STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215025	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Wheaton	4011 Randolph Road Wheaton, MD 20902

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record review, it was determined that the facility failed to invite a resident to their care plan meeting. This was evident in 1 (Resident#35) of 7 residents reviewed for care planning. The findings include: On 03/31/25 at 10:55 AM Resident #35 informed the surveyor that he/she was not invited to and did not attend care plan meetings. On 04/02/25 at 08:26 AM a review of Resident #35's medical record revealed that the resident was admitted to the facility on [DATE] and care plan meetings were held on 1/30/25, 2/5/25 and 2/26/25. Resident #35 attended one care plan meeting on 1/30/25. However, the resident did not attend care plan meetings on 2/5/25 and 2/26/25. The records failed to reveal that the resident was notified. On 04/03/25 at 10:43 AM in an interview, the Regional Social Worker stated it was the practice of the facility to invite residents and their responsible parties in writing to care plan meetings. Further, she would check the records to ascertain whether Resident #35 was invited. On 04/03/25 at 10:43 AM The Regional Social Worker notified surveyor that she could not locate documented evidence to show that Resident#35 was informed of care plan meetings for February 2025. On 04/03/25 at 10:50 AM the Nursing Home Administrator and the Regional Clinical Nurse Consultant were notified of the surveyor's findings.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor record reviews and facility staff interviews, it was determined that the facility failed to offer the opportunity to complete an advance directive and provide educational materials on advance directive for Residents and/or Resident Representatives. This was found to be evident for 3 (Resident #41, 93 and 95) out of 3 Residents reviewed for advance directives. The findings include: An advance directive is a legal document that specifies a person's wishes for end-of-life healthcare. It also specifies who should make healthcare decisions on your behalf if you are unable to do so yourself. On 03/31/2025 at 11:43 AM the surveyor conducted a record review of Resident #93's medical record. During the review of Resident #93's medical record, specifically the social services assessment and documentation - V6 forms dated 8/30/2024 and 11/20/2024, it revealed documentation that Resident #93 did not have an advance directive in place, and the opportunity to complete an advance directive was not offered and advance directive educational materials were not provided for Resident #93 or Resident Representative. The surveyor interviewed the Regional Social Worker at 11:10 AM on 04/03/2025. During this interview the surveyor conveyed to the Regional Social Worker that Resident #93 did not have an advance directive as documented on the August and November 2024 social services assessments. Additionally, the social services assessments indicated that the opportunity to complete an advance directive was not offered and educational materials for advance directive were not provided for the Resident #93 or Resident Representative. The Regional Social Worker acknowledged the surveyor. The surveyor conducted a record review of Resident #41's medical record on 03/31/2025 at 01:52 PM and it revealed that Resident #41 had a social services assessment and documentation - V6 form dated 04/08/2024. This social services assessment indicated that Resident #41 did not have an advance directive in place, and the opportunity to complete an advance directive was not offered and educational materials for advance directive were not provided for Resident or Resident Representative. The surveyor interviewed the Regional Social Worker at 11:10 AM on 04/03/2025. During this interview the surveyor conveyed to the Regional Social Worker that Resident #41's social service assessment in April of 2024 revealed that Resident did not have an advance directive on file, and that the opportunity to complete an advance directive was not offered and educational materials for advance directive were not provided for Resident #41 or Resident Representative. The Regional Social Worker acknowledged the surveyor. On 04/02/2025 at 12:45 PM the surveyor conducted a record review of Resident #95's medical record. Review of the medical record for Resident #95 revealed that the social services assessment and documentation - V6 form completed 11/21/2024 indicated that Resident #95 did not have an advance directive in place. Further review of the social services assessment indicated that the opportunity to complete an advance directive was not offered, and educational materials regarding advance directives were not provided for Resident #95 or Resident Representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Regional Social Worker on 04/03/2025 at 11:10 AM, the surveyor conveyed to the Regional Social Worker that Resident #95 did not have an advance directive in place according to the documentation on the social services assessment dated [DATE], and the opportunity to complete an advance directive was not offered and educational materials regarding advance directives were not provided for Resident #95 or Resident Representative. The Regional Social Worker acknowledged the surveyor. In a follow-up interview with the Regional Social Worker on 04/04/2025 at 12:30 PM the surveyor confirmed with the Regional Social Worker that the documentation revealed that Residents #41, 93 and 95 did not have advance directives in place, and that these Residents or Resident Representatives were not offered an opportunity to complete an advance directive and were not provided educational materials for advance directives.