

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Ballenger Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 347 Ballenger Drive Frederick, MD 21701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, it was determined that the facility failed to ensure that a resident who required assistance with self-care was groomed in a manner that preserved the resident's dignity. This was evident in 1 (Resident #34) of 1 resident reviewed for dignity. 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. The information collected informs resident care planning decisions. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff use care plans to provide resident-centered care, including support, services, and resources to address Residents' needs. An observation on 6/24/26 at 10:43 AM noted Resident #34 seated in a wheelchair by the bedside. The Resident had a significant amount of facial hair on the chin and upper lip. The Resident expressed a desire to have it shaved. A subsequent observation on 6/25/26 at 11:41 AM showed that Resident #34 still had facial hair on the chin and upper lip. A record review on 6/25/26 at 11:47 AM included an admission MDS assessment for Resident #34. The MDS noted that Resident #34 had severely impaired cognition and required staff assistance with self-care, including personal hygiene. A review of Resident #34's care plan noted that the Resident required assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. The review did not indicate that Resident #34 preferred to wear facial hair. During an interview on 6/25/26 at 11:48 AM, staff #10, a nursing assistant, reported that Resident #34 required staff assistance with personal hygiene, including shaving. When asked about Resident #34's facial hair, staff #10 responded, I will take care of it later. In an interview on 6/25/26 at 11:57 AM, staff #2, the unit manager (UM) for the nursing hall where Resident #34 resided, stated that she expected Resident #34's facial hair to have been shaved if Resident #34 preferred it. The UM said she would have it shaved immediately after the surveyor's intervention.		

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 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. Based on interviews, observations and record reviews, it was determined that the facility failed to ensure resident room temperature was maintained based on the resident's comfort level and preference. This was evident for 1 (Resident #129) of 4 residents reviewed for environment. The findings include: Resident #129 was a newly admitted resident of the facility. During an interview with the resident on 6/24/26 at 1:14 PM, s/he stated, the room is too cold, and nobody has an idea what to do. The resident also reported that s/he requested a friend to bring in a thick blanket and was observed using it on top of the facility provided blanket. However, the resident indicated that it was not enough and that s/he was still cold. The resident's room had an air vent cover with fixed louvers and there was no thermostat or control unit found in the resident's room with the ability to change the room temperature. The maintenance director (Staff #31) was interviewed on 6/30/26 at 11:02 AM. During the interview, Staff #31 reported that room temperatures were controlled by a thermostat. However, there was only 1 thermostat for every 4 rooms. Staff #31 was further questioned about his process when a resident wants to change his/her room temperature. Staff #31 explained that he tries to get a median temperature setting for the 4 rooms and if 1 room still needs to be adjusted, the vent covers have adjustable louvers to lessen the air flow and would offer extra blankets to help warm the resident according to their preference and comfort level. An observation of Resident #129's room was then conducted with Staff #31. Staff #31 confirmed that the resident's vent cover did not have adjustable louvers and reported that he would find a replacement. While in the room, the resident again reported to the surveyor and staff that having 2 blankets was not enough to warm him/her up. Staff #31 indicated that he was not aware of the resident's concern about the room temperature and that the facility had an electronic system to report and track maintenance concerns, however facility staff preferred to report concerns by writing it in the maintenance binder. The maintenance binder located in front of the nurse's station was reviewed with Staff #31 on 6/30/26 at 11:10 AM. The review revealed a form titled Work order request with columns for date and time, requested by, request with room number, and completed by. An entry dated 6/23/26 indicated a concern in Resident #129's room that read, s/he reports his/her room is really cold, could we look at adjusting the vent blades. This entry had a signature under the completed by column and Staff #31 reported that it was his assistant's signature (Staff #32). There was no documentation to indicate what was completed by Staff #32 other than his signature. Staff #31 reported that he did not know what was done either and indicated that he would ask Staff #32. An interview with Staff #32, in the presence of Staff #31 was conducted on 6/30/26 at 11:15 AM. During the interview, Staff #32 reported that the thermostat was adjusted (moved up) and that an internal damper was closed to lessen the air flow to Resident #129's room. However, there was no documentation to indicate these actions, only his signature. Further review of the binder revealed another entry for the resident's room dated 6/30/26 that read, air vent blowing cold air - wants covered. This entry had also been signed by Staff #32 as completed and when asked what he had completed he reported that he did not need to do anything because he had already addressed the issue in the past. The surveyor then asked if he had at least explained to the resident today the actions he had done since he signed the request as completed. Staff #32 then stated, oh my god, fu*k this. Then threw his keys on the counter and walked away. Staff #31 stated, He's absolutely wrong with the way he reacted. On 6/30/26 at 11:22 AM, the concern was discussed with Staff #31 that Staff #32 was pre-signing work order request as completed with no documentation, report, and/or evidence that the concern had been addressed. Staff #31 verbalized understanding and acknowledged the concern.		

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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 reviews and staff interviews, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes to maintain current, accurate assessment records. This was evident for 3 (Residents #24, #37, and #34) of 3 residents reviewed for Resident assessment. The findings include: The MDS is a federally mandated assessment tool that nursing home staff use to gather information about each Resident's strengths and needs. The information collected informs Resident care planning decisions. The admission MDS is a comprehensive assessment for new Residents and, under certain circumstances, returning Residents. It must be completed by the end of day 14, with the date of admission to the facility as day 1. The last day of the observation period is the Assessment Reference Date (ARD). It marks the end of the observation period and serves as a common reference point for all team members involved in the assessment. 1) Record review on 6/29/26 at 9:51 AM showed that Resident #24 was admitted to the facility on [DATE]. A continued review included Resident #24's admission MDS assessment dated [DATE], which was due to be completed by the facility on 6/21/26. However, further review showed that the Resident's admission MDS was signed as complete in sections V0200B2 and Z0500B on 6/23/26, 16 days after Resident #24's admission to the facility, making it 2 days late. During an interview on 6/30/26 at 8:46 AM, staff #4, an MDS Coordinator, confirmed that Resident #24's admission MDS assessment was completed late. 2) A review on 6/29/26 at 9:55 AM of Resident #37's admission MDS assessment with ARD 6/14/26 revealed that Resident #37 was admitted to the facility on [DATE]. A continued review of the MDS assessment showed that it was due to be completed on 6/21/26. However, further review showed that it was signed as complete in sections Z0500B and V0200B2 on 6/24/26, 17 days after Resident #37's admission to the facility and 3 days late. During a follow-up interview on 6/30/26 at approximately 9:00 AM, Staff #4 confirmed that Resident #37's admission MDS was completed late. 3) A record review conducted on 6/24/26 at 12:05 PM for Resident #34 included an admission MDS assessment dated [DATE]. The review showed that the Resident was admitted to the facility on [DATE]. Therefore, the admission MDS assessment was due on 6/14/26. However, a subsequent review showed that Resident #34's admission assessment was signed as complete in sections Z0500B and V0200B2 on 6/16/26, 16 days after the Resident's admission to the facility, making it 2 days late. During an interview on 6/30/26 at approximately 9:05 AM, staff #4 checked the completion date of Resident #34's admission MDS and reported that it was completed late.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, 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 who experienced a major decline in health status that impacted more than one area of the Resident's health. This was evident for 1 (Resident #3) of 5 residents reviewed for unnecessary medications. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information about each Resident's strengths and needs. The information collected on the MDS informs Resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. Activities of daily living (ADLs) is a term used to collectively describe the fundamental skills required to care for oneself independently, such as eating, bathing, and mobility. A significant change means a major decline or improvement in the Resident's status that will not normally resolve without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the Resident's health status and requires interdisciplinary review or revision of the care plan, or both. The nursing home should complete a Significant Change in Status MDS assessment within 14 days of a major decline or improvement in a resident's status. A review of Resident #3's medical record on 6/25/26 at 3:25 PM included an MDS assessment dated [DATE], which noted that Resident #3 had a diagnosis of Dementia, severely impaired cognition, and required setup or cleanup assistance from staff with eating, and partial/moderate assistance with oral hygiene, upper-body dressing, and wheeling in a wheelchair for 50 feet. A continued review showed that in March 2026, Resident #3 was hospitalized for a left thigh fracture repair. Upon the Resident's return to the facility, an MDS assessment for Resident #3 was completed with an ARD of 3/23/26. The MDS recorded that Resident #3 required partial/moderate assistance from staff with eating and was fully dependent on staff for oral hygiene, upper-body dressing, and wheel self for 50 feet. The review showed a decline in Resident #3's ability to eat, perform oral hygiene, upper-body dressing, and propel himself/herself once set up in a wheelchair. The review also included a nutrition evaluation note dated 3/24/26, which recorded significant weight loss over 1, 3, 6 months. However, the review failed to show that a significant Change in Status MDS assessment was completed for Resident #3 to reflect the decline in ADLs and significant weight loss. An interview with staff #24, a registered dietitian, on 6/29/26 at 8:18 AM confirmed that Resident #3 was observed to have significant weight loss upon returning from the hospital in March and April 2026. In an interview with staff #4, an MDS nurse, on 6/30/26, at 8:46 AM, she reported that she would complete a Significant Change in Status MDS assessment for a decline in more than one area of a resident's ADLs, significant weight loss, or a fracture. Staff #4 reviewed Resident #3's medical record and confirmed that his/her decline would warrant a Significant Change in Status MDS assessment. Staff #4 added that her corporate MDS person would also be notified of the final decision regarding completion of a Significant Change in Status MDS. However, the interview did not show that the corporate MDS person was notified of Resident #3's decline.		

