25 for Resident #311, which noted that the Resident's range of motion (ROM) to his/her right lower extremity was impaired. However, review of Resident #311's admission MDS dated [DATE] showed documentation that there was no limitation to Resident #311's right lower extremity ROM. In an interview on 6/27/25 at 4:21 PM, staff #5, the Director of Therapy, said per the OT evaluation, Resident #311's right lower extremity ROM was impaired due to the fracture and surgery. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with staff member #13, the MDS Coordinator, she confirmed that the Resident's admission MDS, dated [DATE], documented that Resident #311 had no impairment to his/her right lower extremity ROM. Staff also added that she depended on data from therapy to be pulled into the MDS for completing that part of the MDS; however, she did not have the information about Resident #311's impaired ROM yet. 2a) A review of Resident #311's admission MDS assessment dated [DATE] contained a signature in section Z500B that the MDS assessment was completed on 5/25/25. However, a continued review of the MDS revealed that some sections were completed after the date recorded as the completion date. Sections CDEQS were completed on 5/26/25 by the social worker, Section K was completed on 5/27/25 by the dietitian, and portions of sections A were completed on 5/28/25 by the facility MDS coordinator. Z0500B marks the final step in the MDS assessment process, indicating that an RN assessment coordinator reviewed the entire assessment and validated its completion. This date of completion must be equal to the latest date on which a team member completed any portion of the assessment. An interview with staff #54, Regional MDS Coordinator, confirmed the concern. Staff stated that it was an error on her part because Resident #311's admission MDS was completed on 5/29/25 and should have been documented in section Z0500B as such. 3.) Resident #110 was triggered for a hospital-closed record review during the survey process. A record review revealed that Resident #110 had resided in the facility from [DATE] and was discharged home on 4/15/25. However, the continued review of Resident #110's discharge MDS dated [DATE] revealed that the Resident's discharge status had been recorded as acute hospital. In an interview on 6/30/25, at 7:15 AM, staff #13 stated that Resident #110 was discharged to his/her home on 4/15/25 and that the MDS was recorded in error. Staff said, I'm going to change that now, meaning she would correct the mistake after the surveyor's intervention. 4) An interview on 6/23/25 at 3:50 PM with Resident #25 revealed that s/he had a history of broken bones in the neck and was unable to lift both hands above the head. A review of OT and PT (Physical Therapy) evaluations dated 5/22/25 and 5/23/25, respectively, showed that Resident #25's ROM was impaired in his/her bilateral upper extremities. However, continued review of Resident #25's admission MDS dated [DATE] noted that the MDS had recorded that there was no impairment in the Resident's upper extremity ROM. In an interview on 6/27/25 at 12:03 PM, staff #5, Director of therapy, reported that both PT and OT evaluations recorded impairment to the ROM of both Resident #25's upper extremities. An interview with staff #13, MDS Coordinator, on 6/30/25, at 7:54 AM, confirmed that Resident #25's admission MDS was inaccurately recorded. Staff #13 also said to code impairment to ROM; she used data from therapy, which usually would be pulled into the MDS, but sometimes the information was delayed, depending on when therapy updated their report.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, medical record review, and interview, it was determined that the facility staff failed to develop and implement comprehensive person-centered care plans for residents residing in the facility. This was evident for 4 (Resident , # 56, #26, #77, #40) of 68 residents reviewed during the recertification survey. The findings include: Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. The findings include: 1. Resident #56 has resided at the facility for more than one year and is legally blind. A review of the Minimum Data Set assessment, with an assessment reference date of 7/5/24 revealed the resident was interviewed in regard to activity preferences. This assessment revealed it was very important for the resident to have books, newspapers and magazines to read; to listen to music the resident likes; be around animals such as pets and to participate in religious services or practices. On 6/25/25 a review of the resident's care plan for activities, initiated in 2024 and with a revision date of 5/19/25, failed to include interventions related to the provision of books, newspapers; magazines or music the resident would like. The care plan failed to address the resident's religious preference or that the resident would like to participate in religious services. The care plan failed to include that being around pets is important to the resident. Further review of the care plan addressing activities revealed the following interventions: Staff to encourage resident to attend activities of interest as they occur but failed to include documentation of what type of activity would interest the resident. The care plan also included: Staff to provide a monthly calendar but failed to address the fact that the resident is legally blind and would need assistance reading this calendar. On 6/25/25 the current Activity Director (Staff #39) revealed she had just recently started working at the facility but reported that she would be attending care plan meetings and participating in the development of the care plans. On 6/25/25 at 1:28 PM surveyor reviewed the concern with Nursing Home Administrator regarding the failure to develop a resident centered activity care plan based on the assessment. 2. On 6/23/25 at 3:24 PM Resident #26 a resident admitted to the facility for rehabilitation services, was interviewed. During the interview s/he reported that s/he was not aware of activities in the facility, but sometimes she happens across some of the activities when she is out of her room. On 6/27/25 The review of Resident #26's care plan failed to reveal activities care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/25 at 7:15 AM The Material Data Services coordinator (Staff # 9) was interviewed. She reported that Section F0500 should have been completed for Resident #26 and this information should be implemented into the residents' care plan. She confirmed that Resident #26 did not have active activities care plan. On 6/27/25 at 4:43 PM The above concerns were discussed with the Administrator and Director of Nursing. No additional information was provided prior to the end of the survey. 3. On 6/23/25 at 10:17 AM Resident #77, a long-term resident of the facility was interviewed. During the interview s/he reported that s/he would like to participate in more activities. S/he reported that s/he has only been offered bingo as an activity, and s/he is tired of it. On 6/25/25 02:40 PM Review of MDS annual ARD dated 1/11/2025 revealed that section F was completed. Section F, of F00500 documented that it was very important to have books, newspapers, magazines to read and to go outside to get fresh air. The continuing review revealed that the resident reported that it was not very important for her/him to do things with groups of people. On 6/25/25 at 3:03 PM Review of Resident #77's care plan activities revealed the following inventions were documented: Resident #77 will be invited to participate in group activities of his choice such as bingo. This activity did not match the residents stated activity preference. Information gathered in the MDS assessment and Resident #77 would be offered a weekly activities bulletin. On 6/27/25 at 7:18 AM confirmed that the care plan for resident #77 did not match the most recent MDS activity assessment. On 6/27/25 at 4:30 PM the above concerns were discussed with the director of nursing. No other information was provided prior to the end of the survey. 4. Resident #40 has a history of severe dysphasia (difficulty swallowing) following a cerebral infarction (stroke) and failure to thrive (a state of decline characterized by weight loss and decreased appetite). On 6/23/25 at 8:55 AM, the surveyor observed Resident #40 in bed, feeding themselves unsupervised. Food was spilling from the resident's mouth, and they were making audible gargling and crackling sounds, prompting the surveyor to seek assistance due to concern for choking. The surveyor asked Nurse #44 to assist the resident. A few minutes later, the nurse exited the room with the resident's tray and stated, They are fine and have difficulty swallowing. On 6/23/25 at 1:00 PM, the surveyor observed Resident #40 out of bed, alone in their room, seated in a wheelchair with a meal tray in front of them, eating without supervision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/25 at 3:04 PM, the surveyor reviewed Resident #40's care plan (a personalized document that outlines the specific health and personal care needs of an individual, detailing how those needs will be met) which identified the need for a mechanically altered diet with puree texture and nectar thickened liquids. The resident was care-planned for aspiration (when material enters the airway or lungs while swallowing) precautions every shift, one-person assistance with eating, and supervision during meals. The care plan also noted that the resident should be out of bed for meals and back to bed after lunch and to document any refusals of care. Further review of Resident #40's medical record revealed a Speech Therapy evaluation