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on staff interviews and medical record review, it was determined that the facility failed to provide written notification for Residents that were transferred to the hospital. This was found to be evident for 3 Residents (#4, #18, #48) out of 3 Residents reviewed for hospitalization. The findings include: During medical record review for Resident #48 on 04/04/25 at 11:15 AM. It was revealed that the resident was transferred to the hospital on 4/2/24, 8/27/24 and 8/28/24, the facility did not provide written notification to the resident or the resident ' s representative regarding the reason for the transfer to the hospital. During continued records review on 04/04/25 at 12:57 PM Resident ' s #4 record review revealed resident was transferred to the hospital on 5/18/24, 6/18/24 and 2/16/25 with no evidence that the facility provided written notification and reason for transfer to resident or resident's representative during transfer to the hospital. During an interview with the Regional Clinical Nurse Manager (RCNM) on 04/04/25 at 1:00 PM regarding written notification to residents and/or their representatives about the reason for transfer or discharge to the hospital. The RCNM confirmed that the facility did not have a process in place for providing such notifications. The surveyor informed the RCNM of this concern, and he acknowledged the concern. A review of the nurse ' s note for Resident #18 was conducted on 04/09/25 at 08:13 AM. The note, dated 03/30/25 at 8:49 PM, stated Resident was in bed sleeping with no apparent distress. No further emesis noted. [Resident's family member] came to visit, as [resident's family member] said [resident's family member] was called earlier about the resident. The resident ' s [family member] stated [resident's family member] wanted the resident transferred to the hospital. Writer explained the interventions in place, but [resident's family member] insisted the resident be taken to the hospital. [Resident's family member] called 911; they arrived at approximately 3:05 PM and transported the resident to HCH [Holy Cross Hospital] at 3:16 PM. An interview conducted on 04/09/25 at 10:09 AM with License Practical Nurse (LPN) #1 regarding the process for transferring a resident to the hospital, LPN #1 stated, I will notify the physician for orders, prepare a transfer package which includes the face sheet, MOLST [Maryland Order for Life Sustaining Treatment] form, recent labs, medication list, and complete transfer assessment. I will also provide a copy of the transfer notification to the resident or the resident ' s representative. After the resident leaves, I will call the hospital for updates. The surveyor asked LPN #1, What is the process if a family member calls 911 LPN #1 responded, It ' s the same process. During the continued medical record review on 04/09/25 at 10:11 AM for Resident #18, there was no evidence of written documentation indicating that the reason for the hospital transfer was provided to the resident or their family representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RCNM regarding hospital transfers on 04/09/25 at 10:30 AM, he acknowledged that no written documentation was provided to the residents (#4, #18, and #48) during the transfer. The surveyor informed the RCNM of this concern.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff and Resident interviews and surveyor record review, it was determined that the facility failed to provide written notification of the bed hold policy for a Resident that was transferred to the hospital. This finding was found to be evident for 1 Resident (#95) out of 1 Resident reviewed for hospitalization. The findings include: A Bed Hold is the act of holding or reserving a Resident's bed while the Resident is absent from the facility for therapeutic leave or hospitalization. It must be provided to all facility Residents regardless of payment source. The Bed Hold policy should be disclosed in the admission packet during an initial admission to the facility and it should be disclosed to Resident/Resident Representative at the time of transfer. On 04/01/2025 at 07:40 AM during the tour of the nursing unit, the surveyor interviewed Resident #95. Resident #95 stated that he/she had a recent hospitalization due to stomach collapse. The surveyor reviewed Resident #95's medical record on 04/03/2025 at 07:03 AM and the review revealed that Resident #95 transferred to the hospital on [DATE] (an emergency room visit) and 02/04/2025 (inpatient). The surveyor did not locate any documentation that Resident #95 or Resident Representative received written notification from the facility of the bed hold policy for Resident #95's transfer and admission to the hospital on [DATE]. Further review of Resident #95's medical record revealed that on admission to the facility, the Resident signed an admission packet dated 10/10/2024 which indicated that if Resident #95 should be hospitalized , he/she would be consulted at that time as to whether he/she would choose to hold the bed at the facility. In an interview with the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Nurse Consultant on 04/03/2025 at 09:55 AM the surveyor asked what the procedure was for written notification of bed hold policy when a Resident was transferred to the hospital. The Regional Clinical Nurse Consultant stated, I know what you are asking for but the facility does not provide written notification of the bed hold policy for Residents when they transfer to the hospital. No additional information was provided by the facility at the time of exit.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, it was determined that the facility failed to conduct an accurate Preadmission Screening and Resident Review (PASRR). This was found evident for 1 (Resident #27) out of 1 resident reviewed for PASRR screening. The findings include: According to the Centers for Medicare and Medicaid (CMS), the Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. Furthermore, Congress developed the PASRR program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities. Federal law mandates that Medicaid-certified nursing facilities (NF) may not admit an applicant with serious mental illness (MI), mental retardation (MR), or a related condition, unless the individual is properly screened, thoroughly evaluated, found to be appropriate for NF placement, and will receive all specialized services necessary to meet the individual's unique MI/MR needs. If a resident tests positive for a Level I, they are then evaluated in depth, called ' Level II ' PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. On 04/01/25 at 10:02 AM, a record review for Resident #27 ' s PASRR Level 1 showed that in section D, all of the answers were checked No. The document stated that if all answers in part D are ' No ' , the individual must be referred to AERS [Adult Evaluation and Review Services] for a Level II Evaluation. There was not a PASRR Level II found in this Resident ' s record. On 04/02/25 at 12:45 PM, an interview was conducted with the Social Worker. Resident #27 ' s PASRR was reviewed with the Social Worker. This surveyor asked, based on the results of the PASRR, if she would expect this Resident to have had a PASRR Level II Screening. She reported that the mental disorders that this Resident has do not require him to need a PASRR Level II. She confirmed that the Resident ' s PASRR Level I was not filled out correctly, as it should not have been indicated that he/she needed a PASRR Level II.