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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 interviews and record reviews, it was determined that the facility failed to ensure that a resident's representative participated in the care plan process. This was evident for one (Resident #34) of 3 residents reviewed for care planning. The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. Care plans are developed to guide residents' care in the facility. They must be created within 7 days of completing a resident's comprehensive MDS admission assessment and revised at least quarterly (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team, including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable). Participation in care planning by a resident and a resident representative can take many forms, such as holding care planning conferences (meetings) when the resident representative (RP) is available to participate, conference calls, or videoconferencing. In an interview on 6/24/26 at 10:48 AM, Resident #34 was asked about his/her care plan meeting and stated that he/she did not recall any such meeting. A medical record review showed that Resident #34 was admitted to the facility in June 2026. The review noted that Resident #34 had been assessed by two attending providers, who determined that the Resident lacked adequate decision-making capacity due to a diagnosis of Dementia (Dementia is not a specific disease but a general term for impaired ability to remember, think, or make decisions that interfere with everyday activities). A continued review included an admission MDS assessment for Resident #34, which documented that Resident #34 had severely impaired cognition. The review also included a baseline care plan record dated 6/1/26 for Resident #34, which listed the Resident's son as the Resident's RP. Further review included care plan meeting notes dated 6/9/26 for Resident #34, indicating that the Rehab manager, Unit manager, dietitian, social services, activities director, and the Resident were present. However, a message was left for Resident #34's RP during the meeting. The review lacked supporting evidence that the facility had attempted to involve Resident #34's RP in the Resident's care plan meeting prior to the meeting. The care planning meeting notes also indicated that, during the meeting, Advance Directive offered to complete, resident declined. However, an earlier review of records showed that Resident #34 had been evaluated by two attending providers and deemed incapable of making health care decisions due to a diagnosis of Dementia. Therefore, the Resident's RP needed to be present at the meeting for any decision-making to occur. During an interview on 6/29/26 at 1:09 PM, staff #18, a social services designee, reported that if a resident lacked decision-making capacity, the facility would continue calling the Resident's RP until the RP was available to attend the care plan meeting. However, staff #18 reported that the call to Resident #34's RP regarding the 6/9/26 care plan meeting was made during the meeting, and a voicemail was left. In a follow-up interview on 6/29/26 at 3:22 PM, staff #19, the Social Services director, explained her expectations and indicated that, if a resident lacked decision-making capacity, the Resident's RP should be invited in advance of care plan meetings.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review and interview it was determined that the facility failed to ensure that staff only documented completing tasks that were actually completed. This was found to be evident for one (Resident #117) out of four residents reviewed for pressure ulcer care. The findings include: On 6/24/26 at 2:13 PM surveyor observed Resident #117 seated in their room. The bed had an air mattress which was observed to be set at 180 lbs., and static was set to the on position. Static mode on an air mattress means the mattress maintains a constant even pressure without inflating or deflating. When static is not on the air mattress will cycle the inflation and deflation of air cells providing pressure relief. After the observation at 2:13 PM, review of the medical record revealed there was an order, in effect since 6/5/26, for: LAL (low air loss) alternating pressure mattress: Check function Q [every] shift, set to resident's weight; Static button off unless providing care. The resident's weight on 6/23/26 was documented as 81.8 lbs. On 6/24/26 at 3:08 PM review of the Treatment Administration Record (TAR) for June 2026 failed to reveal documentation to indicate the nurse had completed the check of the air mattress for the day shift, as evidenced by a blank space in the section to document. On 6/24/26 at 3:59 PM further review of the June TAR revealed Nurse #23 had signed off that this order was completed during the day shift on 6/24/26. On 6/24/26 at 4:16 PM surveyor asked Nurse #23 if she had checked the resident's air mattress today and Nurse #23 responded: No, I didn't. Surveyor and Nurse #23 then reviewed the electronic health record and noted the resident's weight was 81.8 lbs. Surveyor then reviewed the TAR with Nurse #23 who confirmed her initials on the documentation that indicated the mattress was checked and that the static button was off. Surveyor and Nurse #23 then entered Resident #117's room. Resident was in bed at this time. Nurse #23 confirmed that the air mattress was set at 180 lbs. and the Static was set to on. On 6/25/26 at 3:20 PM surveyor reviewed the concern with the Unit Nurse Manager (UM#6) regarding the air mattress setting and that the nurse had signed off that it was checked. On 6/30/26 at 2:45 PM surveyor reviewed with the Director of Nursing the concern that staff had documented that they had checked the air mattress setting when they had not.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations, and record review, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received supervision with oral intake and showers. This was evident for 2 (Resident #88, #28) of 5 residents reviewed for ADL care. The findings include: 1) Activities of Daily Living (ADLs) are the essential everyday self-care tasks required to live safely and independently, such as bathing, dressing, and feeding. Resident #88 has complex medical diagnoses which include, in part, squamous cell carcinoma and malignant neoplasm of the tongue and pharynx (cancer of the throat and tongue), dysphagia (difficulty swallowing), and Parkinson's disease, a neurological disorder that affects the brain's control over movement and can make feeding oneself difficult. Motor symptoms, including resting hand tremors, muscle rigidity (stiffness), and bradykinesia (slowness of movement), can make it difficult to lift utensils, chew, and swallow safely. Additionally, the resident has malnutrition and adult failure to thrive. Malnutrition combined with adult failure to thrive is a serious condition in which an adult's body and mind progressively weaken due to inadequate nutrition, resulting in severe weight loss and extreme exhaustion. On 6/24/26 at 12:18 PM, during the initial screening process of the survey, the surveyor interviewed Resident #88, who reported that they had recently finished their 60th radiation treatment for throat cancer, have difficulty swallowing, and have lost their sense of taste. They requested that the surveyor inquire about getting them assistance with eating. They added that they have Parkinson's disease, which causes their hands to shake, and demonstrated how their hand trembles when attempting to raise it to their mouth. The surveyor observed trembling of the resident's hands during the demonstration. The surveyor asked whether anyone assisted them with eating, and they replied, No. On 6/24/26 at 1:49 PM, the surveyor returned to Resident #88's room and observed the resident in bed with their bedside table positioned over the bed. No staff were present. A Magic Cup (a frozen nutritional supplement) and a dish of fruit resembling applesauce were left at the bedside without a spoon. Finger swipes observed in the fruit indicated the resident had attempted to eat it with their fingers. When the surveyor asked if they would like a spoon, the resident replied, That would be nice. The surveyor asked Geriatric Nursing Assistant (GNA #3) to provide the resident with a spoon and asked whether the resident required assistance with eating. GNA #3 replied that they thought the resident used to but were not sure because they were new to that area of