dated 5/6/25, which indicated that the resident had severe impairment and experienced coughing and choking during meals and when swallowing medications. The evaluation identified the resident as being at high risk for aspiration. On 6/23/25 at 3:37 PM, the surveyor interviewed Geriatric Nursing Assistant (GNA #19) and asked about Resident #40, specifically the expectations for meal assistance. GNA #19 stated that the resident used to need to be fed but now [they] can do themselves but should always be watched to eat. GNA #19 added that the resident is normally taken to the dining room but refused to go that day. When asked how supervision is handled for residents who refuse the dining room, GNA #19 stated, Someone should be in [their] room with [them] when [they] eat. The surveyor asked if the resident should be out of bed to eat, and GNA #19 confirmed that [they are] supposed to be out of bed to eat and refusals should be documented. On 6/23/25 at 3:53 PM, the surveyor spoke with the facility Director of Nursing (DON) and expressed concerns regarding observations of Resident #40 eating unsupervised in their room on two occasions, including one instance where the resident appeared at risk of choking. The surveyor also informed the DON that the resident had been observed eating in bed during one of the incidents. The surveyor asked the DON to review the GNA task documentation for that day, which indicated that Resident #40 was out of bed for breakfast. However, the surveyor observed the resident eating in bed without assistance. The surveyor referenced the resident's care plan, which stated that the resident was to be out of bed for meals and that refusals should be documented. On 6/25/25 at 1:14 PM, the surveyor observed Resident #40 seated in a wheelchair at their bedside with two nectar thickened drinks on their tray and no staff supervision present. On 6/26/25 at 12:23 PM, the surveyor spoke with the Director of Nursing (DON), who agreed that, after reviewing the resident's chart and aspiration risk, the orders related to aspiration precautions were confusing and provided evidence that a change of condition note had been entered for Resident #40 following the 6/23/25 incident where the surveyor observed the resident gurgling while eating. She stated that the care plan would be updated so that the GNA's were clear about the resident requiring supervision and that any new speech therapy orders would be included in the care plan update.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and interview it was determined that the facility failed to ensure interdisciplinary care plan meetings were held following Minimum Data Set (MDS) assessments. This was found to be evident for one (Resident #11) out of six residents reviewed for unnecessary medications. Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. The findings include: Review of Resident #11's medical record on 6/24/25 revealed the resident has resided at the facility for several years. A quarterly Minimum Data Set (MDS) assessment, with an assessment date of 3/6/25, was completed in March. A significant change MDS, with an assessment reference date of 5/11/25 was completed in May. Further review of the medical record failed to reveal documentation to indicate an interdisciplinary care plan meeting was scheduled or occurred following either of these MDS assessments. On 6/25/25 at 2:35 PM surveyor requested from the Nursing Home Administrator documentation of care plan meetings held since January 2025. At 4:10 PM the Director of Nursing reported there have been no care plan meetings for this resident since January.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, observations, and record review it was determined that the facility failed to provide activities of daily living (ADL) care to dependent residents. This was evident for five (Resident #83, #25, #112, #15 and Resident #62) out of ten residents reviewed for ADL care. The findings include: 1.On 06/23/25 at 8:44 AM Resident # 83, a long-term resident of the facility, and their family members were interviewed. During the interview they reported that the resident goes a long time without receiving incontinent care from the staff. On 6/25/25 at 7:39 AM an observation in Resident #83 room was made. A family member and a resident were in the room. Observation revealed that the resident's top bedsheet was soaked with liquid, which had a slight smell of urine. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected on the MDS drives Resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. On 6/26/25 review of the quarterly MDS dated [DATE] revealed that Resident #83 was always incontinent of bowel and bladder, indicating that the resident was dependent on the staff for incontinent care. On 6/26/25 at 12:25 PM the Director of Nursing (DON) was interviewed regarding the incontinent care provided to the residents at the facility. She reported that the staff were to check residents every 2 hours and provide incontinent care when needed. In addition, the staff were to document, in the medical record (under TASKS), once a shift that incontinent care was provided during each shift. On 6/26/25 at 12:37 PM the geriatric nursing assistant documentation (TASKS) for incontinent care was reviewed for the time frame 5/28/25 through 6/26/25. The review revealed 15 of the 29 days of that period, failed to record all three shifts documenting that incontinent care was completed. On 06/26/25 at 01:01 PM during an interview the DON confirmed the lack of documentation for Resident #83's incontinent care. No additional documentation was provided prior to the end of the survey. 2.An interview with Resident #25 on 6/23/25 at 9:07 AM, showed that s/he only received one shower a week sometimes. Record review on 6/25/25 at 1:17 PM, showed that Resident #25 had been in the facility since May 2025. A continued review included a care plan for Resident #25. The care plan noted that the Resident was to have showers on Wednesdays and Saturday mornings,, meaning eight showers in a month and required staff assistance with the showers. The review also showed that Resident #25 also went for dialysis on Wednesday mornings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent review of the GNA (Geriatric Nurse Aid) shower documentation for Resident #25 from 5/22/25-6/25/25 was completed. The review showed one shower in May and two showers in June. The review also recorded that Resident #25 refused showers one time in May and twice in June, one of the days being a dialysis day. In an interview on 6/26/25 at 7:19 AM, staff #15, unit manager for the TCU unit, stated that whenever residents refused showers, it was documented which helped flag it so that staff would re-offer the shower to the residents the following day. However, the interview failed to show that Resident #25 was re-offered a shower the next day following a refusal especially when s/he refused shower on a dialysis day. Staff verbalized understanding of concern and added that one of Resident #25's shower days was also a dialysis day so she would talk to the resident to find out if s/he preferred to change it to another day. 3. Resident #112 was admitted into the facility in early 2022. A review of the intake information related to MD00199099 revealed concerns with nursing services that include not feeding the resident. A review of Resident #122's medical record was conducted on 6/23/25 at 10:33 AM. The review revealed a nutrition evaluation by the dietitian (Staff #22) with a service date of 9/27/23 that stated, resident is now fully dependent on staff for meals. Dietitian #22 again indicated in a progress note with an effective date of 10/6/23 that Resident #122 was fully dependent on staff for meals. Further review of the resident's medical record indicated that the resident was placed on hospice care effective 10/16/23. Hospice is a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The main goal of hospice care is to control pain and other symptoms of illness so patients can be as comfortable as possible A review of the task documentation for eating was conducted on 6/23/25 at 11:27 AM. The review conducted was for the dates between 9/27/23 (when Dietician #22 indicated that Resident #122 was dependent on staff for eating) and 10/16/23 (when the resident was placed on hospice care). The review revealed 15 shifts where the nursing staff had not documented any assistance and 3 shifts with set up only. The Director of Nursing (DON) was interviewed on 6/23/25 at 2:07 PM. During the interview, the findings were discussed and the DON reported that during the last couple of weeks before Resident #122 passed, family members were coming in and were feeding the resident and indicated that the holes/absence in the task documentation was because of this reason. The instructions for the task documentation on SUPPORT PROVIDED for eating was reviewed with the DON. Option 8 read, ADL activity did not occur or family and/or non-facility staff provided care 100% of the time. The DON indicated that option 8 was what the staff should have documented on the medical record and that she would continue to review to find out more information and report back to the surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Later, on a subsequent interview with the DON at 2:56 PM, the DON reported that she found a progress note from the provider with an effective date of 10/11/23 that indicated the resident's family came in and fed the resident. However, no other documentation was found to indicate that adequate assistance was provided to Resident #122 to complete the eating task for 15 shifts out of the 18 days reviewed. the DON verbalized understanding and acknowledged the concern. 