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to revise a care plan. This was evident for 3 (#4, #48, and #445) out of 3 residents reviewed for care plans. The findings include: A review of a Nurse ' s note for Resident #4 was conducted on 04/02/25 at 12:43 PM. The note dated 03/04/2025 at 16:07 stated Writer went to assess the patient after receiving a verbal call from a caregiver that the patient was on the floor. Observed patient sitting near the bed and wheelchair with no visible injury. The patient denied pain upon assessment. No swelling or skin discoloration noted. The patient had a light scratch on [resident ' s gender] left side, not related to the fall but sustained while using the bathroom. The patient self-transferred from the floor to the bed. A care plan is a comprehensive, individualized plan of care developed for each resident. It outlines the residents ' medical, psychological, emotional, and social needs, as well as the goals, interventions, and services required to meet those needs. Care plans are created and maintained by the interdisciplinary care team. During continued medical record review on 04/02/25 at 1:14 PM, the care plan was not updated following the resident ' s fall on 03/04/25. An actual fall care plan was not initiated or revised. The original care plan was initiated on 08/05/2024, with the last revision also documented on 08/05/2024. A Gastrostomy tube (G-tube) is a flexible tube inserted through the skin and abdominal wall directly into the stomach to provide nutrition, fluids, and medications when an individual is unable to consume adequate nutrients orally. During a medical record review conducted on 04/03/25 at 7:30 AM, it was revealed that Resident #48 was transferred to the hospital on [DATE], 04/02/24, and 08/27/24 for gastrostomy tube (G-tube) dislodgement and replacement. However, there was no documentation indicating that a care plan for G-tube dislodgement and replacement was initiated or updated. On 04/03/25 at 12:24 PM, during an interview with the Assistant Director of Nursing/Infection Control Preventionist/Staff Educator (RN) (ADON/ICP). The surveyor inquired about the process and expectations for care plan revisions following G-tube dislodgement and replacement. The ADON/ICP further explained that care plans are to be updated whenever there is a change in the resident ' s condition, when concerns arise, as needed, and on a quarterly basis. Additionally, the ADON/ICP clarified that all members of the interdisciplinary team are responsible for updating the care plan in response to any changes in the resident ' s condition. The Unit Manager is responsible for ensuring that all changes are accurately reflected in the care plan. The ADON/ICP further confirmed that updates should be made immediately following any such changes. On 04/03/25 at 1:10 PM, the surveyor informed the Administrator and the Regional Clinical Nurse Manager of concerns regarding the revision of the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medical records review on 04/09/25 at 7:30 AM Resident #445 had a witnessed fall on 12/16/24, as documented in staff statements. However, there was no evidence that a fall-specific care plan revision was initiated or documented.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor record review, interviews with facility staff and Residents, it was determined that the facility failed to revise Resident care plans and conduct timely care plan meetings. This was found to be evident in 4 (Resident #10, 41, 93, and 106) out of 4 Residents reviewed for timing and revision of care planning. The findings include: 1) On the initial tour of the facility 03/31/2025 at 09:58 AM Resident #10 stated that he/she remembered attending one care plan meeting last summer and does not recall having received invitations for care plan meetings. Resident stated, I have been here for 2 years. A care plan is a document that outlines a person's healthcare or support needs, how those needs will be met, and by whom. It serves as a roadmap for providing consistent and effective care. The care plan helps organize and prioritize caregiving activities, ensures continuity of care, and promotes collaboration among healthcare providers. It is a vital tool for effective and personalized care. It ensures that individuals receive the right support, at the right time, and from the right people, ultimately improving their well-being and quality of life. The surveyor conducted a record review of Resident #10's medical record on 04/02/2025 at 09:30 AM. During the review of the medical record, it revealed that there were two care conference notes in the progress note section of the electronic medical record dated 05/22/2024 and 12/19/2024. Both care conference notes indicated that Resident #10 and his/her son attended the care conferences. However, there were no meetings held for February of 2024, August of 2024 and March of 2025. Additionally, there was a care plan attendance sheet located in the miscellaneous section of Resident #10's electronic medical record dated 12/19/2024 with Resident's signature on the sheet. There were no other care plan attendance sheets located in the electronic medical record for Resident #10 for the past year. In an interview with the Licensed Nursing Home Administrator (LNHA) on 04/02/2025 at 10:08 AM the surveyor requested care plan attendance sheets and care plan meeting notes for the past year for Resident #10. At 11:05 AM, the LNHA provided the surveyor with the care conference note and attendance sheet for 12/19/2024 and stated that was all the documentation that was found. In an interview with the Regional Social Worker on 04/03/2025 at 11:10 AM the surveyor conveyed to the Regional Social Worker that the only care plan meeting documentation for the past year was for December of 2024 for Resident #10. The Regional Social Worker stated that she would investigate this. On the follow-up interview with the Regional Social Worker at 12:30 PM on 04/04/2025 she provided the surveyor with the care conference notes for 05/22/2024 and 12/19/2024 and the care plan attendance sheet for 12/19/2024 for Resident #10. The Regional Social Worker acknowledged that there was no additional documentation on care planning meetings for the past year for Resident #10. The surveyor asked the Regional Social Worker what the expectation was for the care plan meeting process. The Regional Social Worker stated that written invitations were mailed to the Resident Representatives and given to the Residents, the attendance sheets were maintained in the miscellaneous section of the electronic medical record and the