the building. The surveyor observed GNA #3 provide the resident with a spoon and leave the room without assisting or supervising the resident while eating. On 6/29/26 at 11:49 AM, the surveyor conducted a medical record review for Resident #88, which revealed the following: (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan:The resident requires assistance with ADL care, including assistance with eating, specifically stating, [Resident #88] to be supervised 1:1 during meals: promote out of bed eating, and provide resident with x1 assistance for eating. Medical Orders:1/3/26 - Patient to be supervised 1:1 during all meals: promote eating out of bed every shift.5/28/26 - Nutritional supplement two times daily (frozen nutritional treat at lunch and dinner) to aid nutritional status. On 6/29/26 at 12:06 PM, the surveyor reviewed the nursing assistant assignment tasks for Resident #88, which stated, Patient to be supervised 1:1 during all meals; promote out of bed eating. Review of documentation from 6/24/26 revealed that a GNA documented that the resident had been supervised while eating despite the surveyor's observation that the resident was eating without supervision and without a spoon. On 6/29/26 at 12:17 PM, the surveyor observed the resident in bed and asked whether they typically remained in bed to eat. The resident stated that staff leave them in the chair and do not return for hours; therefore, they requested to remain in bed. When asked whether staff help them eat, the resident stated, No, they just set up the tray and leave. The resident's roommate stated that they regularly witness that staff do not stay to help the resident. On 6/29/26 at 12:52 PM, the surveyor observed staff deliver a meal tray to Resident #88's room and leave shortly afterward. The surveyor entered the room and observed the meal tray set up for the resident; however, no staff member was present to provide the required 1:1 supervision. When asked whether staff had said they would return to assist, the resident stated, No, and the roommate added that the nurse had only provided tray setup. On 6/29/26 at 12:54 PM, the surveyor approached the staff member who had delivered the tray. The staff member identified themselves as the Unit Nurse Manager (Nurse #2). When asked about the resident, Nurse #2 explained that the resident was just finishing radiation therapy for neck and throat cancer. When asked about the level of assistance the resident required during meals and oral intake, Nurse #2 replied, They like to try to do it themselves at first and then we will cue, if needed. When asked whether they were aware of the physician's order requiring 1:1 supervision while the resident ate, Nurse #2 replied, No, I thought s/he was still cue (prompt) only. The surveyor informed Nurse #2 that the resident's orders required 1:1 supervision during meals for safety, and Nurse #2 stated that they would immediately get someone to supervise the resident. On 6/29/26 at 2:22 PM, the surveyor interviewed the Director of Nursing (DON), who confirmed that the resident was required to receive supervision while eating all meals. On 6/29/26 at 2:30 PM, the surveyor conducted a further review of the resident's medical record, which revealed a Speech Therapist evaluation dated 1/3/26 stating that the resident was at high risk for aspiration and must be closely monitored during all PO (oral) intake. The evaluation stated: Aspiration [accidentally breathing food, liquid, saliva, or stomach contents into the airway and lungs (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instead of swallowing them into the stomach] precautions and close 1:1 supervision by staff during all meals. Additionally, the evaluation instructed: Sit upright at 90 degree during and 30-45 minutes following intake, small bites/sips, slow rate, supervise patient during all PO [oral] intake. On 6/29/26 at 2:41 PM, the surveyor observed Resident #88 in their room eating oranges and chips without supervision. The DON was immediately notified by the surveyor. The DON stated that the family may have brought food into the facility and that they would contact the family to request that staff be notified whenever food is left for the resident so staff could provide the required supervision. On 6/29/26 at 2:43 PM, the surveyor interviewed the Unit Manager (Nurse #2) and asked how the GNAs know which residents require 1:1 supervision while eating. Nurse #2 stated that GNAs receive a daily assignment list identifying residents who require supervision. Nurse #2 showed the surveyor a document titled LTC-6 assignment sheet, which identifies each GNA's assignment and the residents requiring supervision. The surveyor confirmed with Nurse #2 that Resident #88 was included on the daily 1:1 supervision list and she was unable to provide rationale for why the resident was not receiving supervision while eating despite being included on the 1:1 supervision list. On 6/30/26 at 10:40 AM, the surveyor discussed concerns with the Nursing Home Administrator (NHA) regarding Resident #88 not receiving 1:1 supervision during all oral intake. The NHA confirmed that the DON had previously informed them of the surveyor's concerns and stated that the facility was addressing the issue. 2) The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to collect information on each Resident's strengths and needs. The information collected informs Resident care planning decisions. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff use care plans to provide resident-centered care, including support, services, and resources to address Residents' needs. During an initial tour of the facility, Resident #28 was observed sitting in a motorized wheelchair by the bedside, with white, flaky particles in his/her facial hair and on his/her clothing. An interview with Resident #28 at that time indicated that the Resident did not receive regular showers. A record review for Resident #28 on 6/25/26 at 1:57 PM included an MDS assessment dated [DATE], which indicated that Resident #28 had bilateral below-the-knee amputations, did not walk, and relied on staff for most of his/her self-care needs. A review of the shower schedule for the nursing unit where Resident #28 resided showed that the Resident was scheduled for bed baths on Wednesdays and Saturdays during the 11 PM-7 AM shift. A review of Resident #28's care plan for ADLs, initiated on 7/15/25 and revised on 5/9/26, indicated that the Resident's shower schedule, per preference, was Saturday at 4 AM. A follow-up review of the GNA (geriatric nursing assistant) shower documentation for Resident #28 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from January 2026 to June 26, 2026, was completed. The review showed that, per preference, Resident #28's shower schedule was on Saturday, averaging 4 showers per month. The GNA documentation recorded 14 N (No &ndash; No showers), 7 Y (Yes &ndash; the Resident received showers), 4 blanks (no answer recorded), and 2 RR (Refusal &ndash; Resident refused showers). The review did not show that Resident #28 was consistently offered 1 shower every Saturday morning. In an interview on 6/25/26 at approximately 1:57 PM, staff #2, the unit manager (UM) for the unit where Resident #28 resided, was asked how staff determined which day to give Residents showers. UM reported that staff checked both the unit's paper shower schedule and the electronic health record (EHR). However, an earlier review of the EHR showed that Resident #28 was scheduled to receive showers on Saturday. In contrast, the paper shower schedule indicated that Resident #28 was to receive only bed baths (washing the Resident in bed). In a follow-up interview on 6/25/26 at 2:19 PM, the UM indicated that she would correct the discrepancy between the EHR and the paper shower schedule for Resident #28 to ensure that Resident #28 receives showers on Saturdays. During an interview on 6/30/26 at 10:54 AM, Resident #28 reported to the surveyor that the facility told him/her that he/she would start receiving showers beginning the Saturday after the surveyor's intervention.