4) Resident #15 has a medical history of stroke and hemiplegia (complete loss of strength on one side of the body) which requires that s/he has total assistance for activities of daily living. S/He has a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/25/25 at 1:40 PM, Resident #15 informed the surveyor that they had not received a bed bath or been changed since sometime during the night shift and stated that they are incontinent. The surveyor observed that the resident was still in bed and wearing a gown. The surveyor located Geriatric Nursing Assistant (GNA #17) and asked whether she had attended to Resident #15 during the current shift. She stated that she had not yet been in the room to turn, bathe, or change them, adding that they sometimes refuse care and prefers to sleep in. When asked if she documents such refusals, she stated that she does so occasionally but had not documented anything for today. The surveyor then asked whether she had offered to change the resident that day, and GNA #17 admitted she had not, explaining that she waits for them to call if they want assistance. When asked about the facility's expectations for turning and changing dependent residents, she stated that she understands residents should be turned and changed every two hours. The surveyor informed the GNA that the resident is requesting that she attend to their care and subsequently observed GNA #17 entering Resident #15's room. On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #15, who confirmed that GNA #17 had cleaned and changed them the previous day but stated they had not yet been attended to that morning. Later, at approximately 9:01 AM, the surveyor asked if they had received a shower on 6/25/25. The resident stated that a shower had not been offered. When asked if they ever refuse showers, they responded that they do on occasion but generally enjoy them. At 9:04 AM, the surveyor reviewed the medical record, which indicated that the resident had received a shower on 6/25/25. However, the resident and his roommate, Resident #62, stated that Resident #15 had not received, nor had s/he been offered, a shower on 6/25/25. Both residents have a BIMS score of 15 and have been articulate when interviewed by the surveyor. On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to express concerns that Resident #15 was documented as having received a shower, despite the resident denying that a shower was provided. The DON stated she would look for a corresponding shower sheet, which is required for all residents who receive showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 1:27 PM, the surveyor followed up with the DON, who confirmed that there was no shower sheet on file for Resident #15 for 6/25/25 to support the documentation that a shower was provided. 5) Resident #62 has a history of stroke, which requires him/her to depend on staff for total care. They have a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/23/25 at 7:55 AM, the surveyor interviewed Resident #62, who reported that they had not received a shower in at least two weeks. The resident stated that they require the use of a Hoyer lift to get out of bed and that the facility does not have enough staff to operate the lift with only one aide. As a result, the resident reported that they often remain in bed and do not receive showers. The surveyor observed that the resident had greasy hair and face, an untrimmed beard and hair, extremely dry skin on the legs and feet, and an odor of sweat and urine. On 6/25/25 at 12:30 PM, the surveyor spoke with Resident #62, who reported that they still had not received a bed bath or shower. The surveyor observed the same dried skin flaking from the resident's feet onto the linens, as well as greasy hair, unshaven facial hair, and body odor. The surveyor had not observed the resident out of bed or cleaned since arriving at the facility on 6/23/25. On 6/25/25 at 12:42 PM, the surveyor reviewed Resident #62's medical record, which documented that the resident received a shower at 2:50 AM on 6/25/25. Further review confirmed that the resident is fully dependent on staff for ADL care, including personal grooming, bathing, and showering. The record also included an order dated 12/27/22 for the use of a Hoyer lift to assist with transfers. On 6/25/25 at 1:31 PM, the surveyor conducted an interview with Geriatric Nursing Assistant (GNA #17), who stated that Resident #62 is scheduled for nightly showers twice weekly and bed baths during the day shift. When asked if the resident ever gets out of bed, GNA #17 responded, We will get [her/him] up if we can, and explained that the resident uses a Hoyer lift and requires more staff to assist with transfers. When asked if the resident had received a bed bath that day, she replied, I haven't had time to get to [her/him], and added that because the resident often refuses care, I just leave [her/him] because [s/he] will call if [s/he] needs me. On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #62, who reported that they still had not received a bath or shower. The surveyor observed that the resident continued to have extremely greasy hair, oily facial skin, debris in an untrimmed beard, body odor, and flaky dry skin on the legs, which had shed onto the bed linens. When asked if they ever refuse showers, the resident replied, No, I would love to get cleaned up. The surveyor then asked if they had been out of bed recently, and the resident stated that the last time they were out of bed was when they attended a baseball game with the activities department, which occurred about two or three weeks ago. When asked if they would get out of bed if offered, the resident responded that they want to get up daily but are not asked. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to express concerns that Resident #64 was documented as having received a shower, despite the resident denying that a shower was provided. The DON stated she would look for a corresponding shower sheet, which is required for all residents who receive showers. On 6/26/25 at 1:27 PM, the surveyor followed up with the DON, who confirmed that there was no shower sheet on file for Resident #62 for 6/25/25 to support the documentation that a shower was provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Resident #56 has resided at the facility for more than one year and is legally blind. A review of the Minimum Data Set assessment, with an assessment reference date of 7/5/25 revealed the resident was interviewed in regard to activity preferences. This assessment revealed it was very important for the resident to have books, newspapers and magazines to read; to listen to music the resident likes; be around animals such as pets and to participate in religious services or practices. During an interview with the resident on 6/23/25 at 10:58 AM the resident denied that activity staff visit him/her. On 6/25/25 a review of the medical record revealed a care plan for activities, initiated in 2024 and with a revision date of 5/19/25. The interventions included, but were not limited to: Staff to provide 1:1 room visits as desired/available; Staff to assist resident in locomotion to activities as desired; and Staff to encourage resident to attend activities of interest as they occur. On 6/25/25 at 12:40 PM review of the Activity Participation logs for June 2025 failed to reveal documentation to indicate the resident participated in any activity or received a 1:1 visit during the 24 days reviewed. Review of the Activity Participation logs for May 2025 failed to reveal documentation to indicate the resident participated in a group activity during May; and the resident received 1:1 visits on May 20 and 23 only. On 6/25/25 at 12:57 PM interview with the Activity Assistant (Staff #38) revealed staff document 1:1 visits on the participation logs. She also reported there was a separate paper documentation to document refusals. On 6/25/25 at 1:09 PM surveyor asked the Activity Director (Staff 39) and the Nursing Home Administrator (NHA) about documentation by activity staff when/if a resident refuses services. They were unable to locate documentation for May or June for refusals. On 6/25/25 at 1:28 PM surveyor reviewed the concern with NHA regarding the failure to provide activity services for Resident #56. As of time of survey exit on 6/30/25 at 1:15 PM the facility had not provided additional documentation regarding these concerns. Cross reference to F 656 Based on observations, record review, and interview, it was determined the facility failed to implement an ongoing resident centered activities program designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident. This was evident of 4 (Residents #26, #56, #83, and #77), of the 4 residents reviewed for activities. The findings include: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS (Minimum Data Set), is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, which provides appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1. On 6/23/25 at 3:24 PM Resident #26, admitted to the facility for rehabilitation, was interviewed. During the interview s/he reported that s/he is not aware of activities happening in the facility. On 6/23/25 brief review of Resident #26's medical records revealed Resident #26 had a BIMS of 12 (moderately impaired cognition). On 6/25/25 at 10:59 AM review of Resident #26's MDS dated [DATE] failed to reveal that section F 0500, titled Interview for Activity Preferences Assessment, was completed. On 6/25/25 at 11:40 AM Review of Care Plan for Resident #26 failed to reveal a activities care plan. On 6/27/25 at 7:20 AM the MDS coordinator was interviewed. During the interview it was confirmed that the Section F assessment should be completed on every admission MDS assessment. She confirmed that this assessment was not completed for Resident #26. She reported that she was aware of the issue and had been taking steps to correct it. On 6/25/25 the Administrator provided the resident's activities attendance records. On 6/25/25 at 11:01 AM the attendance activity records for the month of May, 2025 and June first through June 24th 2025 were reviewed. The review revealed that Resident #26's only documented activity for the above time period was beauty shop on June 4th On 6/25/25 AT 1:05 PM the activities assistant (Staff #38) was interviewed. During the interview staff #38 reported that residents #26 often refuses to go to activities. Staff #38 reported that the refusals are documented. On 6/25/25 at 1:20 PM during a subsequent interview with activities assistant (Staff #38) she reported that the activities department was unable to provide refusal documentation that the Resident #26 refused participating in activities. On 6/27/25 at 4:43 PM the above concerns were discussed with the Director of Nursing. The Director of Nursing confirmed the concerns. No further information was provided prior to the end of the survey. