STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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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 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 observation, interview, and record review it was determined the facility failed to ensure maintenance of dignity and provide for self determination for Residents. This was evident for 2 (#150, #56) out of 42 Residents on Unit D during surveyor observation conducted in response to Complaint #3026233 and 1 (#106) out of 4 residents reviewed for dignity during the facility's recertification survey. The findings include: 1. On 6/4/26 at 6:56AM surveyors conducted observations of nursing Unit D in response to Complaint #3026233 which documented concerns regarding treatment of facility Residents by staff. On 6/4/26 at 6:56AM surveyors approached the end of the hallway farthest from the Unit D nursing station and heard Resident #150 from the hallway asking for water to drink and repeating: Water, H20. Upon closer observation, no staff were present within Resident #150's room and Resident #150 was observed by surveyors laying in bed with no beverage present. Resident #165 was observed sleeping in their bed located in the same room across from Resident #150 with a cup of clear liquid sitting on their over bed table which was dated 6/2. 2. During continued dual surveyor observation of Unit D on 6/4/26 at 7:01AM surveyors heard from the hallway, Resident #56 repeatedly yelling: F this place. Surveyors observed Geriatric Nursing Assistant (GNA) #13 enter the room of Resident #56. GNA #13 was heard by surveyors inquiring as to why Resident #56 was upset, at which time Resident #56 stated to GNA #13: I'm wet. Resident #56 was heard by surveyors communicating to GNA #13 that they needed their incontinence product changed at which time GNA #13 was observed and heard by surveyors telling Resident #56: You have to wait, we are just getting started. On 6/4/26 at 7:02AM the surveyor conducted an interview of GNA #13 who confirmed the Resident was not on their assignment and they were unsure if the GNA assigned to that Resident's care had arrived for their shift yet. On 6/4/26 at 7:06AM the surveyor conducted an interview of Resident #56 at which time they continued to voice concern that they were wet from incontinence and needed staff assistance to be changed. GNA #13 was observed by surveyors entering and exiting several other Resident rooms. On 6/4/26 at 7:09AM the surveyor conducted an interview of Unit Manager #14 and night shift Nurse #15 who both confirmed that 2 out of 4 GNA's assigned to the 7am shift had not yet arrived, however, the two night shift GNA's had not yet left. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/26 at 7:11AM surveyors continued to observe GNA #13 entering and exiting other Resident rooms. On 6/4/26 at 7:17AM surveyors noted that Resident #56 had not yet received additional response by facility staff for their incontinence care concern. At this time, surveyors shared concerns with Unit Manager #14 who acknowledged the concerns and confirmed understanding of the concerns. On 6/4/26 at 7:26AM the surveyor shared the concern with the Director of Nursing who acknowledged the surveyor's concerns and stated: It's an education that needs to be reinforced again, there's no reason that if the two night shift GNA's are still here, they are getting paid on the clock, we still have four GNA's that is what is needed for the unit, they should be taking care of the needs even if the dayshift GNA' s are not here yet. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 3. On 6/01/2026 at 11:25 AM, Resident #106 was interviewed about how s/he enjoys life at the facility. Resident #106 stated that s/he loves living at the facility; however, some staff members speak to her/him like they are 5 years old. Resident #106 continued to state that s/he is more with it (comprehending) than some of the other residents, and that s/he doesn't like to be spoken to like that. Then s/he stated that s/he wanted to remain anonymous because s/he didn't want anyone to get in trouble. Resident #106 would not identify who the individuals were. On 6/04/2026 at 9:47 AM, the surveyor spoke with Resident #106 again about our initial conversation about the staff speaking to her/him as a child. Resident #106 confirmed that it has occurred on a number of occasions, but s/he could not give the exact remark stated. Resident #106 was asked if the surveyor could speak with NHA or the Unit Manager about this concern. Resident #106 stated that s/he trusted the NHA with their life, and of course, it was okay to tell them. On 6/04/2026 at 10:00 AM, the surveyor interviewed the NHA and Unit Manager #32 about the resident's concerns. The NHA and the Unit Manager were asked if they knew that Resident #106 felt as if some of the staff members spoke to him/her as if s/he were a child. The NHA stated that he knows Resident #106 well and that Resident #106 did not tell him this. The NHA then stated that he would start the grievance paperwork for the resident and that he would speak with Resident #106 about it. The NHA asked if Resident #106 gave any names of the staff members who treated them in this manner. The surveyor stated that Resident #106 did not state the names of the staff members who were speaking to her in this manner.