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review, observation and interview it was determined that the facility failed to ensure air mattresses were kept at the appropriate settings. This was found to be evident for two (Resident #117 and #1) out of four residents reviewed for pressure ulcer care. The findings include:1)Review of Resident #117's Minimum Data Set (MDS) assessment, with a reference date of 5/29/26, revealed the resident's weight was 89 lbs., the resident was at risk of pressure ulcers and that there was a pressure reducing device for the resident's bed. Review of the care plan revealed a plan to address the resident's risk for skin breakdown. On 6/5/26 the following intervention was added to this care plan: LAL [Low Air Loss] alternating pressure mattress: Check function Q shift, set to resident's weight. Static button off unless providing care.Static mode on an air mattress means the mattress maintains a constant even pressure without inflating or deflating. When static is not on the air mattress will cycle the inflation and deflation of air cells providing pressure relief.On 6/24/26 at 2:13 PM surveyor observed Resident #117 seated in their room. The bed had an air mattress which was observed to be set at 180 lbs., and static was set to the on position.After the observation at 2:13 PM, review of the medical record revealed there was an order, in effect since 6/5/26 for: LAL (low air loss) alternating pressure mattress: Check function Q [every] shift, set to resident's weight; Static button off unless providing care. The resident's weight on 6/23/26 was documented as 81.8 lbs. Review of the Treatment Administration Record (TAR) for June 2026 revealed Nurse #23 had signed off that this order was completed during the day shift on 6/24/26.On 6/24/26 at 4:16 PM surveyor asked Nurse #23 if she had checked the resident's air mattress today and Nurse #23 responded: No, I didn't. When asked if she knew what the mattress was supposed to be set at the nurse responded that she did not know the resident's weight right now. Surveyor and Nurse #23 then reviewed the electronic health record and noted the resident's weight was 81.8 lbs. Surveyor then reviewed the TAR with Nurse #23 who confirmed her initials on the documentation that indicated the mattress was checked and that the static button was off. Surveyor and Nurse #23 then entered Resident #117's room. Resident was in bed at this time. Nurse #23 confirmed that the air mattress was set at 180 lbs. and the Static was set to on.On 6/25/26 at 3:20 PM surveyor reviewed the concern with the Unit Nurse Manager (UM#6) regarding the failure to ensure the air mattress was set at the correct setting.2) Review of Resident #1's medical record revealed the resident had acquired a deep tissue injury (DTI) to the heel on 5/4/26. The resident was followed by a wound specialist and treatment was instituted. Review of the 5/20/26 wound assessment report completed by the wound specialist revealed the DTI had resolved. Review of the 6/24/26 wound specialist note revealed the presence of a stage one pressure ulcer on the resident's heel; that the wound was acquired on 5/4/26 and had reopened. Review of the resident's care plan addressing impaired skin integrity revealed the following intervention, which was initiated 4/18/26: LAL alternating pressure mattress: Check function Q shift, set to resident's weight. Static button off unless providing care.On 6/24/26 at 2:59 PM surveyor observed Resident #1 lying in bed. The resident had an air mattress that was set at 320 lbs.On 6/25/26, the medical record revealed the resident's weight on 4/11/26 was 328.8 lbs. The resident's weight on 5/11/26 was 288.4 lbs. The resident had an order for monthly weights, but no weight was found in the vital sign section after 5/11/26.On 6/25/26 at 2:54 PM the resident's air mattress was observed to be set at just above 280. On 6/25/26 3:11 PM the Unit Nurse Manager (UM #6) reported, in regard to the air mattress setting, that staff is supposed to check the weight of the resident. Surveyor reviewed with the nurse manager that the air mattress was set at 320 yesterday and today it is at 280. Surveyor asked when the resident was most recently weighed. The unit manager checked (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the electronic health record and then stated: Looks like 5/11, no that can't be right, because I just got weights. I could swear I had somebody give me [his/her] weight recently. I need somebody to go get [his/her] weight. On 6/30/26 at 2:45 PM surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure air mattresses were set at the correct setting.Cross Reference to F 692		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview it was determined that the facility failed to ensure weights were obtained as ordered and failed to ensure accurate assessment of a resident's body mass index. This was found to be evident for two (Resident #117 and #1) out of four resident reviewed for pressure ulcer care. The findings include: 1a)Review of Resident #117's medical record revealed a Nutrition Evaluation signed by the Registered Dietitian (RD #24) on 5/26/26. The resident's diagnosis included, but was not limited to, adult failure to thrive and dysphagia (difficulty swallowing). This evaluation revealed the resident's weight was 89 lbs. and height was 51 (no designated unit of measurement) and the BMI (body mass index) was documented as 23 or greater. A height of 51 inches means that the resident was 4 foot 3 inches tall. BMI is a measurement of body fat based on height and weight. According to https://www.nhlbi.nih.gov/calculate-your-bmi a healthy BMI is between 18.5 and 24.9. Review of Resident #117's Minimum Data Set (MDS) assessment, with a reference date of 5/29/26, revealed the resident's weight was 89 lbs., and that the resident's height was 51 inches. The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 6/24/26 at 2:13 PM surveyor observed Resident #117 seated their room. Resident appeared to be of average height. An interview was conducted with the Registered Dietitian (RD #24) on 6/29/26 at 9:52 AM. When asked about the height assessment, RD #24 reported that nursing staff normally do that and if it is not obtained she will request it or look at the discharge summary and sometimes asks the resident themselves. When asked how tall Resident #117 was, RD #24 reported very short and indicated she did not want to provide an incorrect answer. Surveyor reviewed the concern that the assessment indicated the height was 51 inches but the resident did not appear to be that short. The RD indicated she would clarify the height measurement. On 6/29/26 at 10:48 AM RD#24 reported they just obtained the resident's height and got 65 inches, which puts the resident's BMI at 13.6. RD #24 went on to report the resident is very slender and that she didn't know where the 51 came from. b) Further review of the 5/26/26 Nutrition Evaluation revealed the nutritional interventions included, but were not limited to: Monitor weights as ordered. Review of the Medication Administration Record (MAR) revealed an order, in effect from 5/23/26 until it was discontinued on 6/24/26, to weigh the resident every Monday for 4 weeks. There was also an order in effect from 5/23/26 until it was discontinued on 6/24/26 to weigh every month, starting on the 1st for 3 days. The MAR had areas for nursing staff to document weights on 5/25, 6/1, 6/2, 6/3, 6/8, and 6/15. No weight values were found on the MAR for these dates. Review of the Vital signs section of the electronic health record revealed the following weight values: On 5/23/26: 89 lbs. On 6/19/26: 81.2 lbs. On 6/23/26: 81.8 lbs. No other weight values were found for this resident. Further review of the medical record revealed on 6/19/26 the RD #24 wrote a note addressing the resident's 7.8 lbs weight loss, which represents a significant loss of 8.7% in a month. This note revealed a recommendation to change the resident's supplement orders. On 6/26/26 at 3:46 PM surveyor reviewed the concern with the Unit Nurse Manager (UM #6) regarding the order for weekly weights but no weights were found for 5/25, 6/1, 6/8 or 6/15. UM #6 stated: I honestly can't tell you what happened, I'll have to follow up on that, [the resident] may have refused. Review of the May TAR revealed that on 5/25 nursing staff documented a 9 which means to see nurse's note, however review of the corresponding nursing note revealed the following notation: Weigh every day shift every Mon for 4 Weeks. No documentation was found as to why the weight was not obtained when due on 5/25/26. Review of the June TAR revealed (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blanks in the area to record the weights when due on June 1, 2, 8, 15. Staff documented 9 on 6/3/26, review of the corresponding nurse's note revealed that the resident declined. Staff documented a 9 on 6/16/26 (which was the day after the weight was due), review of the corresponding nursing note revealed Unable to due to resident resting quietly with eyes closed. No documentation was found to indicate why the weights were not obtained when due on the other dates. During the 6/29/26 at 9:52 AM interview with RD #24, she reported normally weights are initially ordered weekly for 4 weeks and then monthly, unless there is a change or if they want to monitor more frequently. After addressing the concern regarding the failure to obtain the ordered weekly weights the RD reported: at one point the resident did not want their weight obtained and then the RD indicated she would check the medical records. At 10:48 AM RD #24 presented with the progress notes that corresponded to the 5/25, 6/3 and 6/16 notations on the MAR. No additional documentation was provided to indicate the resident was refusing to be weighed on any date except 6/3/26. Further review of the medical record revealed a new order for weekly weights for 4 weeks was put in place on 6/24/26. On 6/30/26 at 2:45 PM surveyor reviewed with the Director of Nursing the concern regarding the failure to weigh the residents as ordered and failure to assess the resident's height correctly. 