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 6/23/25 at 8:40 AM Resident #83, a long-term resident of the facility, was interviewed. During the interview s/he reported that s/he rarely gets out of bed, and no one comes into the room for activities. On 6/25/25 at 11:05 AM the Review of annual MDS section F, dated 11/16/24 failed to reveal that sectionF0500, titled Interview for Activity Preferences, was completed. Continued review of section C revealed that the resident had BIMS of 15 indicating the resident had intact cognition On 6/27/25 at 7:23 AM the MDS coordinator was interviewed. During the interview she reported that an activities assessment should be completed on every annual MDS assessment. She confirmed that this assessment was not completed for Resident #83. She reported that she was aware of the issue and had been taking steps to correct it. 06/25/25 the Administrator provided the residents activities attendance records. On 6/25/25 at 11:01 AM the attendance activity records for the month of May 2025 and June first through June 24th, 2025, were reviewed. The review failed to reveal that Resident #83 participated in activities during the above time frame. In addition, the facility failed to provide documentation that the resident was offered activities but refused to participate. 3. On 6/23/25 at 10:17 AM Resident #77, a long-term resident of the facility, was interviewed. During the interview s/he reported that s/he would like more activities. S/he reported that s/he has only been asked to do bingo, and s/he did not like bingo. Observation of resident's room at the time of the interview failed to reveal any books or magazines in the resident's room. On 6/23/25 a brief review of Resident #77 medical records revealed the resident had a BIMS of 15 indicating intact cognition. On 06/25/25 at 2:40 PM Review of MDS, dated [DATE], section F revealed that Resident #77 reported that it was very important for her/him to have books, newspapers, magazines to read and it is very important for her/him to go outside and get fresh air. Continued review revealed that it was not very important for Resident #77 to do things with groups of people. On 6/25/25 at 3:03 PM review of Resident #77's Care plan revealed activities care plan. Review of the activities care plan revealed a Goal of Resident will have the opportunity to enjoy group activities and bingo. The intervention to invite the residents to group activities did not match the information gathered in the MDS assessment. On 6/25/25 observation of Resident #77s room revealed a TV but failed to reveal any books or magazines. 06/25/25 11:01 AM The Administrator provided the activities attendance records for the morning of 06/25/25. Review of the activity attendance for June 1st, 2025, and June 24th failed to reveal that the resident was offered any reading material or the opportunity to go outside. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/25 at 4:43 PM the above concerns were discussed with the Director of nursing. The director of nursing confirmed the concerns. No further information was provided prior to the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and relevant interviews it was determined that the facility failed to provide care consistent with professional standards of practice to promote healing of an existing diabetic foot wound. This was evident for one (Resident #116) of two residents reviewed for pressure injuries during the survey process. The findings include: Negative Pressure Therapy is a vacuum assisted closure (VAC) therapy that uses suction and a dressing to remove excess wound drainage and to promote wound healing. Nursing responsibility for proper VAC functioning and care includes assessing and monitoring that the vacuum device is properly calibrated and functioning and to document the findings. On 6/24/25 at 12:39 PM a record review of the admission face sheet revealed Resident #116's diagnosis was Type 2 Diabetes Mellitus with foot ulcer, Encounter for orthopedic aftercare following surgical amputation, Bipolar Disorder, Post-Traumatic Stress Disorder and Cerebral Infarction, also known as a Stroke. On 6/24/25 at 1:13 PM a review of Resident #116's Care Plan revealed a risk for skin breakdown related to amputation; wound VAC per orders. The Treatment Administration Record (TAR) dated August 2024 revealed a lack of documentation for Negative Pressure Therapy on August 2, 3, 4, 5, and 6. On 6/24/25 a record review of Resident #116's closed medical record including the electronic health record, PointClickCare (PCC) revealed the following: A long-standing Physician order for Negative Pressure Therapy to Right foot SET Unit to 125 mmHg continuously every shift for right great toe. On 8/1/24 Licensed Practical Nurse (LPN #29) wrote a Progress Note, VAC to the right great toe in working order. On 8/2 and 8/3/24 a review of Nurse Progress Notes lacked PCC documentation that the VAC was assessed. On 8/4/24 LPN #29 entered a Nurse Progress Note, patient has wound VAC to the right foot for the right great toe amputee working well. On 8/5/24 a review of Nurse Progress Note lacked PCC documentation that the VAC was assessed. On 8/6/24 Nurse Practitioner (NP #30) wrote a Progress Note that resident was seen as follow up for diabetic right foot abscess. Collaborated with NP wound specialist today regarding worsening of right foot wound now with cellulitis. Assessment and Plan indicated continue negative pressure therapy to right foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 Wound Specialist (NP #31) wrote a General Nurse Note late entry that indicated Wound VAC therapy is in progress; however, it apparently stopped working. Right surgical site deteriorated today. On 8/7/24 at 5:00 PM a General Nurse Note revealed Resident #116 attended the podiatry appointment and was later sent to [NAME] Memorial Hospital for further evaluation. Review of the closed records indicated Resident #116 was hospitalized on [DATE] for right foot wound. On 6/25/25 at 11:55 AM an interview with Registered Nurse (RN #35) revealed that any resident with a pressure ulcer, stage 2 and higher, non-healing surgical sites, and vascular concerns were seen every Tuesday by the wound specialist, Nurse Practitioner (NP #31). Her role was to assist NP #31 with assessments, measurements, treatments and to enter orders into the electronic health record, (PCC). She acknowledged it was nursing responsibility and her expectation that nursing staff would give VAC care in her absence. She also acknowledged that if it's not documented, then it wasn't done. On 6/25/25 at 1:04 PM during an interview with NP #31 it was acknowledged that residents with non-healing surgical sites and a VAC are seen every Tuesday. She indicated that the wound care on the weekends was sub-par. It was also acknowledged that the wound VAC appeared to have not been working over a couple of days prior to her documented assessment on 8/6/24. She acknowledged that it was her expectation that the floor nurses should have known that the VAC was not functioning properly and should have applied the rescue dressing per the order. On 6/25/25 at 2:12 PM in an interview, the Director of Nursing (DON) agreed in principle, if it's not documented, it's not done. She stated that nursing care should be documented on the resident's TAR and/or in the Nurse Progress Notes in PCC. The DON reviewed Resident #116's August 2024 TAR and confirmed it appeared that the VAC was not assessed on August 2, 3, 4, 5 or 6th and that there was a lack of Nursing Progress documentation in PCC on August 2, 3 and 5th. The DON acknowledged that based on documentation and/or the lack thereof, it looks like nursing failed to provide care consistent with professional standards of practice to promote healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, medical record review and interview it was determined that the facility failed to ensure care plan interventions to assist with resident safety were implemented. This was found to be evident for three (Resident #11, #56 and #99) out of six residents reviewed for accidents. The findings include: 1. Review of Resident #11's medical record on 6/24/25 revealed the resident has resided at the facility for several years. The resident has a history of falls, including a fall from bed in 2025. The resident has had a care plan addressing fall risk for several years and on 5/5/25 the following intervention was initiated: low bed with bilateral floor mats. In addition to the care plan intervention, the resident has a physician order, dated 5/5/25 for low bed with bilateral floor mats. Review of the Treatment Administration Record (TAR) revealed an area for nursing staff to document regarding this order every shift. On 6/24/25 at 8:49 AM the resident was observed in bed eating breakfast, no fall mats observed on the floor at this time. On 6/24/25 at 3:20 PM surveyor observed resident in bed at this time; no fall mats on the floor. This observation was confirmed by the unit nurse manager (Staff # 8). At approximately 3:30 PM medical record review revealed the nurse #45 had already signed off on the TAR for the day shift to indicate the bed was in low position with floor mats in place. On 6/24/25 at 3:35 PM the unit nurse manager reported that she had contacted central supply to obtain the floor mats for Resident #11. Surveyor reviewed the additional concern with the unit nurse manager that the day nurse had signed off that the bed was low and floor mats were in place but observation made at 8:30 AM also failed to reveal floor mats being in place. 