care plan meeting note was documented in the progress note section of the electronic medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) The surveyor conducted a record review of Resident #93's medical record, specifically the care plan on 04/02/2025 at 10:06AM. Review of Resident #93's care plan revealed that Resident had a care plan for anticoagulant therapy (blood thinner) dated 08/28/2024 with a revision on 09/11/2024 and a target date of 05/30/2025. Review of the physician orders revealed that there was no current physician order for anticoagulant therapy for Resident #93. According to the discontinued orders for Resident #93, the anticoagulant therapy (Lovenox) was discontinued on 10/15/2024. The surveyor interviewed the Regional Clinical Nurse Consultant (RCNC) at 09:50 AM 04/07/2025 regarding Resident #93's care plan and anticoagulant therapy. The surveyor conveyed to the RCNC that Resident #93 had a current care plan for anticoagulant therapy and that there was not a current physician order for an anticoagulant medication and that the anticoagulant medication was discontinued 10/15/2024. The RCNC reviewed Resident #93's physician orders and care plan and acknowledged the surveyor. The RCNC stated that Resident #93 was no longer receiving an anticoagulant medication (Lovenox), the medication was discontinued on 10/15/2024, and the care plan should have been resolved. A low air loss mattress (LAL) is a medical-grade mattress designed to prevent and treat pressure injuries by reducing moisture and health buildup. The LAL mattress uses a system of inflated air cells that continuously circulate air, providing a dry, comfortable sleeping surface that delivers consistent pressure redistribution. Pressure ulcers are injury to the skin and underlying tissue resulting from constant and prolonged pressure on the skin. This pressure can lessen blood flow to the affected area, which may lead to tissue damage and tissue death. Venous ulcers (stasis ulcers) are open wounds on the leg or ankle caused by abnormal or damaged veins due to poor circulation and high pressure in the veins. Arterial ulcers (ischemic ulcers) are painful skin wounds caused by poor blood circulation and inadequate blood supply to the lower extremities. 3) The surveyor conducted a review of Resident #41's medical record on 04/07/2025 at 08:10 AM. Review of Resident #41's medical record revealed that Resident #41 had a physician order for a low air loss mattress (LAL). Further review of the medical record revealed that Resident had care plans for pressure ulcers, arterial ulcers, venous ulcers and skin impairment that were resolved but remained on the current care plan. Review of the current physician orders for Resident #41 revealed that there were no treatment orders for any ulcers. In addition, Resident #41 had a care plan for an antiplatelet medication (inhibits blood clots), but review of Resident #41's physician orders revealed that there was not a current order for antiplatelet medication. In an interview with the Director of Nursing (DON) at 11:05 AM on 04/07/2025 the surveyor conveyed to the DON that Resident #41 had a care plan for an antiplatelet medication but did not have a physician order for an antiplatelet medication. The DON reviewed Resident #41's physician orders and care plan and acknowledged that Resident did not have an order for an antiplatelet medication but had a care plan for antiplatelet medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor conducted an interview with the East Wing Nurse Unit Manager (UM) on 04/07/2025 at 12:55 PM. During this interview, the surveyor conveyed to the UM that Resident #41 had care plans for pressure, arterial and venous ulcers and these care plans were resolved but remained on the current care plan, and that there were no physician orders for wound treatment for these ulcers. The UM acknowledged the surveyor and confirmed that Resident #41 did not have any ulcers at present and all previous ulcers were healed, and that the care plan should have been revised to reflect Resident #41's current skin condition. No additional information was provided by the facility at the time of exit. Care Plan meetings are meetings with a team of care providers including the attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of food and nutrition services, the resident, and the resident ' s representative if applicable to ensure the care plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. 4) During a telephone interview with the family of Resident #106 on 4/03/25 at 5:31 PM he/she reported having difficulty scheduling Care Plan Meetings with the Interdisciplinary Team. During a review of Resident #106 Electronic Medical Records (EMR) on 4/04/25 at 07:45 AM it was discovered that Resident #106 was admitted to the facility on [DATE] and discharged on 9/04/24. The following Care Plan meetings were found in the EMR. On 11/16/23 a Care Plan Meeting was held. The sign-in sheet shows the attendees were the Social Worker, Director of Rehab, Nursing and family members. On 2/08/24 a Care Plan Meeting was held. The sign-in sheet shows the attendees were the Director of Rehab, Activities Director, Ombudsman, Registered Dietician, Unit Manager and family members. On 5/17/24 a Care Plan Meeting was scheduled but the family did not attend. The facility planned to reschedule. There were no additional Care Plan meetings documented. During an interview with the Regional Social Worker on 4/09/25 at 2:28 PM, the social worker was notified of the limited documentation of Care Plan Meetings and attendance rosters for Resident #106. She reported Care Plan meetings are done quarterly and would expect a Care Plan Meeting note to be documented along with an attendance sign in sheet to be scanned into the EMR when the Care Plan meeting occurred. She stated if the documents are not in the EMR, maybe they are in medical records and not uploaded yet. She advised she would attempt to find additional Care Plan documentation. During an interview with the Regional Social Worker 4/10/25 at 11:13 AM the Social Worker reported she was unable to find any additional Care Plan documentation for Resident #106.