2) On 6/25/26 a review of the vital sign section of the electronic health record revealed the following weights for Resident #1: On 4/11/26 weight was 328.8 lbs. On 4/13/26 weight was 327.9 lbs. On 4/29/26 weight was 324.2 lbs. On 5/2/26 weight was 292.6 lbs. On 5/3/26 weight was 292.6 lbs. On 5/11/26 weight was 288.4 lbs. Review of the progress note, written by RD #24 on 5/11/26 revealed: [Resident's name] is noted with a weight change based on weekly weight (5/11: 288.4). The note addressed possible medications that could be affecting this weight change and included: Will continue to monitor weights as ordered (weekly). On 6/25/26 no weight was found in the vital sign section after 5/11/26. Review of Resident #1's medical record revealed an order, dated 5/8/26 to weigh the resident every Monday for 2 weeks. Review of the May 2026 Medication Administration Record (MAR) revealed this order was included and there were areas for nursing staff to document a weight when due. Review of the MAR revealed a weight of 288.4 on 5/11/26 and also on 5/18/26. The 5/18/26 weight was documented by Nurse #25. Review of the progress notes revealed a note written by RD #24 on 5/19/26 revealed: Weekly weight was obtained (5/11: 288.4) which reflects a weight change in the past month. is currently being monitored weekly with [his/her] weights until 5/25. Review of the vital signs section of the electronic health record revealed documentation of the 288.4 lbs. on 5/11/26 but no weight was recorded in this section for 5/18/26. The RD's progress note from 5/19 failed to address the fact that a weight was due to be obtained on 5/18 but was not in the medical record. Further review of the medical record revealed an order, dated 5/8/26, to weigh every day shift every 1 month starting on the 1st for 3 days. Review of the June 2026 MAR revealed there were places to record weights for June 1, 2, and 3. Further review of the MAR revealed Nurse #25 recorded a weight of 288.4 on June 1st and 3rd. The area to document for a weight on June 2nd was noted to be blank. On 6/25/26 at 3:11 PM the Unit Nurse Manager (UM #6) reported they have between the 1st and the 5th to get the monthly weights done. She stated that the GNAs (geriatric nursing assistants) obtain the weights and report them to the nurses and that the nurses help if they need or have to. UM #6 reported that these weights go in the vital sign section. While discussing the documentation process, UM #6 reported that there is an option when documenting on the MAR to use the last recorded value. Review of the vital signs section of the electronic health record failed to reveal documentation of a weight between 5/12/26 and 6/25/26. No documentation was found to indicate the resident was refusing to be weighed. On 6/25/26 at 3:42 PM surveyor reviewed the concern with UM #6 that the RD notes indicated there would be weekly weight monitoring but there has been no weight obtained since (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/11/26; and that the 5/18 RD note failed to address the fact that no weight was obtained when due on 5/18. On 6/25/26 at 3:51 PM interview with GNA #26 revealed that after obtaining a weight they verbally tell the nurse the weight. GNA #27 reported that they either verbally tell the nurse or write the weight down on a piece of paper, she confirmed that the GNAs cannot enter the weight into the electronic health record. On 6/30/26 at 2:45 PM surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure weights were obtained as ordered.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interviews, observation, and record review, it was determined that the facility failed to ensure that a resident had physician orders and a care plan for the use and care of a Continuous Positive Airway Pressure (CPAP) device. This was evident for 1 (Resident #11) of 2 reviewed for respiratory care. The findings include: A CPAP (Continuous Positive Airway Pressure) machine is a medical device used to treat sleep-related breathing disorders, most commonly obstructive sleep apnea. It delivers a continuous stream of pressurized air through a tube and mask to help keep the airway open during sleep. A resident care plan is a personalized document used in nursing homes to outline a resident's specific medical, emotional, and daily living needs. It acts as a roadmap for staff to provide consistent, safe, and person-centered care. Doctor's orders are legally binding, written directives issued by a physician that specify a resident's care plan, medications, diet, and treatments. They are the required legal authorization that nursing and facility staff need to legally provide and bill for care. Resident #11 has medical diagnoses of obstructive sleep apnea, a chronic breathing disorder that occurs when the muscles in the back of the throat relax during sleep, causing the airway to become partially or completely blocked, and insomnia (persistent difficulty falling asleep, staying asleep, or achieving restorative sleep). On 6/24/26 at 12:04 PM, during an initial screening of facility residents, Resident #11 reported that they use a CPAP at times but stated that only some staff know how to use it correctly, so they do not always get to use it. The resident stated they have trouble sleeping and would like to use the CPAP. The surveyor observed a CPAP machine on the resident's bedside table. On 6/26/26 at 1:25 PM, the surveyor performed a medical record review for Resident #11 and found no physician orders or care plan addressing the resident's CPAP, including directions for use, settings, cleaning and maintenance, or related nursing interventions. The surveyor confirmed the residents' diagnoses of obstructive sleep apnea and insomnia. On 6/26/26 at 1:32 PM, the surveyor interviewed the Director of Nursing (DON) and asked what the protocol is for residents who use a CPAP. The DON stated that the facility would obtain physician orders specifying the CPAP settings and when the device is to be used, as well as orders for sterile water and cleaning and maintenance of the equipment. She stated that nurses and nursing assistants are trained in the use and care of CPAP equipment. The surveyor then asked whether she was aware that Resident #11 was using a CPAP. The DON stated that the resident began using the CPAP following a sleep study. The surveyor asked the DON to review Resident #11's medical record. After reviewing the record, the DON confirmed that the resident had no physician orders, care plan interventions, or nursing assistant and nursing staff tasks related to the use and care of the CPAP. The DON stated that she would immediately contact the physician to obtain orders and update the resident's care plan and staff tasks to address the CPAP. On 6/26/26 at 2:46 PM, the surveyor confirmed that the DON had obtained physician orders and updated the resident's care plan to include interventions related to the resident's CPAP. On 6/30/26 at 10:40 AM, the surveyor interviewed the Nursing Home Administrator (NHA), who confirmed awareness of the surveyor's concerns regarding Resident #11's CPAP. The NHA confirmed that, following surveyor identification of the deficiency, the DON obtained physician orders and updated the resident's care plan.		