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation and interview it was determined the facility failed to ensure a homelike environment, This was evident during multiple observations by the surveyor for 1 (Unit D) out of 4 nursing units and during the surveyor's review of the environment task during the facility's recertification survey. The findings include: On 6/1/26 at 7:49AM during the surveyor's initial tour of the facility the air vent located in the main lobby was observed with thick dark grey debris present on it. On 6/1/26 at 9:45AM the surveyor observed the nursing Unit D carpeting present within the main hallways of the unit to be in severely worn condition with various staining throughout. On 6/2/26 at 11:47AM the surveyor observed an exterior vent with extensive yellow and green debris present on it on the front side of the facility adjacent to the driveway.On 6/2/26 at 11:48AM the surveyor observed a crack in the Unit D nursing wing window glass pane located in the main dining area which extended several feet in length.On 6/2/26 at 11:51AM the surveyor observed a large depressed and cracked area in the facility's parking lot with mud present within it located across from the Resident smoking area.On 6/3/26 at 8:32AM the surveyor observed Resident #127's bedroom furniture with worn areas of unfinished appearing surface material. On 6/3/26 at 8:35AM the surveyor observed Resident room signage throughout the nursing unit D hallway at which time multiple signage was observed in disrepair. Cracks were observed to be present in various room signage, and tape was observed present affixing 104B's name to the signage. Resident room doors throughout the nursing Unit D hallway were observed by the surveyor to have various chipping and scraping present. On 6/3/26 at 8:38AM the surveyor observed 2 of 4 circular ceiling lights located above the Unit D nurse station which were unfinished in appearance with observable chipped drywall surrounding them. On 6/8/26 at 12:06PM the surveyor conducted an interview of and shared concerns with Maintenance Director #16 who acknowledged the concerns. Regarding the parking lot condition, Maintenance Director #16 reported the facility was in the process of continuing to get proposal estimates for repair of the damaged area. During surveyor initiated dual observation of all concerns with Maintenance Director #16 on nursing Unit D on 6/8/26 at 12:13PM, various Resident room furniture was observed from the hallway of the D wing nursing unit with severely worn and stained appearance. The bird enclosure located in the main area of Unit D was additionally observed with unclean creamy debris present on the surface of the glass. Maintenance Director #16 observed and acknowledged the surveyor's concerns. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. Regarding the condition of the carpeting, the Administrator communicated to the survey team that a corporate approval for carpeting replacement was necessary, and reported that quotes were being obtained for the damaged parking lot area.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interviews with staff, and review of facility reported incident #2669738 it was determined the facility failed to report and ensure timely reporting of injuries of unknown origin to the Office of Health Care Quality (OHCQ). This was evident for:1.1 out of 9 facility reported incidents (#2669738)2.1 Resident (#165) reviewed for change in condition 3.1 (#144) out of 6 residents reviewed for accidents during the facility's recertification survey. The findings include: 1. On 6/8/26 at 9:21AM the surveyor reviewed the facility provided complete investigative file for facility reported incident #2669738 which documented an initial self report form made to the Office of Healthcare Quality dated as made on 11/17/25 at 1:07AM for an allegation type of both physical abuse and injury of unknown source. Further review of the initial self report by the surveyor revealed documentation that on 11/16/25 at 9:30PM, GNA #17 became aware of multiple discolorations present on the face of Resident #158 and reported to Assistant Director of Nursing (ADON) #18 at 11:20PM. It was noted by the surveyor that on the initial self report form the following information was documented: The Resident refused to tell facility staff members what happened but told the officer that on Friday or the day of lunch, whoever served her lunch knocked the plate over because s/he did not like the food and hit his/her hand with the plate. The facility's initial self report form additionally was observed by the surveyor with documentation that law enforcement was contacted on 11/16/25 at 11:25PM. Surveyor review of a nursing progress note dated 11/16/25 at 9:43PM documented by the ADON revealed the following information: 1.) Primary chief complaint: ecchymosis (bruising), 2.) Head: Ecchymosis above rt brow and older appearing area higher on forehead, 3.) Diagnosis, Assessment/Plan: Unspecified Injury of head, initial encounter, primary, given s/he is on Eliquis (blood thinning medication) and unclear nature of incident, needs imaging, 