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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 surveyor observation, facility staff interviews and surveyor record review it was determined that the facility failed to follow appropriate respiratory care and services. This finding was found to be evident in 1 (Resident #93) out of 1 Resident reviewed for respiratory care and services. The findings include: On tour of the East Wing Nursing Unit on 03/31/2025 at 11:49 AM the surveyor observed Resident #93 with oxygen in use. There was an oxygen humidifier bottle and oxygen tubing attached to the oxygen concentrator and an oxygen cannula in Resident #93's nostrils. The surveyor did not observe an oxygen usage sign on the Resident door or on the doorframe of Resident #93's room. The surveyor conducted a record review of Resident #93's medical record on 04/02/2025 at 10:30 AM. The record review revealed that Resident #93 had physician orders for oxygen and to change the oxygen humidifier bottle tubing every Thursday on the night shift. Further review of the medical record revealed that Resident #93 had a care plan for oxygen therapy related to respiratory illness. In addition, the surveyor reviewed the facility's oxygen administration policy dated 03/14/2023 and revised 09/12/2024 from The Compliance Store policy platform that was provided by the Director of Nursing (DON) on 04/10/2025 at 09:07 AM. The policy guidelines were to place an oxygen warning sign on the Resident's room door where oxygen was in use, change the oxygen tubing/cannula weekly and as needed, and change the oxygen humidifier bottle when empty or every seventy-two hours. The surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 04/10/2025 at 11:55 AM and reviewed Resident #93's oxygen usage and the facility's oxygen administration policy. The surveyor asked the ADON/IP what the expectation was for oxygen signage and changing oxygen tubing and humidifier bottles when oxygen was used for Residents. The ADON/IP stated that the oxygen tubing and humidifier bottles were to be changed weekly on the night shift, and that she was not aware of the posting of oxygen signage where oxygen was in use. The ADON/IP further stated that the facility does not place oxygen signs on the Residents' rooms where oxygen was in use. The surveyor conveyed to the ADON/IP that item #6 on the facility's oxygen administration policy indicated that oxygen warning signs must be placed on the door of the Residents' rooms where oxygen was in use. ADON/IP acknowledged the surveyor that item #6 on the facility's policy for oxygen administration indicated that oxygen warning signage must be placed on the Resident's room door where oxygen was in use. No additional information was provided by the facility at the time of exit.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of employee records and staff interview, it was determined that the facility failed to complete annual performance reviews for Geriatric Nursing Assistants (GNAs). This was evident for 2 (#10, #17) out of 5 GNA staff members reviewed during the annual survey. The findings include: Performance evaluations are to be completed once every 12 months to identify in-service education needed to address competencies of the geriatric nursing assistants. On 04/08/25 at 1:44 PM, a review of GNA #10 and GNA #17's employee records revealed that no performance reviews for 2023 and 2024 were included. On 04/09/25 at 11:59 AM, an interview conducted with the Nursing Home Administrator (NHA) confirmed that annual GNA performance evaluations for 2023 and 2024 had not been done for GNA #10 and GNA #17. At the time of exit conference, the facility did not provide any additional evidence to show that performance evaluations for 2023 and 2024 were completed for GNA #10 and GNA #17.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation of medication administration, medical record reviews, and staff interviews, it was determined that the facility licensed staff failed to maintain a medication error rate of less than 5 percent for 2 out of 2 residents (#94 and #81). This finding was evident for 3 out of 26 opportunities observed for errors which resulted in a medication error rate of 11.54%. The findings Include: 1) On 04/02/25 at 8:20 AM, during a medication administration observation for Resident #94, the surveyors observed Licensed Practical Nurse (LPN) #1 administer scheduled medications to the resident. The medications included 1 tablet Amlodipine 10 mg (milligram). LPN #1 stated, I am holding the Amlodipine due to the resident ' s heart rate of 59 and I will contact the physician. 2) During medication administration on 04/02/25 at 8:52 AM for Resident #81, the surveyors observed Licensed Practical Nurse (LPN) #1 administer scheduled medications to the resident. The surveyors observed LPN #1 administer 1 drop of Brimonidine Tartrate Ophthalmic Solution 0.2% to the resident ' s right eye. During the continued medication administration observation, the LPN #1 stated that she was unable to administer Cholecalciferol 25 mcg (microgram) because it was not available . During medication administration reconciliation, on 04/02/25 at 9:30 AM, following medication administration, Resident #94 ' s April 2025 Medication Administration Record (MAR) was reviewed. The review revealed that there was no physician order to withhold Amlodipine 10mg heart due to a 59 bpm (beats per minute). Additionally, LPN #1 documented the medication as administered, despite having stated that it was to be withheld. On 4/2/25 at 10:05AM Resident #81 ' s April 2025 Medication Administration Record (MAR) was reviewed . The review revealed that Cholecalciferol 25mcg (Vitamin D) was documented as administered, although the medication was not available at the time of the observation. On 4/3/25 at 11:00AM during the continued medication administration reconciliation for Resident #81. The physician's order stated to instill 1 drop of Brimonidine Tartrate Ophthalmic Solution 0.2% (Brimonidine Tartrate) in both eyes three times a day for glaucoma. However, the surveyors observed LPN #1 instill 1 drop in the right eye only. During an interview on 04/03/25 at 12:07 PM, the surveyor asked LPN #1 about the process for medication administration when medication is not available. LPN #1 stated, I will call the pharmacy to send the correct dose, notify the physician, and document in the MAR using 'indicate 7' to show that the medication is not available. Sometimes I check in the Pyxis first, but most of the time, I call the pharmacy. LPN #1 confirmed that the eye drop was administered to the right eye only and that she used nursing judgment to hold the Amlodipine due to a low heart rate of 59. The surveyor informed LPN #1 that during medication reconciliation, both Vitamin D and Amlodipine were documented as administered. LPN #1 responded, I thought I documented '7' (which indicates 'not given'). I ' m sorry, I will fix it. The LPN #1 advised that the Amlodipine was administered later that day after speaking with the Nurse Practitioner (NP). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/25 at 12:50 PM, the surveyor notified the Nursing Home Administrator (NHA) and the Regional Clinical Nurse Manager (RCNM) regarding the medication error, and both acknowledged the concern.