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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 reviews and interviews, it was determined that the facility failed to ensure pain management was provided to residents according to professional standards of practice that included administration of pain medication according to the physician order, administer/attempt non-pharmacological interventions (NPI) prior to any as needed pain medications, routine pain medication was re-ordered in a timely manner, and to access pain medication from interim supply when needed. This was evident for 3 (Resident #6, #13, #97) of 3 residents reviewed for pain management. The findings include: 1) Resident #6 was a newly admitted resident of the facility. A review of the resident's medical record was conducted on 6/25/26 at 11:40 AM. The review revealed medical orders for pain management that included Acetaminophen (with instructions to give every 8 hours as needed for pain level 1-6), Hydromorphone (a narcotic pain medication with instructions to give every 8 hours as needed for pain level 7-10), and non-pharmacological interventions (NPI- with instructions to administer/attempt prior to administering any as needed pain medication.) A review of Resident #6's administration record for June 2026 was conducted on 6/25/26 at 12:47 PM. The review revealed the following concerns: On 6/1/26, Hydromorphone was administered for a 0/10 pain, and no documentation was found to indicate NPI was provided/attempted prior to the medication. On 6/7/26, Acetaminophen was administered with no documentation found to indicate NPI was provided/attempted prior to the medication. On 6/12/26, Acetaminophen was administered for a 0/10 pain. The findings were reviewed with the Director of Nursing (DON) on 6/26/26 at 11:05 AM. The DON reported that pain medications must be administered based on the physician orders and that NPI's must be attempted and documented prior to giving as needed pain medications. She also reported that she would review Resident #6's medical record and report back to the surveyor. On 6/26/26 at 3:46 PM, the DON confirmed the findings, verbalized understanding, and acknowledged the concerns. 2) Resident #13 was a newly admitted resident of the facility. During an interview with the resident on 6/24/26 at 10:59 AM, s/he reported having constant pain and stated, all they do is Oxycodone (narcotic pain medication) and Tylenol (Acetaminophen). A review of Resident #13's medical record was conducted on 6/25/26 at 2:35 PM. The review revealed orders for pain management that included Acetaminophen (with instructions to give every 8 hours as needed for pain level 1-4), Oxycodone (with instructions to give every 6 hours as needed for pain level 5-10), and Non-Pharmacological interventions (NPI- with instructions to administer/attempt prior to administering any as needed pain medication). (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13's administration record for June 2026 was reviewed on 6/25/26 at 2:38 PM. The review revealed the following concerns: There was only a total of 39 documented NPI's out of the 53 documented administration of the as needed pain medications (Acetaminophen and Oxycodone). On 6/6/26, Oxycodone was administered for a 0/10 pain. On 6/13/26, Oxycodone was administered for a 1/10 pain. On 6/21, Oxycodone was administered for a 0/10 pain. The findings were reviewed with the Director of Nursing (DON) on 6/26/26 at 11:08 AM. The DON reported that pain medications must be administered based on the physician orders and that NPI's must be attempted and documented prior to giving as needed pain medications. She also reported that she would review Resident #13's medical record to see if the nurses had documented the initial pain score and NPI's elsewhere and report back to the surveyor. On 6/26/26 at 3:46 PM, the DON confirmed the findings, verbalized understanding, and acknowledged the concerns. 3) Review of Resident #97's medical record revealed a care plan addressing alterations in comfort related to osteoarthritis and chronic pain syndrome. One of the interventions in the care plan is to administer the pain medications as ordered. Review of the 6/3/26 Minimum Data Set (MDS) assessment revealed that the resident's pain occasionally affects sleep and frequently effects day to day activities and that the resident receives regularly scheduled pain medication, including opioids (which are narcotics). Further review of the medical record revealed an order, in effect since 4/16/26, for hydromorphone 4 mg every 6 hours for pain. Hydromorphone is an opioid medication also known as Dilaudid. Review of the Medication Administration Record (MAR) revealed this medication was scheduled to be given at 5:00 AM, 11:00 AM, 5:00 PM, and 11:00 PM. Review of the MAR for June 2026 revealed that the doses that were due to be administered on 6/19/26 at 11:00 AM and 5:00 PM were not administered. Nurse #17 had documented a 9 indicating there was a corresponding nursing note. Review of the progress notes revealed a note written by Nurse #17 at 1:09 PM which just repeated the order but did not provide documentation to indicate why the hydromorphone was not administered when due at 11:00 AM. The note written by Nurse #17 at 6:57 PM also repeated the order but included: contacted pharmacy should be here on evening medication delivery. Review of the drug control sheet for the hydromorphone 4 mg revealed that on 6/19/26 at 5:50 AM one tablet was removed and the quantity remaining was 0. On 6/20/26 at 12:40 AM staff documented receiving 30 tablets of the hydromorphone. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/26 at 4:25 PM the Unit Nurse Manager (UM#6) reported that the facility did have an automated medication delivery system that staff can access when medications have not yet been delivered from the pharmacy. This is known as an interim supply of medication. Review of the inventory list (titled Cubex Inventory) for the interim supply revealed 10 tablets of Dilaudid 2 mg are kept in the supply. Further review of the medical record failed to reveal documentation to indicate the interim supply of hydromorphone was accessed by the nursing staff on 6/19/26. On 6/29/26 at 4:30 PM Nurse #21 reported that if they are out of a scheduled narcotic they will call the physician or nurse practitioner to obtain a new prescription, get a new C-2 form (paperwork required for narcotics), the provider will then e-sign or staff will fax it for a signature. Once the new prescription is obtained then nursing staff call the pharmacy and they can give us an access code to pull from the back up supply. If available, the medication is pulled from the backup supply. When asked if there is a process for re-ordering regularly scheduled medication before they run out, Nurse #21 responded: scheduled full time nurses will re-order when it's getting low, some nurses just brush it under the rug, if I see that only one is left I ask if it's been re-ordered. On 6/29/26 at approximately 4:35 PM the Director of Nursing (DON) confirmed that the Cubex Inventory was an available medication list. Surveyor then reviewed the concern that the hydromorphone is included on the list but was not accessed when the resident's supply ran out. On 6/30/26 at 2:45 PM surveyor reviewed with the DON the concerns regarding the failure to ensure the pain medication was re-ordered in a timely manner and the failure to access the interim supply. As of time of survey exit on 6/30/26 at 4:15 PM no additional documentation was provided regarding these concerns.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review and interview it was determined that the facility failed to ensure residents were free from unnecessary medications. This was found to be evident for one (Resident #4) out of eight residents who were reviewed for medication usage. The findings include: On 6/26/26 review of Resident #4's medical record revealed an order for metoprolol succinate 25 mg to be administered in the evening for atrial fibrillation (Afib) and to hold if the pulse was 60 or less. Afib is an irregular heartbeat. People with Afib are at a higher risk of serious complications such as heart attack or stroke. Review of the June 2026 Medication Administration Record (MAR) revealed that on June 2, 3, and 17, 2026 the resident's pulse was documented as less than 60 and the metoprolol was administered to the resident. On 6/26/26 at 10:28 AM the Unit Nurse Manager (UM #2) confirmed that she would expect the staff to hold the metoprolol if the pulse was less than 60. After review of the MAR for the metoprolol for June 2, 3 and 17, UM #2 stated that is an issue. On 6/26/26 at 11:09 AM further review of the medical record revealed the resident had an order, in effect from 5/20/26 to 6/24/26 for Midodrine 10 mg every 8 hours for hypotension (low blood pressure) and to hold if the SBP was equal to or greater than 140. SBP stands for systolic blood pressure and is represented by the top number of a blood pressure reading. Further review of the medical record revealed a note written by the primary care nurse practitioner (NP #6) on 6/24/26, which revealed a plan to Continue Midodrine - add hold if SBP >=95. A new order was written on 6/24/26 at 2:49 PM, for Midodrine 10 mg to be given every 8 hours for hypotension. This order also included: HOLD (DO NOT GIVE) if SBP 95 or greater. Review of the June MAR revealed that on 6/24 at 10 PM; 6/25 at 2 PM and 10 PM ; and on 6/26 at 6 AM the recorded SBP was above 95 and the Midodrine was administered. On 6/26/26 at 12:51 PM surveyor reviewed the concern with the Director of Nursing (DON) that since the parameters to hold the Midodrine were recently changed, there have been multiple occasions when the medication was administered when the SBP indicated it should have been held. The DON indicated she was aware of issue with the metoprolol and indicated she would make the physician aware of the issue with the Midodrine.