4.) Transfer to ED (Emergency Department), 5.) This is an acute new problem, 6.) Condition is guarded, 7.) Transfer pt to ED via 911 EMS. Review by the surveyor of the facility's documentation present within the complete investigative file included definitions of key indicators of physical abuse which included: Unexplained bruises, fractures or marks. Review by the surveyor of the complete investigative file revealed an email documenting confirmation of the submission of the initial self report to the Office of Healthcare Quality as occurring on 11/17/25 at 1:09AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/8/26 at 10:16AM the surveyor shared concerns and conducted an interview of the facility Administrator who acknowledged and confirmed understanding of the surveyor's concerns. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 2. During surveyor review of Resident #165's medical record on 6/2/26 at 9:02AM documentation was observed regarding the presence of skin discoloration and hematoma. On 6/8/26 at 9:13AM the surveyor conducted an interview of the facility's Director of Nursing (DON) and inquired as to the origin of Resident #165's documented skin discoloration and hematoma at which time the DON reported to the survey team that they needed to review the Resident's medical record to refresh their memory on the events surrounding it. Further review of the medical record by the surveyor revealed a monthly follow up note documented by Nurse Practitioner (NP) #19 dated 5/7/26 at 3:30PM which documented their assessment of Resident #165 which included that the Resident was receiving comfort care, was fully dependent for activities of daily living and unable to participate in history of present illness due to cognitive impairment related to advanced dementia. Review by the surveyor of a health status note documented by Assistant Director of Nursing #18 dated 5/7/26 at 9:09PM revealed the following information: Resident noted with discoloration to the groin area during care giver clean his/her up, assessed small swollen but no open area or active drainage observed, NP notified. Review by the surveyor of documentation dated 5/8/26 at 2:30PM revealed NP #19 conducted a follow up assessment of the Resident which included the following information: 1.) groin swelling and discoloration, 2.) (Resident #165) is seen for evaluation of groin swelling and discoloration at the request of nursing staff, 3.) A small area of hematoma was observed in the groin area; skin is intact, 4.) nonverbal/confused/legally blind with advanced dementia, and full ADL dependence, 5.) Groin hematoma with discoloration, 6.) Hematologic/lymphatic: No easy bruising or bleeding, no enlarged lymph nodes, no history of anemia or clotting disorders, 7.) Contusion of groin initial encounter, small area of hematoma with associated discoloration observed in the groin area. Review by the surveyor of a follow up assessment of Resident #165 by NP #19 dated 5/13/26 at 2:30PM revealed the following information: The hematoma which was noted to be resolving on 5/12/26, now appears to be spreading to his/her hips and flank area, with a large area of discoloration, and confirmed the Resident was not taking any blood thinning medications. On 6/8/26 at 11:09AM the surveyor conducted an interview of the facility's DON and inquired as to if (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility had made any self reports to the Office of Health Care Quality regarding Resident #165's injury of unknown origin at which time they confirmed that there was no self report made and no investigation performed. During the interview, the DON confirmed with the surveyor that they did consider this a situation in which required a self report to be made. After surveyor intervention, the DON expressed that they would begin investigation into the injury and a self report would be made. On 6/8/26 at 11:14AM the surveyor shared the concern with the facility's Administrator who acknowledged understanding of the concern and reported that they would look into where the facility was with their investigation. On 6/8/26 at 11:33AM the surveyor was approached by NP #19 at which time an interview was conducted. During the interview, NP #19 reported that per information relayed from facility staff, there was no fall or trauma, there was nothing. When the surveyor inquired as to how NP #19 ruled out trauma, they stated not really. NP #19 reported during the interview that on or around 5/21/26 they discussed with Unit Manager to follow up with staff to see if anything had happened to the Resident and at that time, facility staff were talked to and it was reported that nothing happened. At this time, the surveyor inquired as to the location of the injury at which time NP #19 showed the survey team a large area which extended from both inner thighs wrapping around their waist and extending up over and behind the hips. NP #19 stated that when she previously had observed it, it wasn't that extensive. During an interview conducted by the surveyor of NP #19 on 6/8/26 at 11:58AM, NP #19 reported that they had the discussion with the Unit Manager on 5/14/26 and confirmed that all lab work that they had ordered in response to the injury had come back normal. On 6/8/26 at 11:59AM NP #19 confirmed that this was a reportable injury, and the facility was now taking steps to perform investigation of it. NP #19 reported their initial observation of the injury included both thighs of the Resident and that they were initially called by facility staff to look at swelling and discoloration of the Resident. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 3. On 6/8/2026 at 10:21AM, during a review of Resident #144's electronic medical record, the Surveyor discovered a 3/28/2026 eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers note which revealed that the resident was noted with redness and swelling to the right wrist and fingers and complained of pain when touched. Recommendations included an X-ray of the right wrist, hand, and fingers. Further review revealed a 3/30/2026 physician follow-up note stating the resident's x-ray was obtained on 3/28/2026 with the impression: right wrist no acute fracture. There was no documentation which identified the origin of the injury or a facility investigation into an injury of unknown origin reported to OHCQ. On 6/8/2026 at 11:00AM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #144 sustained an injury and that there was no documentation of an explanation for the injury, investigation by the facility, and report submitted to OHCQ. The DON stated that she would review the resident's medical record and the facilities reported incidents to determine if there was an investigation into the injury. On 6/8/2026 at 2:55PM, during a follow-up interview with the DON, the Surveyor confirmed there was no documentation of an explanation for Resident 144's injury and no facility reported incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the resident's injury of unknown origin. The Surveyor was informed that education will be provided on documentation and reporting requirements of injuries of unknown origin. On 6/8/2026 at 3:50PM, the Assistant Director of Nursing (ADON) provided the Surveyor with a Facility Reported Incident Initial Report Form for Resident #144.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews with the resident and staff, and review of complaint #2655036, it was determined that the facility failed to ensure a resident's call bell was in reach and document and report a resident's fall and administer medications according to professional standards of practice. This was found to be evident for 1 (Resident #41) out of 6 residents reviewed for accidents and 1 (#2655036/Resident #184) out of 6 complaints reviewed during the annual recertification survey. The findings include: 1. On 6/1/2026 at 8:45AM, during an initial interview conducted with Resident #41, the Surveyor learned that a couple days prior, the resident slid out of his/her wheelchair and hurt his/her tail bone while reaching for the call bell which was on the other side of the bed at the time. The resident continued to say that a facility staff member observed him/her on the ground upon returning to the room and called for another facility staff member to assist the resident back into the bed. On 6/3/2026 at 1:39PM, a review of Resident #41's electronic medical record failed to reveal documentation of a fall since admission on [DATE]. During an interview conducted with the Unit Manager (UM) #24 of the B wing unit on 6/3/2026 at 1:50PM, the Surveyor learned that Resident #41's fall a couple days ago was not reported and there was no record or documentation of the fall anytime during their admission to the facility. The Surveyor reported that Resident #41 stated that they fell a couple of days ago in their room. UM #24, in the Surveyor's presence, interviewed the resident in order to submit a formal fall report. The resident informed UM #24 that facility staff told them not to report the fall. UM #24 stated they would start an investigation to determine the staff involved and the circumstances surrounding the resident's fall. On 6/3/2026 at 2:10PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #41 informed both the Surveyor and UM #24 that they sustained a fall on 5/30/2026 while trying to reach for the call bell; however, there was no documentation of a fall in the resident's medical record. The Surveyor was informed that the facility would start an investigation into Resident #41's fall. On 6/4/2026 at 8:43AM, the DON confirmed that Resident #41 sustained a fall on 5/30/2026 during the evening shift while trying to reach for the call bell and the nurse failed to document and report the incident at the time of occurrence. Facility staff involved received education on ensuring call bells are within reach, timely reporting of falls and incidents, and completing required documentation. 