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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 observation, staff interviews and record review, it was determined that the facility failed to properly store medications. This was found to be evident in 2 of 2 medication storage rooms and 3 of 3 medication carts observed during the recertification survey. The findings include: During a medication cart observation conducted on 04/07/25 at 9:17 AM of the [NAME] Wing (Cart #2) with Licensed Practical Nurse (LPN) #14, the following were observed, two Tylenol tablets and 1 Vitamin tablet were found stored in a medication cup inside the cart. LPN #14 stated that the resident initially requested the medications but later refused them and asked for Oxycodone instead. Further observations of the medication cart revealed an open, used and undated Basaglar 100-unit insulin pen, twelve 12 loose pills, 10 individually packaged Spiriva Handi Haler 18 mcg (microgram) capsules that were not labeled with a resident ' s name, and 1 individually packaged Ondansetron 4 mg (milligram) tablet also not labeled with a resident ' s name. On 04/07/25 at 9:25AM, the surveyor interviewed LPN#14 about the process for handling medications refused by a resident and the process of disposing of medications. LPN #14 stated, I will notify the physician, document the refusal, and discard the medication in a trash can. During the Medication administration reconciliation review conducted on 4/7/25 at 9:30AM, the Medication Administration Record (MAR) for April 2025 confirmed that Oxycodone was administered at 7:27 AM to Resident ' s #121. During an observation of the Camelot wing medication cart conducted on 04/07/25 at 9:44 AM, the surveyors and LPN #2 observed 2 loose brown oval tablets, 1 opened and undated bottle of Active Liquid Protein, and 1 opened and undated bottle of Vitamin C. During an interview conducted on 04/07/25 at 9:48 AM , the surveyor asked LPN #2 to explain what the facility ' s policy was for labeling a bottle of medication. The LPN stated, The process is to date bottles upon opening. LPN #2 confirmed that the bottles of Active Liquid Protein and Vitamin C had been opened but not dated. During the medication cart observation for the East Wing conducted on 04/07/25 at 10:08AM, the surveyors and LPN #13 observed 7 loose tablets found in the medication cart. The surveyors and LPN #13 observed 1 bottle of MiraLAX, 3 bottles of Robitussin, 1 bottle of mouthwash, 1 container of Aspercreme opened and undated. Further observation of the medication cart revealed 1 bottle of Liquid Morphine and 1 bottle of Liquid Lorazepam each belonged to expired resident #90. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 10:10:08AM, during an interview with LPN #13, the surveyor inquired about the process for handling medications belonging to discharged or expired residents. The LPN#13 stated that typically, two nurses crush the medications and place them in a Ziplock bag, which is then given to the Unit Manager. The Director of Nursing (DON) is usually responsible for disposing of narcotics. On 04/07/25 at 10:33 AM during the observation of the East Wing Medication Storage room with the Unit Manager LPN UM #5, medications that belonged to residents #90 and #18 were found in an open gray pharmacy bag on the bottom shelf of a metal rack. The drug buster medication disposal system deactivates and contains the active chemicals in unused OTC and prescription medications, preventing misuses, abuse and contamination. During an interview with Unit Manager #5 conducted on 4/7/25 at 10:33AM he stated that the process for handling medications of discharged or expired residents was to remove the medications from the cart and return them to the pharmacy. The Unit manager #5 noted that the pharmacy delivers medications daily, and depending on the delivery personnel, they may also collect returns. The Unit Manager #5 further confirmed that the expectation for refused medications that were not a narcotic should be crushed and flushed. For narcotics 2 licensed nurses must destroy the narcotic with the use of a drug buster. During an observation in the [NAME] Wing storage room on 4/7/25 at 10:51 AM with Unit Manager LPN #3, 1 bottle of enteral feeding formula (Nepro with CarbSteady) was observed to be expired (use before 1 Sep 2023). The refrigerator temperature log was missing signatures for three consecutive days (4/3/25, 4/4/25, 4/5/25). The Unit Manager LPN #3 admitted failure in monitoring and documentation. On 4/7/25 at 10:55AM, during an interview with Unit Manager #3, she stated that the process for disposing of medications for discharged or expired residents involves returning the medications to the pharmacy. Unit Manager #3 confirmed that the pharmacy delivers and collects medications daily. Additionally, Unit Manager #3 acknowledged that monitoring and documenting refrigerator temperatures is the responsibility of the nursing staff but stated, I guess they are not doing it. LPN #3 further confirmed that it is the responsibility of both the nurses and the unit manager to routinely check the medication storage room for expired medications and expired enteral feeding products. During an interview with the Regional Clinical Nurse Manager (RCNM) on 04/07/25 at 11:08AM, the surveyor inquired about the process for disposing medications and returning them to the pharmacy. The RCNM confirmed that the expectation is to dispose of non-narcotic medications by discarding them, while narcotic medications are destroyed using a Drug Buster by two licensed nurses. The RCNM also confirmed that the pharmacy picks up return medications during deliveries but was uncertain about the frequency of these pickups. Additionally, the RCNM acknowledged that the facility policy states all unused, contaminated, or expired medications must be disposed of in accordance with state laws and regulations, and that prescription drugs may not be flushed down the toilet, per EPA guidelines. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concerns observed were shared with the RCNM, who acknowledged them and stated that an in-service will be conducted for staff.