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, observations, and record review it was determined that the facility failed to ensure that controlled medications were stored in a permanently affixed compartment, medication carts were locked when unattended, and medications were kept in a secure location . This was evident for 2 of 3 medication refrigerators, 1 of 4 medication carts observed while completing the medication storage task, and a random surveyor observation.The findings include: 1) Under federal long-term care regulations, nursing facilities are required to secure high-risk controlled substances, including refrigerated controlled medications, inside separately locked, permanently affixed compartments. A facility cannot simply place narcotics inside a locked refrigerator or an unattached lockbox. The security container must be permanently affixed to the refrigerator to prevent the entire container from being removed. A controlled medication is a drug regulated by the government because it has a risk of misuse, dependence, or addiction. Review of facility Medication Storage Policy and Procedure implemented on 12/14/22 states, Narcotics and Controlled Substances are to be stored within a separately locked permanently affixed compartment. On 6/29/26 at 3:40 PM, the surveyor requested that Nurse #15 escort the surveyor to the medication storage room near the 400's hallway. The surveyor asked where refrigerated controlled medications were kept. Nurse #15 stated they were stored in a black box inside the medication refrigerator. She opened the refrigerator and removed a black lock box that was not permanently affixed to the refrigerator. When asked whether the box was supposed to be secured, she replied that she thought it used to be nailed down. On 6/29/26 at 3:51 PM, the surveyor asked Nurse #16 to escort the surveyor to the medication storage room near the 500's hallway. The medication refrigerator contained another black carry-away lock box. The surveyor asked what was stored inside the box. Nurse #16 opened it and showed the surveyor two boxes of Lorazepam (a controlled medication). She confirmed that the lock box was not permanently affixed to the refrigerator. On 6/29/26 at 3:56 PM, with Nurse #6 present, the surveyor observed the medication storage room serving the 100, 200, and 300 halls. The medication refrigerator contained a narcotics lock box that was permanently affixed. On 6/29/26 at 4:19 PM, the surveyor interviewed the Director of Nursing (DON) regarding the facility's expectations for storing refrigerated controlled medications. The DON stated that controlled medications are to be double locked and secured to the refrigerator. The surveyor informed the DON that two of the three medication storage rooms observed contained removable carry-away lock boxes rather than permanently affixed lock boxes. The DON stated that she did not think that was correct (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because a previous surveyor had identified the same concern and the facility had installed permanently affixed clear locking containers in response. The surveyor requested that the DON accompany the surveyor to observe the medication refrigerators. On 6/29/26 at 4:33 PM, the surveyor, DON, and Assistant Director of Nursing (ADON) toured the medication rooms. The ADON stated that the nurses had notified her of the surveyor findings and that they had immediately secured the black lock boxes to the refrigerators. The DON stated that she believed that each refrigerator had a clear permanently affixed lock box and questioned why those containers were not being used. The ADON stated that the clear locking box had just been removed from the 500's hallway medication refrigerator and that the 400's hallway medication refrigerator did not have one. She further explained that the Lorazepam boxes were too large to fit inside the clear locking containers. The surveyor confirmed that the black lock boxes in both the 400 and 500 hall medication refrigerators had been permanently affixed since the surveyor had observed them as being loose earlier in the day. The ADON stated that nurses began using the black lock boxes because the medications would not fit inside the clear locking containers. The surveyor expressed concern that staff did not recognize that any lock box used to store controlled medications must be permanently affixed and that staff failed to report that the controlled medications did not fit into the affixed containers or that the black lock boxes had not been secured. The DON confirmed that staff should have reported the issue to nursing supervisors. On 6/30/26 at 10:40 AM, the surveyor discussed the findings with the Nursing Home Administrator (NHA). The NHA stated that she would follow up with the DON regarding the controlled medication storage issues identified during the survey. 2) Review of facility Medication Storage Policy and Procedure implemented on 12/14/22 states, All drugs and biologicals will be stored in locked compartments (i.e., medication carts and that during medication pass, medications must be under direct observation of the person administering the medications or locked in the medication storage cart. On 6/29/26 at 3:51 PM, while walking through the 500's hallway, the surveyor observed an unattended medication cart that had been left unlocked. The surveyor was able to open the medication drawers. After opening one of the drawers, the surveyor waited for staff to return. Nurse #16 approached and stated that she had been only gone for a minute, but acknowledged that the medication cart should never be left unlocked and unattended and confirmed that it should have been locked. On 6/29/26 at 4:19 PM, the surveyor interviewed the Director of Nursing (DON) and asked whether it was ever acceptable to leave a medication cart unlocked while unattended. The DON stated that the expectation is to always lock medication carts when unattended. After the surveyor informed the DON of the finding, the DON stated that the nurses know better. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/26 at 10:40 AM, the surveyor discussed the findings with the Nursing Home Administrator. The NHA confirmed that the issues identified during the survey would be addressed. 3) On 6/24/26 at 2:13 PM surveyor observed Resident #117 sitting in a chair in their room. The resident had an overbed table in front of them in which a small medicine cup was sitting on. The medicine cup contained one small pill. No nurse was in the room at the time of this observation. Shortly after making this observation Nurse #21, who was assigned to care for Resident #117's roommate but not Resident #117, arrived at the room. When asked if she could identify the medication in the cup, Nurse #21 confirmed there was one pill in the cup and reported that the resident takes vitamins but was unable to definitively identify the medication in the cup. Nurse #21 indicated she would follow up regarding this observation. On 6/24/26 at 2:33 PM Nurse #23, who was assigned to care for Resident #117 at that time, reported the medication was famotidine. Nurse #23 went on to report she had just given the medication to the resident but got called away urgently and had asked Nurse #21 to watch. Famotidine, also known as Pepcid, is used to treat gastroesophageal reflux disease (GERD). On 6/30/26 at 2:45 PM surveyor reviewed with the Director of Nursing (DON) the concern regarding the medication left in the resident's room. DON indicated she was already aware of this observation.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews, record reviews, and observations, it was determined that the facility failed to ensure that Residents received their meals at a palatable temperature. This was evident in 2 of 3 kitchen observations. The Findings include: During an initial tour of the facility on 6/24/26, several residents reported that the facility's food was usually cold by the time they received their trays. A follow-up review of the facility's service line checklist records for June 1-24, 2026, was conducted. A notation on the forms stated that item names and temperatures for all hot and cold foods should be taken prior to service and recorded. However, the review found missing item names and temperatures for breakfast and dinner on 6/3/26; for breakfast on 6/13/26 and 6/18/26; and for breakfast and lunch on 6/23/26. During an observation of the facility's tray line service for dinner on 6/25/26 at 5:08 PM, the surveyor requested a test tray. The tray included a meal slip for Resident #49. The slip noted that Resident #49 was on a regular diet and was to be served 3 oz of roast turkey, 2 oz of poultry gravy, 1/2 cup of creamed spinach, 1/2 cup of bread dressing, 1 dinner roll, 1 margarine, 1 chocolate chip cookie, and 1 serving of a cold beverage of choice. On the tray were: roast turkey, gravy, creamed spinach, bread dressing, 1 dinner roll, 1 margarine, 1 chocolate chip cookie, and cranberry juice. Before the surveyor tasted the food items, staff #28, a corporate dietary manager, was present and recorded the food temperatures: 122.3 F for the roast turkey, 126.9 F for the creamed spinach, and 70 F for the cranberry juice. A review of the facility's Hazard Analysis and Critical Control Point (HACCP) plan (ensures food safety for the immunocompromised elderly population) on 6/26/26 found that hot foods were held at 135 F or higher and cold foods and drinks at 41 F or lower. However, the test tray for Resident #49 on 6/25/26 contained hot foods served below 135 F and a cold drink served above 41 F. In a follow-up interview on 6/29/26 at 10:40 AM, staff #29, the dietary manager, was asked about acceptable holding temperatures for serving food to residents. Staff #29 reported that hot foods should be at least 135 F and cold foods at or below 41 F. He added that he would continue to provide staff education to address concerns about food temperatures.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review, and interviews, it was determined that the facility failed to ensure that food was prepared in a form suitable for individuals with altered ability to chew and swallow. This was evident in 1 of the 3 tray-line service observations conducted during the annual survey. The findings include: A Regular Diet, Chopped Texture requires foods to be cut into small, bite-sized pieces (usually 1/2 inch or 1.2 cm). It is designed for residents with mild chewing difficulties and must remain moist. Dry, tough, or stringy foods should be avoided to prevent choking. A Regular Diet Chopped (or mechanically altered) texture, peas must be heavily modified-pureed or creamed-so they are easily manageable and do not require intact chewing. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff use care plans to provide resident-centered care, including support, services, and resources to address Residents' needs. During an observation of the facility's tray line service for lunch on 6/26/26 at 12:18 PM, it was noted that the kitchen had run out of pureed peas and had prepared some. The surveyor requested a test tray. The tray contained a meal slip for Resident #25. A review of the slip showed that Resident #25 was on a regular chopped diet and was to be served chopped Parmesan-crusted fish fillet, white sauce, pureed buttered green peas, mashed potatoes, hot tea, sugar, salt, pepper, and chopped marble cake with white frosting. However, upon tasting the food items served on the tray for Resident #25, it was noted that the pureed peas contained significant chunks of pea skin. Staff #28, a corporate dietary manager, was present and asked whether staff tasted the pureed food to ensure it had the right texture before serving it to residents. Staff #25 responded that they did. However, an earlier observation of the preparation of pureed peas did not show that the staff tasted it before serving it to residents. Record review for Resident #25 included a care plan initiated on 1/22/25 and revised on 5/24/25, which noted that the Resident was at nutritional risk [related to] need for therapeutic and mechanically altered diet due to a previous stroke and difficulty swallowing. During a follow-up interview on 6/29/26 at 11:19 AM, staff #24, a registered dietitian, reported that a resident on a regular chopped meal required certain items, such as peas, to be pureed for the Resident's safety. Staff #24 added that pureed foods should have a pudding-like texture or be smooth and should not be chunky or rough. However, an earlier observation of Resident #25's pureed, buttered green peas revealed significant chunks of pea skin. In a subsequent interview on 6/30/26 at 11:50 AM, staff #30, a speech therapist, reported that pureed, textured food is food a resident would not need to chew to swallow, so pureed foods should not contain chunks of the food item. However, Resident #24's pureed buttered peas contained pea skin chunks.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, it was determined that the facility failed to adhere to infection control practices when handling clean laundry and failed to ensure appropriate Personal Protective Equipment (PPE) were donned during care for residents on Enhanced Barrier Precautions (EBP) and Contact Precautions. This was evident for 1 of 1 laundry room observed and for 2 (Resident #11, 130) of 6 residents reviewed during the infection control task. The findings include:1) Clean laundry must be protected from contamination during storage and transport. Clean linen carts are expected to remain covered, and the clean laundry room must be maintained as a protected environment. Leaving linen carts uncovered and propping open the clean laundry room door increases the risk of environmental contamination of linens intended for resident use. On 6/26/26 at 9:14 AM, the surveyor toured the lower level of the facility which contained the laundry room. As the surveyor approached the entrance of the clean side of the laundry room, the surveyor observed two linen carts containing clean folded linens positioned in the hallway. Both carts had covers; however, the covers were pulled back exposing the clean linens. No staff were present. The surveyor also observed the door to the clean side of the laundry room propped open with a container placed in the doorway to keep the door from closing. Inside the clean laundry room, two of four linen carts had covers pulled back, and clean laundry was observed on a table in the process of being folded. Laundry worker Staff #7 stated he was aware the clean laundry room door was supposed to remain closed but that it had been propped open due to the room being hot and humid. Staff #8 stated she had never been told the door could not remain open. Staff #8 further stated a fan was present in the room but could not be used due to electrical circuits tripping when in operation, as directed by the Maintenance Director. Both Staff #7 and #8 confirmed understanding that linen carts must be covered. Manager #9, identified as the Environmental Services Manager responsible for laundry operations, was observed entering the area and covering the linen carts. When questioned regarding the uncovered carts and propped door, Manager #9 initially denied that the carts had been uncovered until informed that the surveyor had observed and documented the condition. During interview, Manager #9 stated she maintains laundry records such as lint cleaning documentation but does not conduct infection control rounds. She stated she was aware the clean laundry room door is required to remain closed and that clean linen carts are required to remain covered. She further stated staff had been educated on these expectations and that the district manager had been notified regarding heat concerns in the laundry room. On 6/26/26 at 9:42 AM, the surveyor interviewed the Infection Preventionist (IP #1), who stated she conducted infection control rounds in the laundry area for a few months following the previous annual survey but discontinued routine monitoring once the area was believed to be in substantial compliance. She stated she occasionally enters the area and corrects staff when issues are identified but does not maintain any log or documentation of monitoring activities. IP #1 confirmed the expectation that clean linen carts are to remain covered, and the clean laundry room door is to remain (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed. On 6/26/26 at 9:53 AM, the Nursing Home Administrator (NHA) confirmed that staff are expected to keep clean linen carts covered and the clean laundry door closed. The NHA acknowledged the facility had previously received a similar citation related to laundry practices during the prior annual survey and stated the issue would be investigated. On 6/26/26 at 11:39 AM, an anonymous staff member (Staff #13) reported that the clean laundry room door had been propped open daily for at least three months. On 6/26/26 at 10:19 AM, the NHA stated the facility was developing a plan to ensure linen carts remain covered and the clean laundry room door remains closed. 2) Enhanced Barrier Precautions (EBP) is an infection control intervention requiring staff to use appropriate Personal Protective Equipment (PPE), including gowns and gloves, during high-contact resident care activities for residents with identified risk factors such as open wounds. Resident #11 had physician-ordered Enhanced Barrier Precautions due to open wounds, requiring staff to wear gloves and gowns during high-contact care activities, including transfers. On 6/26/26 at 3:51 PM, the surveyor observed an Enhanced Barrier Precautions sign posted on Resident #11's door indicating staff must wear gloves and gowns during high-contact care activities, including transfers. Upon entry, the surveyor observed two Geriatric Nursing Assistants (GNA #12 and GNA #14) assisting Resident #11 with a transfer. Neither staff member wore gowns; both wore gloves only. GNA #12 exited the room, removed his gloves, and stated that he was Only helping to transfer her and didn't touch her. When asked about the precaution requirements, he reread the sign on the door and asked, Am I supposed to wear a gown when I am transferring the resident? The surveyor advised him to clarify requirements with the facility Infection Preventionist. GNA #12 then stated, I'm sorry, you are right, I should have also worn a gown. GNA #12 subsequently returned to the room with a gown and handed it to GNA #14. GNA #14 questioned what it was for, at which time Resident #11 stated, You are supposed to wear a gown. The surveyor then approached GNA #14 and asked her to confirm whether she was aware that a gown was required during care under EBP. GNA #14 stated, Yes, I should be wearing the gown. GNA #14 then applied the gown while still wearing the same gloves that had been used during the resident transfer. On 6/26/26 at 4:00PM, the surveyor met with the facility IP#1 who confirmed that the staff should have been wearing gowns and gloves during EBP care for Resident #11. The Nursing Home Administrator (NHA), who was present during the interview, stated staff know better regarding PPE requirements. 3) Contact precautions are infection-control measures used in healthcare settings to prevent the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spread of germs transmitted through direct or indirect contact. They require strict adherence to personal protective equipment (PPE) protocols, including wearing gloves and a gown for all interactions with the patient or their environment. Resident #130 was a newly admitted resident of the facility with diagnosis that included Bacteremia. Bacteremia is the medical term for the presence of bacteria in the bloodstream. Because blood is normally a sterile environment, this condition always indicates an abnormality and requires rapid treatment to prevent life-threatening complications like sepsis, endocarditis, or organ failure. Management centers on aggressive intravenous (IV) antibiotics. On 6/24/26 at 1:48 PM, a contact precaution sign was observed on Resident #130's door with PPE supplies located in a bin by the door. Nurse #11 walked in the resident's room and was observed taking the resident's blood sugar reading. Nurse #11 had a pair of gloves on but was not wearing a gown. As she walked out of the resident's room, she was interviewed by the surveyor. During the interview, she confirmed taking the resident's blood sugar reading and was asked why she did not put a gown on. Nurse #11 answered, my understanding is we put on gowns when we do things with the wounds. She further explained that the resident was on contact precautions due to having wounds and she only dons gown and gloves when treating the wounds. A review of Resident #130's medical record was conducted on 6/26/26 at 9:01 AM. The review revealed that the resident was on IV antibiotic indicated for MRSA bacteremia that started on 6/16/26. (MRSA -Methicillin-resistant Staphylococcus aureus is a type of staph bacteria that is highly resistant to many common antibiotics.) The review also revealed the order to put the resident on contact precautions related to MRSA with the same start date of 6/16/26. During an interview with the Director of Nursing (DON) on 6/26/26 at 9:32 AM, the concern was discussed that staff failed to don the appropriate PPE before entering Resident #130's room. The DON reported that she was already aware and acknowledged the concern.		