2. Resident #56 has resided at the facility for more than one year. The resident has a care plan addressing fall risk since June 2023 and on 3/13/25 the following intervention was initiated: low bed with bilateral floor mats. In addition to the care plan intervention, the resident has a physician order, dated 3/13/25, for low bed with bilateral floor mats. Review of the Treatment Administration Record (TAR) revealed an area for nursing staff to document regarding this order every shift. On 6/23/25 at 10:44 AM the resident was observed in bed but no fall mats were observed on the floor. On 6/24/25 at 4:35 PM resident was observed asleep in bed, no floor mat was observed on the floor next to the bed, or elsewhere in the room. This observation was confirmed by unit nurse manager (Staff # 8). Surveyor reviewed the concern that there is an order for the fall mats. Unit nurse manager confirmed that the mats are to remain in place unless a specific order to remove during care. Further review of the medical record revealed staff had signed off for the 6/24/25 day shift indicating the fall mats were in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 4:15 PM surveyor reviewed with the Director of Nursing (DON) the concern regarding the failure to have fall mats in place for Resident #11 or #56 as indicated in their orders and care plans. The DON reported she was aware of this concern and that a full house audit was completed last night. 3. Review of Resident #99's medical record revealed the resident was assessed as being at risk for elopement (when a resident who is deemed not capable of making health care decisions exits the facility unsupervised). The resident has a care plan in place to address the risk of elopement and orders for the use of a wander guard bracelet. A wander guard is an electronic device that alerts staff when a resident is too close to specific exits. The resident was observed wearing a wander guard bracelet on 6/25/25 at 11:03 AM while the resident was ambulating in the hallway. Review of the medical record revealed the order to check for placement of the wander guard was changed on 6/15/25 from the left ankle to the left wrist. On 6/27/25 further review of the elopement care plan revealed an intervention, in place since 2/25/25, indicating the functional status of the wander guard should be checked every shift. Review of the orders and the June Treatment Administration Record (TAR) revealed documentation to indicate staff were completing a check of functionality until the order was discontinued on 6/15/25. On 6/27/25 continued review of the medical record revealed a current order for the wander guard usage and staff were documenting it's presence on the left wrist every shift since 6/15/25. But no documentation was found to indicate the functionality was checked since 6/15/25. On 6/27/25 at 12:28 PM the unit nurse manager (Staff # 8) was asked about checking the functionality of the wander guards. She reported there is an order every shift to check the functionality and that they have a gray box that is used to check the function. The unit nurse manager was able to quickly produce the device (gray box) that is used to check the functionality and was able to demonstrate how it works. The unit nurse manager confirmed that there should be an order to check placement and another order to check function. Surveyor reviewed the concern that no current order was found for Resident #99 to check function since it was discontinued on 6/15/25. On 6/27/25 at 12:59 PM surveyor reviewed the concern with the Nursing Home Administrator that the care plan indicated every shift check for functionality but no documentation to indicate the functionality has been assessed since the 15 th of June.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, it was determined that the facility failed to provide pain management, per physician orders, to residents. This was evident for 2 (Resident #50, and #42) of 5 residents reviewed for pain management during the recertification survey. The findings include: 1. A review of Resident #50's medication orders revealed an order dated 6/17/25 for the short-acting pain medication oxycodone to be given every 4 hours as needed (PRN) for acute pain [rated] 7-10. On 6/23/25 at 10:22 AM an interview was conducted with Resident #50. They said they were in severe pain and that they had been waiting since 6:00 AM to receive the PRN oxycodone but was told by their nurse that the medication was not available. On 6/23/25 at 10:57 AM an interview was conducted with Resident #50's assigned nurse (Staff #16) who said the night shift agency nurse told her she medicated the resident at 6:00 AM but that it was the last one so needed to be re-ordered. On 6/23/25 at 11:10 AM an interview with the Unit Nurse Manager (Staff #15) and nurse (Staff #16) was conducted at the resident's medication cart to review Resident #50's medication orders and medication supply. The review revealed that the resident received the PRN oxycodone at 2:39 AM, and that the pill blister pack was empty. A review of the narcotic sign out sheet for the oxycodone showed that the last tablet was removed at 2:39 AM. The Unit Nurse Manager #15 and Nurse #16 confirmed that there was no medication available to provide to the resident. On 6/30/25 at 9:30 AM an interview was conducted with the DON to review the survey findings and she acknowledged the deficiency. 2. In an interview on 6/23/25 at 10:05 AM, Resident #43 reported that pain was his/her biggest issue when s/he was first admitted to this facility. A review of Resident #43's medical record on 6/25/25 at 9:33 AM showed that s/he had been residing in the facility since April 2025 with diagnoses including chronic pain. The continued review included an attending provider's order for Resident #43, which was initiated on 4/21/25. The order indicated to attempt Non-Pharmacological Interventions (NPIs) before giving Resident 43 any PRN pain drug (NPIs- are interventions without the use of medications). Further review of Resident #43's medication administration records (MAR) for April 2025 contained an attending provider's order to give Resident #43 Oxycodone 5mg every 4 hours as needed for pain level 4-10. A pain scale/level ranges from 0 to 10; 0 means no pain, and 10 represents the worst pain. It is used to assess a patient's level of pain, allowing for more effective treatment to be provided. Resident #43's MAR had recorded that the nurses administered the medicine to the Resident from 4/21/25 to 4/30/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, the review failed to show a record of Resident #43's pain assessment before administering the medicine, including the location and the type of pain. The review also lacked documentation that NPIs were attempted on 4/21/25, 4/27/25, 4/28/25, and 4/29/25 before administering the medicine to Resident #43. In an interview with the Unit Nurse Manager #15, she expressed an understanding of concerns. She stated that she would educate staff on pain assessment before and after giving PRN pain medicine.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observations, medical record review and interviews it was determined that the facility failed to ensure behavioral health care services were provided as needed. This was found to be evident for one (Resident #56) out of three residents reviewed for behavioral health services. The findings include: Resident #56 has resided at the facility for more than one year. Minimum Data Set (MSD)assessments were completed by facility staff in January and April of 2025. Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. Review of Section D Mood of the 4/4/25 MDS revealed that, based on a Resident Mood Interview the resident had a severity score of 10, indicating moderate depression. On 6/23/25 at 11:18 AM during an interview with the surveyor, the resident became agitated and teary eyed. Surveyor informed nurse (Staff #45) that the resident had become upset during the interview when discussing an event in the past, the nurse reported the resident has anxiety issues. Review of the medical record on 6/26/25 revealed the psychiatric nurse practitioner (Staff #46) saw the resident on 3/27/25. Review of the note for this visit revealed the resident was seen for evaluation and medication management. The resident was diagnosed with Anxiety disorder and insomnia (difficulty sleeping). The patient should continue Ativan 1.5 mg Q [every] Mon, Wed, and Fri, Ativan 0.5 mg QHS [at bedtime], and Melatonin 3 mg to prevent the return of symptoms. The note also indicated the resident would benefit from continued behavioral health. Also found in the 3/27/25 psychiatric nurse practitioner note: [S/he-Resident] also mentions uncertainty about whether [s/he] is receiving [his/her] prescribed Ativan in the evenings as recommended. Continue current medication regimen and supportive care. Ativan, also known as Lorazepam, is a controlled substance. Therefore, there are controlled drug sheets that staff are required to document on whenever a dose of the Ativan is removed from the supply. Staff must document how many doses are removed and how many are remaining in that supply at the time of the dose removal. On 6/26/25 review of the drug control sheets for Resident #56's Ativan supply failed to reveal documentation to indicate the evening dose of Ativan was removed from the supply on 7 out of the 25 days in June that were reviewed. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 3:49 PM surveyor reviewed with the Director of Nursing (DON) the 7 dates in which no documentation was found to indicate the Ativan was removed from the supply in June. Surveyor also informed the DON of the psychiatric nurse practitioners documentation in March that the resident thought s/he was not receiving the Ativan as ordered every evening. As of time of survey exit on 6/30/25 no additional documentation was provided to indicate the the Ativan was obtained to be administered as ordered to the resident on those seven occasions in June. Cross reference to F 760. On 6/26/25 further review of the medical record revealed a note completed by psychologist (Staff #47) for a visit completed on 4/2/25. This note indicated the resident had the cognitive ability and verbal capacity to participate and benefit from psychotherapy; the patient's condition results in significant impairment in social, behavioral, psychological and emotional functioning; as well as interfering with compliance of recommended medical treatments or therapies; and patient's condition will deteriorate if patient does not participate in psychotherapy or if treatment discontinues. The last sentence of the Session Summary states: Encourage participation in social/physical/outdoor activities as possible to improve/maintain mood; follow up in approx. 2-3 weeks to reassess. Underneath psychologist #47's signature is the following statement: The above-signed certifies that the services recommended above are necessary for patient care. Further review of the medical record failed to reveal documentation to indicate a follow up visit by either the psychiatric nurse practitioner, the psychologist, or other behavioral health service provider after 4/2/25. On 6/26/25 at 5:00 PM surveyor requested from the Nursing Home Administrator any additional psychiatric notes since April 2025. On 6/26/25 at 5:11 PM the psychiatric nurse practitioner #46 reported the resident does not want any psychiatric medications other than Ativan. She reported psychologist #47 no longer sees residents at this facility, that he only comes in for competency evaluations but does do telehealth visits. After surveyor reviewed the concern that psychologist #47's note from April revealed a plan to follow up with the resident in 2-3 weeks but then no follow up was found, the nurse practitioner indicated she will let the new therapist know to come see the resident. On 6/26/25 at 6:06 PM the Nursing Home Administrator confirmed that there were no additional psychiatric notes since April 2025. On 6/30/25 at 9:45 AM surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure behavioral health services, specifically in regard to the failure of the psychologist to return for follow up as indicated in the note as well as the failure to administer the Ativan as ordered on multiple occasions.

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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 medical record review and interview it was determined that the facility failed to ensure pharmacist reviewed sufficient sections of the resident's medical record to identify significant medication errors. This was found to be evident for one (Resident #56) out of three residents reviewed for behavioral health services. The findings include: Review of Resident #56's medical record on 6/26/25 and 6/30/25 revealed significant medication errors in regard to the anti-anxiety medication Ativan during the month of June 2025. These errors included the failure to administer an evening dose of Ativan on 7 out of 25 days reviewed; and the administration of an extra 0.5 mg of Ativan on 5 occasions. These errors were identified by reviewing the drug control sheets for the resident's Ativan as well as the Medication Administration Record in the electronic health record. Cross reference to F 760. Review of the facility's drug control sheets revealed they are kept in a bound book located on each of the medication carts. These sheets were not found in the electronic health record. On 6/30/25 review of the June Medication Administration Records (MAR) revealed that there was an order, originally written 12/30/24 and in effect on 6/25/25, for Ativan 0.5 mg give 1 tablet by mouth in the morning every Monday, Wednesday and Friday for anxiety, give with 1 mg tab to total 1.5 mg. Staff had documented the administration of this 0.5 mg tablet at 5:00 AM as ordered every Monday/Wednesday/Friday from June 2 thru June 25. No documentation was found to indicate this order was discontinued on or before June 25. In addition to the 12/30/24 order for Ativan 0.5 mg to be given with the 1.0 mg M/W/F, there was a duplicate order, written on 6/16/25 for 0.5 mg give 0.5 mg every M/W/F for anxiety; Give with 1mg on dialysis days; total dose of 1.5 mg on dialysis days. Staff had documented that this dose was administered on June 18, 20, 23, and 25. Review of the June MAR revealed staff documented in the mornings of June 18, 20, 23 and 25 the administration of one 1.0 mg Ativan; and two 0.5 mg Ativan. Review of the drug control sheets support that on the mornings June 20 and 23 staff actually administered a total of 2.0 mg of Ativan to the resident, rather than the 1.5 mg as indicated in the order. On 6/30/25 further review of the medical record revealed pharmacist (Staff #51) had completed a monthly medication regimen review (MRR) on 6/25/25 at 11:18 PM with No Recommendations. On 6/30/25 at 11:14 AM interview with pharmacist #51 revealed she covers when other pharmacist are on vacation. She reported that as part of the MRR she reviews the medications, the labs and any pertinent changes from the last month. She confirmed she reviews any medications orders that are active on the resident's profile. Surveyor then reviewed the concern that a duplicate order for Ativan was in place: two orders for the 0.5 mg to be given with the 1.0 MWF. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 6/30/25 at 11:44 AM, pharmacist #51 reported that the duplicate order did not show up on the recap summary when she reviewed the orders. She confirmed that she does look at the Medication Administration Record (MAR) but stated that the recap summary report and the MAR should be identical. When asked if she compares the MAR with the drug control sheets, the pharmacist reported they try to periodically check those as well, but she completed the MRR remotely and was not in the building at the time of the review.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on review of the medical record and interviews it was determined that the facility failed to keep a resident safe from significant medication errors. This was found to be evident for one (Resident #56) out of three residents reviewed for behavioral health services. The findings include: Review of Resident #56's medical record revealed the resident received dialysis treatments Mondays Wednesdays and Fridays in the mornings, and the resident also has a diagnosis of Anxiety. Review of the most recent psychiatric nurse practitioner note, dated 3/27/25, revealed the resident: should continue Ativan 1.5 mg Q [every] Mon, Wed, and Fri; and Ativan 0.5 mg QHS [at bedtime]. a.On 6/26/25 review of the medical record revealed an order for Ativan Oral Tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth at bedtime for anxiety was in effect from 3/20/25 until it was discontinued on 6/19/25. Further review of the medical record revealed a current, identical order, was put in place on 6/19/25 for the 0. 5 mg of Ativan at bedtime. Review of the medication administration record on 6/26/25, revealed staff documented the administration of the 0.5 mg Ativan to the resident at 9:00 PM every evening from 6/1/25 through 6/25/25. Ativan, also known as Lorazepam, is an antianxiety medication and considered a controlled substance. Therefore, there are controlled drug sheets that staff are required to document on whenever a dose of the Ativan is removed from the supply. Staff must document how many doses are removed and how many are remaining in that supply at the time of the dose removal. On 6/26/25 review of the drug control sheets for Resident #56's Ativan supply failed to reveal documentation to indicate the evening dose of Ativan was removed from the supply on June 2, 3, 4, 7, 12, 14 or 15th. On 6/26/25 at 3:49 PM surveyor reviewed with the Director of Nursing (DON) the 7 dates in which no documentation was found to indicate the Ativan was removed from the supply in June. Surveyor requested any additional documentation to indicate if the medication was pulled from the interim supply or if there was another drug control sheet. As of the time of survey exit on 6/30/25 no additional documentation was provided to indicate the the Ativan was obtained to be administered as ordered to the resident on those seven occasions in June. b. The resident also had a supply of 1.0 mg Ativan tablets to be given with a 0.5 mg for a total of 1.5 mg to be given prior to dialysis. These doses were scheduled to be given at 5:00 AM Monday/Wednesday/Friday. Further review of the drug control sheets revealed doses of the 1.0 mg tablets were removed from the supply in the evening of June 9, 11 and 16. No documentation was found to indicate 0.5 mg doses were removed on these evenings. On 6/26/25 at 3:49 PM the surveyor reviewed this information with the DON. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c.Further review of the drug control sheets revealed that on the morning of June 20th and 23 staff pulled one 1.0 mg dose and two 0.5 mg doses, for a total of 2.0 mg being pulled in the morning. On 6/26/25 at 3:49 PM the surveyor reviewed this information with the DON. On 6/30/25 further review of the June Medication Administration Records (MAR) revealed that there was an order, originally written 12/30/24 and in effect on 6/25/25, for Ativan 0.5 mg give 1 tablet by mouth in the morning every Monday, Wednesday and Friday for anxiety, give with 1 mg tab to total 1.5 mg. Staff had documented the administration of this 0.5 mg tablet at 5:00 AM as ordered every Monday/Wednesday/Friday from June 2 thru June 25. No documentation was found to indicate this order was discontinued on or before June 25. In addition to the 12/30/24 order for Ativan 0.5 mg to be given with the 1.0 mg M/W/F, there was another order, written on 6/16/25 for 0.5 mg give 0.5 mg every M/W/F for anxiety, give with 1mg on dialysis days; total dose of 1.5 mg on dialysis days. Staff had documented that this dose was administered on June 18, 20, 23, and 25. Review of the June MAR revealed staff documented in the mornings of June 18, 20, 23 and 25 the administration of one 1.0 mg Ativan; and two 0.5 mg Ativan. Review of the drug control sheets support that on the mornings June 20 and 23 staff actually administered a total of 2.0 mg of Ativan to the resident, rather than the 1.5 mg as indicated in the order. On 6/30/25 at 9:46 AM surveyor reviewed with the DON the concerns regarding the following Ativan medication errors: -failure to administer medication as ordered: No documentation to indicate the evening dose of Ativan was pulled from a supply on 7 out of 25 occasions in June 2025; - failure to ensure correct dosage: On three other occasions a 1 mg dose was pulled, rather than the ordered 0.5 mg dose indicating twice the ordered dose was administered to the resident on the evenings of June 9, 11 and 16. - failure to ensure correct dosage: A duplicate order was in place from June 16 to June 25, for 0.5 mg to be given with 1.0 mg, review of MAR and drug control sheets indicate the resident received 2 mg on the mornings of June 20 and 23 rather than 1.5 mg. In a follow up interview with the DON on 6/30/25 at 10:01 AM the DON acknowledged that she did not have additional documentation/information to dispute the missing doses or the instances when an additional 0.5 mg was administered in error. The DON did report the medical director was notified, they were addressing the medication errors with the specific nurses, had instituted some process changes and began education with nursing staff. She confirmed these actions were in response to the concerns brought up by surveyor last week. Cross reference to F 740

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

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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 record review, it was determined that the facility failed to store and prepare food in accordance with professional standards. This deficient practice has the potential to affect all residents. The findings include: 1) An observation of the facility's walk-in refrigerator on 6/23/25 at 7:08 AM, with staff #48, Interim dietary services manager present, showed 9 cartons of milk with expiration dates of 6/22/25. A continued observation of the walk-in freezer showed 10 bags of veal meat in a paper box. Staff stated the meat was received on 10/9/24; however, there was no label of the expiration date. Staff was questioned about the use-by date and said, I see what you mean, it should have been labeled with the expiration date. A subsequent observation of the LTC unit snack refrigerator on 6/24/25 at 12:29 PM, with staff #52, a licensed practical nurse present, showed a plate of cold salad with no label indicating the date it was prepared or the use-by date. The observation also noted milk, sandwiches, a bowl of applesauce, and cups of pudding on the top rack of the fridge. However, below that was a brown paper in a brownish liquid. Staff #52 was asked about the cleanliness of the refrigerator, and she responded that it looked disgusting and dirty. Staff also said she would find out who was responsible for cleaning it and report back to the surveyor. During an interview on 6/24/25 at 1:35 PM, staff #8, the unit manager for the LTC unit, indicated that housekeeping usually cleaned the unit refrigerator monthly. Staff also added that the concern about the fridge not looking clean would be addressed immediately. 2) During the initial tour of the facility on 6/23/25, Residents #43, #39, #62, and #61 reported that the facility's food was usually cold by the time they received their trays. Later that day, a review of the food service temperature logs was done. The review failed to show food service line temperatures for dinner on 3/28/25, breakfast and lunch on 3/29//25, Dinner on 3/31/25, Dinner on 5/9/25, Lunch on 5/16/25, Dinner on 5/26/25, Breakfast and lunch on 6/13/25, Lunch on 6/16/25, Dinner on 6/18/25, breakfast and lunch on 6/21/25. During an interview on 6/23/25 with staff #49, the Regional Training manager reported that staff were expected to check food temperatures for every meal before service. And if the reading was below the acceptable temperature, they were to reheat it before serving it to the residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review, observation and interview it was determined the facility failed to ensure staff accurately documented in the medical record. This was found to be evident for one (Resident #56) out of three residents reviewed for behavioral health service; and three (Resident #40, #62, and #268) out of ten residents reviewed for Activities of Daily Living. The findings include: 1. Review of Resident #56's medical record on 6/26/25 revealed an order for Ativan Oral Tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth at bedtime for anxiety, was in effect from 3/20/25 until it was discontinued on 6/19/25. Further review of the medical record revealed a current, identical order, was put in place on 6/19/25 for the 0.5 mg of Ativan at bedtime. Review of the medication administration record on 6/26/25, revealed staff documented the administration of the 0.5 mg Ativan to the resident at 9:00 PM every evening from 6/1/25 through 6/25/25. Ativan, also known as Lorazepam, is an antianxiety medication and considered a controlled substance. Therefore, there are controlled drug sheets that staff are required to document on whenever a dose of the Ativan is removed from the supply. On 6/26/25 review of the drug control sheets for Resident #56's Ativan supply failed to reveal documentation to indicate the evening dose of Ativan was removed from the supply on June 2, 3, 4, 7, 12, 14 or 15th. On 6/26/25 at 3:49 PM surveyor reviewed with the Director of Nursing (DON) the 7 dates in which no documentation was found to indicate the Ativan was removed from the supply in June. On 6/30/25 at 11:35 AM surveyor informed the Nursing Home Administrator of the concern regarding staff documenting administration of the Ativan that was not pulled from supply on 7 occasions. As of time of survey exit on 6/30/25 no additional documentation was provided to indicate that the Ativan was obtained to be administered as ordered to the resident on those seven occasions in June. 4. On 6/25/25 at 12:12 PM a record review of Geriatric Nursing Assistant (GNA) Task documentation for Resident #268 revealed blank spaces where staff should have documented what personal hygiene care was given on 6/17/25 night shift, and on 6/18/25 for both the day shift and night shift. Further review revealed blank spaces for the task turned and repositioned on 6/18/25 for day and night shift, on 6/19/25 night shift, and on 6/21/25, 6/22/25, and 6/23/25 night shifts. On 6/26/25 at 2:46 PM in an interview with the Unit Nurse Manager (Staff #15), she reviewed the GNA care documentation and confirmed that GNA care was not documented. On 6/30/25 at 9:30 AM an interview was conducted with the Director of Nursing to review the deficiency, and she acknowledged that the facility failed to document care activities for Resident #268. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #40 has a history of severe dysphagia (difficulty swallowing) following a cerebral infarction (stroke) and failure to thrive (a state of decline characterized by weight loss and decreased appetite). On 6/23/25 at 8:55 AM, the surveyor observed Resident #40 in bed, feeding themselves unsupervised. On 6/23/25 at 3:04 PM, the surveyor reviewed Resident #40's care plan (a personalized document that outlines the specific health and personal care needs of an individual, detailing how those needs will be met) which identified the need for a mechanically altered diet with puree texture and nectar thickened liquids. The resident was care-planned for aspiration (when material enters the airway or lungs while swallowing) precautions every shift, one-person assistance with eating, and supervision during meals. The care plan also noted that the resident should be out of bed for meals and back to bed after lunch and to document any refusals of care. On 6/23/25 at 3:53 PM, the surveyor spoke with the Director of Nursing (DON) and expressed concerns regarding observations of Resident #40 eating unsupervised in their room and informed the DON that the resident had been observed eating in bed during one of these observations. The surveyor asked the Director of Nursing (DON) to review the Geriatric Nursing Assistant (GNA) task documentation for the day, which indicated that Resident #40 was out of bed for breakfast. However, the surveyor observed the resident eating in bed without assistance. The surveyor referenced the resident's care plan, which states the resident is to be out of bed for meals, and that any refusals should be documented. The DON confirmed that the GNA should have documented the resident's refusal to get out of bed and should not have recorded that the resident was out of bed when they were not. 3. Resident #62 has a history of stroke, which requires them to depend on staff for total care. They have a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/23/25 at 7:55 AM, the surveyor interviewed Resident #62, who reported that they had not received a shower in at least two weeks. The surveyor observed that the resident had greasy hair and face, an untrimmed beard and hair, extremely dry skin on the legs and feet, and an odor of sweat and urine. On 6/25/25 at 12:30 PM, the surveyor spoke with Resident #62, who reported that they still had not received a bed bath or shower. The surveyor observed the same dried skin flaking from the resident's feet onto the linens, as well as greasy hair, unshaven facial hair, and body odor. On 6/25/25 at 12:42 PM, the surveyor reviewed Resident #62's medical record, which documented that the resident received a shower at 2:50 AM on 6/25/25. On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #62, who reported that they still had not received a bath or shower. The surveyor observed that the resident continued to have extremely greasy hair, oily facial skin, debris in an untrimmed beard, body odor, and flaky dry skin on the legs, which had shed onto the bed linens. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to express concerns that Resident #64 was documented as having received a shower, despite the resident denying that a shower was provided. The surveyor added that the resident has appeared unwashed since the survey entrance. The DON stated she would look for a corresponding shower sheet, which is required for all residents who receive showers. On 6/26/25 at 1:27 PM, the surveyor followed up with the DON, who confirmed that there was no shower sheet on file for Resident #62 for 6/25/25 to support the documentation that a shower was provided. She stated that it is the expectation that staff accurately documents ADL care and records refusals.

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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 review of medical records and facility policies, interviews, and observations, it was determined that the facility failed to implement an effective infection prevention program that ensured staff implemented infection control practices. This was found to be evident for two (Resident #96, #70) of the 68 resident's reviewed and has the potential to affect all residents.The findings include:1. On 6/26/25 at 8:23 AM surveyor observed nurse #24 prepare and administer Resident #96's medications. At 8:38 AM the nurse was observed wearing gloves while washing the resident's feet prior to administration of a medicated cream. The nurse changed gloves after washing the resident's feet and prior to applying the medicated cream, however the nurse failed to perform hand hygiene after removing the gloves worn while cleaning the resident's feet. After applying the medicated cream the nurse remove his/her gloves, did not perform hand hygiene, and then removed two new gloves from the clean supply but did not put them on. The nurse proceeded to put those gloves back in the box of clean gloves. The nurse then left the room to obtain the dirty laundry cart from the hallway. The nurse re-entered the room and obtained two gloves which s/he put on and proceeded to remove the dirty laundry generated from washing the resident's feet. After discarding this pair of gloves the nurse did perform hand hygiene.On 6/26/25 at 9:28 AM the unit nurse manager (Staff #15) confirmed the expectation is for staff to perform hand hygiene between glove changes. Surveyor then reviewed the observation of the nurse's failure to perform hand hygiene between glove changes and replacement of removed gloves back into a box of gloves. 2. An observation made on 6/23/25 at 10:31 AM noted signage on Resident #70's door that indicated that the Resident was on EBP, which required wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions (EBP) are infection control measures designed to reduce the transmission of infections in healthcare settings, including nursing homes. It involves the use of gowns and gloves during high-contact Resident care activities, such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with infections or colonization of MDROs (multi-drug-resistant organisms), indwelling medical devices, or wounds.A subsequent observation on 6/23/25 showed that staff #43, a geriatric nurse aide (GNA), was providing morning care to Resident #70. Staff #43 had put on gloves, but the observation failed to show that she wore a gown.A record review later that day noted that Resident #70 was on EBP due to having dialysis access and a wound.In an interview on 6/23/25 at 10:38 AM, GNA#43 was asked what the EBP signage on Resident #70's door meant. GNA #43 stated that it was intended to wear gloves and a gown when providing direct care to Resident #70 because s/he had a wound. Staff then added that she initially wore a gown, but it got wet, so she took it off and continued to provide direct care to Resident #70 without a gown. Staff confirmed concern and said, You are right, I should have replaced the gown before continuing to provide care to Resident #70. An interview on 6/26/25 at 9:24 AM with staff #15, unit manager for the TCU unit, revealed that staff were expected to gown and wear gloves when providing direct care to Resident #70. Staff #15 also said she would give education to the staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 06/25/25 at 11:26 AM, the surveyor interviewed the Laundry Assistant Manager (Staff #41) and Laundry Assistant (Staff #42) and requested to see the soiled linen room. Staff guided the surveyor from the clean area into the dirty area, which was separated by a swinging door. The surveyor observed several wheeled bins overflowing with clothing and linens. The bins did not have lids and were not labeled as clean or dirty. When asked what the bins contained, Staff #41 and Staff #42 collectively stated that they held dirty laundry.When asked whether the bins have lids, Staff #41 stated that, in her 11 years of employment, the bins have never had lids. She added that a request had been made in the past, but lids were never received. When asked how often the bins are cleaned, Staff #41 stated they are wiped out about every two weeks.The surveyor asked about the process for removing clean laundry from the soiled side to be taken to the clean side for drying. Staff #41 retrieved a bin from the clean side of the laundry and verbally identified it as a clean bin, though it was not labeled and did not have a lid. She demonstrated rolling the bin into the soiled room, where it had to be placed directly next to the dirty linen bins to transfer the freshly washed laundry for drying. At the end of the interview, the Director of Environmental Services (DES #37) joined the conversation and stated that he had only been working at the facility for three weeks. He confirmed that the soiled linens have not been covered since his arrival and noted that, at times, he will throw a sheet over the dirty linens. On 6/25/25 at 11:47 AM, the surveyor discussed concerns regarding the handling and storage of soiled linens with the Nursing Home Administrator (NHA). The NHA acknowledged that the Director of Environmental Services (DES #37) was new to the facility and agreed that the current practices were a concern.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on employee file reviews and staff interviews, it was determined that the facility failed to ensure that staff were offered and educated about COVID-19 immunizations. This was evident in five (Staff #14, #25, #26, #27, #28) out of six employee files reviewed for staff immunization compliance. The findings include: On 6/26/25 at 4:19 PM, the surveyor reviewed six employee records and was unable to find evidence that education or an offer of the most recent 2024-2025 COVID-19 vaccine had been provided for five out of the six reviewed. On 6/27/25 at 11:54 AM, the surveyor spoke with the facility's Infection Preventionist to inquire about evidence of staff education and documentation indicating that the 2024-2025 COVID-19 immunization had been offered. She stated that she was not aware it was an annual requirement and, as a result, had not provided education or offered the vaccine to any staff members this year. Of the six staff reviewed, she was only able to provide one immunization record reflecting a booster received this year. On 6/30/25 at 8:30 AM, the surveyor spoke with the Nursing Home Administrator and asked if she was aware of the requirement to annually educate and offer the COVID-19 immunization. She stated that she is now aware of this requirement.