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record review, it was determined that the facility failed to ensure that residents who required dental services on a routine basis, received the necessary services in a timely manner. This was evident for 1(Resident#59) of 1 resident reviewed for dental services. The findings include: Resident #59 was admitted to the facility on [DATE] with diagnoses including Dementia, and Cognitive Communication Deficit. On 03/31/25 at 09:36 AM Resident#59 informed the surveyor that he/she experienced pain when chewing food. On 04/03/25 at 10:36AM a review of Resident# 59's clinical record revealed that the resident had not seen a dentist since admission to the facility on [DATE]. On 04/07/25 at 08:20 AM the surveyor observed Resident #59 for 25 minutes eating breakfast. The resident took small bites and at the end of the 25 minutes had consumed one slice of toast, one half bowl of Oatmeal and one serving of Cheerios. Resident #59 stated that he/she experienced pain in the right jaw while chewing the toast. On 04/07/25 at 08:49 AM in an interview the Registered Dietitian (RD) stated that Resident #59 was interviewed recently on 01/31/25 regarding concerns for weight loss and at that time, the resident did not mention any dental pain. 04/07/25 at 09:26 AM the surveyor informed the Regional Clinical Nurse Consultant (RCNC) and the NHA of the findings. After the surveyor's intervention on 04/07/25, the physician ordered medications to address the resident's oral pain. An oral health evaluation was completed on 04/07/25 at 10:18AM by Unit Manager Staff #3 and it revealed that Resident #59 had 1-3 decayed or broken teeth. On 4/10/25 at 10:06 AM the RCNC informed the surveyor that an appointment was scheduled for Resident #59 to see a Dentist on 04/12/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation, facility staff interview and facility record review, it was determined that the facility failed to maintain proper sanitation for storage of food on the nursing units and in the kitchen. This was found to be evident on 1 out of 3 nursing units and on the initial tour of the kitchen during review of food storage and sanitation. The findings include: During the initial tour of the kitchen on 03/31/2025 at 08:15 AM with the Food Services Director (FSD) in attendance, the surveyor observed the following sanitation concerns: personal coffee mug on meal tray cart; employee personal items (coat, back pack and keys) in the chemical storage room; opened container of stir fry sauce, opened container of distilled vinegar and opened container of salt not dated on bottom shelf of the food prep table; no thermometer on the inside of the walk in-freezer and walk-in refrigerator (only a thermometer on the outside of walk-in freezer and refrigerator). In an interview during the initial tour of the kitchen on 03/31/2025, the Food Services Director (FSD) acknowledged the surveyor's sanitation concerns and the FSD placed thermometers inside the walk-in freezer and walk-in refrigerator. On 04/01/2025 at 07:30 AM the surveyor conducted a review of the facility's policy and procedure for Use and Storage of Food Brought in by Family and Visitors dated 03/20/2023 and revised 03/26/2025. This food policy indicated that food items that were brought in by family and visitors and stored in the nourishment refrigerators on the nursing units were to be labeled and dated. At 07:20 AM on 04/02/2025 the surveyor toured the Camelot Nursing Wing of the facility and conducted an observation of the nourishment refrigerator. This observation revealed two rolls of bread each in an individual plastic bag on the refrigerator door without a label or date. On follow-up observation of the nourishment refrigerator on the Camelot Nursing Unit on 04/03/2025 at 12:30 PM, the surveyor observed a bag of red grapes in a plastic bag on the refrigerator door that was not labeled or dated. In an interview on 04/03/2025 at 12:40 PM with the LPN Unit Manager (UM) on the Camelot Nursing Unit, the surveyor asked what the expectation of labeling and dating food items that were stored in the nourishment refrigerators. The LPN Unit Manager (UM) stated that the food should be labeled and dated. The LPN Unit Manager (UM) acknowledged the surveyor and labeled and dated the bag of red grapes. The Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Nurse Consultant were notified of sanitation and food storage concerns at 03:20 PM on 04/09/2025. No additional information was provided by the facility at the time of exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on surveyor observation and facility staff interview it was determined that the facility failed to dispose garbage and refuse properly. This finding was found to be evident during the tour of the outside dumpster area. The findings include: On 03/31/2025 at 08:55 AM the surveyor toured the outside dumpster area with the Food Services Director (FSD) in attendance. This tour revealed the observation of the dumpsters not covered with the attached lids. Additionally, next to the dumpsters were an old mattress, dresser and a soda can. In an interview on 03/31/2025 following the tour with the Food Services Director (FSD) the surveyor asked what the expectation was for the dumpsters being covered with lids. The FSD stated that the dumpsters should be covered with lids. The FSD acknowledged the surveyor and covered the dumpsters with the respective lids that were attached to the dumpsters. The surveyor reviewed the findings with the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Nurse Consultant on 04/09/2025 at 03:20 PM. No additional information was provided by the facility at the time of exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed to ensure that the medical records for a resident who was required to wear a cervical collar, were maintained in the most accurate form. This was evident for 1(Resident #35) of 1 resident reviewed for cervical collar application. The findings include: A Treatment Administration Record (TAR) is an essential document in health care settings that provides detailed information about the treatments prescribed to a resident, including dosage, administration times and special instructions. It serves as a crucial tool for nurses to ensure safe and accurate treatment administration. On 04/02/25 at 7:30AM a review of Resident #35's clinical record revealed that the resident sustained a fall on 02/14/25 which resulted in a head injury. The resident was transferred to the emergency room and returned to the facility on [DATE] with a physician's order for Aspen cervical collar to remain in place at all times. May remove to check skin integrity and provide ADL care and replace collar every shift for Cervical fracture On 03/31/25 at 10:50AM, 04/01/225 at 8:00AM and 04/03/25 at 10:15AM the surveyor observed the resident was not wearing the Aspen cervical collar. Further review of Resident 35's progress notes revealed that the resident refused to wear the Apen cervical collar on 03/17/25, 03/20/25, 03/21/25 and 03/29/25. A review of Resident #35's medical record revealed that the nurses signed the Treatment Administration Record (TAR) indicating the resident wore the cervical collar on the days of refusals and on the days the surveyor observed the resident was not wearing the cervical collar. On 04/03/25 at 10:19AM the surveyor interviewed the Unit Manager Staff #3 who stated that the resident sometimes refuses to wear the cervical collar, and the physician and responsible party were aware. Further, the nurses document the resident's refusal on the TAR and progress notes. Unit Manager Staff#3 reviewed the documentation in the presence of the surveyor and confirmed that the nurses were not accurately documenting Resident #35's refusals on the TAR. The Unit Manager Staff#3 stated that she would conduct an in-service on documentation to address the issue. On 04/03/25 at 10:45 AM the Nursing Home Administrator and Regional Clinical Nurse Consultant were made aware of the surveyor's findings. On 04/03/25 at 11:20 AM the Unit Manager gave the surveyor a copy of an inservice conducted on 04/03/25 by the Unit Manager Staff #3 for the nursing staff who worked on the morning shift that day.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, it was determined that the facility failed to have the minimum required members in attendance at the Quality Assessment and Assurance (QAA) committee. This was found evident during the Quality Assurance and Performance Improvement (QAPI) and Quality Assessment and Assurance (QAA) review, which has the potential to affect all residents. The findings include: According to the Centers for Medicare and Medicaid, Quality Assessment and Assurance (QAA) specifies the QAA committee composition and frequency of meetings in nursing facilities and requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies. On 04/10/25 at approximately 10:50 AM, the facility's QAA attendance sheets were reviewed. It was found that there were inconsistencies with attendance sheet sign-ins. For the QAPI meetings of 02/25/25 and 03/25/2025, all signatures for the federal-required employees are present except for the Infection Preventionist (IP). Attendance sheets for the dates of 10/29/2024, 02/25/2025, 01/28/2025, 11/26/2025, and 01/28/2025, it is not clear who was in attendance and who was not. On the bottom of each attendance sheet, it stated the Federal Requirement for who needs to be in attendance to the QAA meetings. However, this was incorrect, as it did not include the IP. On 04/10/25 at 11:00 AM, an interview was conducted with the Administrator. He confirmed that his system for the attendance sheet has had issues, and it was not clear who was in attendance for the meetings. He admitted that there was inconsistency in the attendance sheets and a better system would be to utilize signatures of employees to ensure that they were in attendance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215025	A. Building B. Wing	04/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, it was determined that the facility failed to follow Enhanced Barrier Precautions (EBP). This was evident for 1 (Resident #53) out of 1 Resident reviewed for infection control. The findings include: According to the Centers for Medicare and Medicaid Services (CMS), Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Furthermore, EBP are indicated for residents with any of the following: Infection or colonization with a CDC (Centers for Disease Control and Prevention)-targeted MDRO (multi-drug resistant organism) when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. An indwelling urinary catheter is a thin, hollow tube that is inserted into the urethra to reach the bladder in order to drain urine into a bag. On 03/31/25 at 10:30 AM, an observation of Resident #53 ' s room showed that there was an EBP sign posted on the entry door. The sign indicated that the staff must use Personal Protective Equipment (PPE), such as gloves and a gown during High-Contact Resident Care Activities. At this time, it was observed that Geriatric Nursing Assistant (GNA) #11 was giving Resident #53 a bed bath and was not wearing a gown. This Resident had an indwelling urinary catheter. On 03/31/25 at 10:37 AM, an interview was conducted with GNA #11. When asked if she knew which resident was on EBP, she was not aware that Resident #53 was on EBP. When asked which Personal Protective Equipment (PPE) is required when caring for a resident with EBP, she stated gloves and a gown. During this interview, GNA #11 was made aware that it was a concern that she had given Resident #53 a bed bath (High-Contact Resident Care Activity) without a gown on. She confirmed understanding and reported she would remember to wear a gown in the future. On 04/08/2025 at approximately 1:30 PM, a record review of Resident #53 confirmed there was an order for Enhanced Barrier Precaution - PPE during High Contact Resident Care. On 04/08/2025 at 2:00 PM, an interview was conducted with the Administrator and Director of Nursing, to make them aware of the concern for GNA #11 not following EBP with Resident #53. On 04/09/25 at 11:31 AM, the Administrator provided documentation showing that education was provided to GNA #11 regarding utilizing proper PPE for EBP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, it was determined that the facility failed to keep a sanitary environment. This was evident during the tour of the laundry room conducted as part of the facility's annual recertification survey. The findings include: On 04/01/25 at 11:31 AM the surveyor did a tour of the laundry room with the Environmental Services Supervisor (ESS) and Staff# 16. The surveyor observed the floor tiles in the room with the washing machines were visibly dirty. There were brown spills on the floor covering an area of approximately 1.5 ft x1.5ft in front of a platform where the chemicals for the washing machines were located. A brown dirt-like substance was observed throughout the length of the laundry room leading to the platform. In the clean area of the laundry room was a Heating Ventilation and Air Conditioning (HVAC) unit with 3 rusty grille vent covers that had thick layers of dust. Staff #ESS acknowledged the findings and stated we need to do some cleaning On 04/02/25 at 07:00 AM the surveyor informed the Nursing Home Administrator (NHA) of the findings in the laundry room. On 04/02/25 at 01:05 PM the NHA invited the surveyor to do another walk through the laundry room. The surveyor observed that the floors were clean, and the HVAC vent covers were free of dust but remained rusty.