2. On 6/3/26 at 12:17 PM, the surveyor reviewed complaint # 2655036. Complaint #2655036 indicated that Resident #184's medication was not administered. On 6/8/26 at 9:08 AM, the surveyor reviewed the resident's medical records. The resident record review revealed that the resident's Medication Admin Audit Report indicated that the resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received the following medications late on 09/18/25: -Empagliflozin Oral Tablet 10 MG (Empagliflozin) for diabetes mellitus, was scheduled for 8:00 AM on 9/18/25, administered at 9:24 AM on 9/18/25, and documented at 9:27 AM on -Escitalopram Oxalate Oral Tablet 20 MG (Escitalopram Oxalate) for depression, was scheduled for 8:00 AM on 9/18/25, administered at 10:05 AM on 9/18/25, and documented at 10:08 AM -Bumetanide Oral Tablet 1 MG (Bumetanide) for CHF, was scheduled for 8:00 AM on 9/18/25, administered at 10:06 AM on 9/18/25, and documented at 10:08 AM -Lidocaine HCl External Lotion 1 % (Lidocaine HCl) for lower back pain, was scheduled for 8:00 AM on 9/18/25, administered at 10:07 AM on 9/18/25, and documented at 10:08 AM -Atovaquone Oral Suspension 750 MG/5ML (Atovaquone) for PCP prophylaxis, was scheduled for 8:00 AM on 9/18/25, administered at 10:06 AM on 9/18/25, and documented at 10:08 AM -Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) for bowel regimen, was scheduled for 8:00 AM on 9/18/25, administered at 10:09 AM on 9/18/25, and documented at 10:09 AM -Spironolactone Oral Tablet 50 MG (Spironolactone) for CHF, was scheduled for 8:00 AM on 9/18/25, administered at 10:09 AM on 9/18/25, and documented at 10:09 AM -Insulin Asp Prot &Asp FlexPen (70-30) 100 UNIT/ML Suspension pen-injector Inject 18 unit for diabetes mellitus 2, was scheduled for 8:00 AM on 9/18/25, administered at 10:26 AM on 9/18/25, and documented at 10:29 AM -Calcitriol Oral Capsule 0.25 MCG (Calcitriol) for CKD, was scheduled for 8:00 AM on 9/18/25, administered at 2:42 PM on 9/18/25, and documented at 2:27 PM -Genvoya Oral Tablet 150-150-200-10 MG (Elvitegravir-Cobicistat-Emtricitabine-Tenofovir Alafenamide) for HIV/AIDS, was scheduled for 8:00 AM on 9/18/25, administered at 3:00 PM on 9/18/25, and documented at 8:06 PM -rifAXIMin Oral Tablet 550 MG (Rifaximin) for HIV/AIDS, was scheduled for 8:00 AM on 9/18/25, administered at 9:06 AM on 9/18/25, and documented at 8:07 PM -PredniSONE Oral Tablet 50 MG (Prednisone) for IgA, was scheduled for 8:00 AM on 9/18/25, administered at 10:07 AM on 9/18/25, and documented at 8:07 PM -Lidocaine External Cream 4 % (Lidocaine) for back pain, was scheduled for 10:00 AM on 9/18/25, administered at 2:42 PM on 9/18/25, and documented at 2:42 PM -Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) for supplement, was scheduled for 1:00 PM on 9/18/25, administered at 4:28 PM on 9/18/25, and documented at 4:29 PM on 9/18/25; -Ferrous Fumarate Oral Tablet 324 MG (Ferrous Fumarate) for supplement, was scheduled for 1:00 PM on 9/18/25, administered at 3:28 PM on 9/18/25, and documented at 4:29 PM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lactulose Oral Solution 10 GM/15ML (Lactulose) for liver cirrhosis, was scheduled for 2:00 PM on 9/18/25, administered at 3:28 PM on 9/18/25, and documented at 4:29 PM on 9/18/25. On 06/08/26 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) #2. During the interviewer, the surveyor mentioned to DON #2 that according to Resident #184's Medication Admin Audit Report, Resident #184 received mediation late on 9/18/25. The surveyor asked the DON #2 what the expectation is when administering medication to residents. The DON #2 stated that the expectation is to administer medications one hour before or one hour after the mediation is due.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, interviews with staff, and a review of complaint #3026233, it was determined that the facility failed to 1.) provide supervision of residents and 2.) ensure that standard electrical power strips were not used for resident's motorized beds. This was found to be evident for 1.) 1 nursing unit (D Wing) out of 4 nursing units observed and 2.) 1 (Resident #171) out of 20 residents observed on the A wing nursing unit during the annual recertification survey. The findings include: 1. Review by the surveyor of Complaint #3026233 on 6/1/26 at 8:29AM revealed an allegation in which a night shift nurse and certified nursing assistant (GNA) were observed sleeping behind a desk. On 6/4/26 at approximately 3:50AM this surveyor and the survey team entered the facility unannounced and began conducting observations of the facility's nursing units and staff. On 6/4/26 at 3:54AM surveyors observed night shift Licensed Practical Nurse (LPN) #15 sitting in a chair at the Unit D nurse's station sleeping with their eyes closed and head resting on their right shoulder. Two computers at the nursing desk in front of them were observed with dark screens. On 6/4/26 at 3:55AM surveyors observed GNA #20 sitting at a Resident dining table sleeping in front of their computer which had a dark screen, with their upper body resting on their arms on the table and their eyes closed. The dining table was observed located in front of the nurse's station and kitchenette on Unit D. On 6/4/26 at 3:55AM surveyors observed GNA #21 sleeping in a geri-chair with their feet up, eyes closed, their sweatshirt hood up on their head, and shoes off. On 6/4/26 at 3:55AM surveyors toured the Unit D hallway while staff continued to sleep. On 6/4/26 at 3:55AM surveyors observed a Resident room door which was closed with signage that read in capitalized letters: This door must remain open at all times. On 6/4/26 at 4:01AM the surveyor observed and reviewed the staffing sheet assignment document posted at the nurse's station which documented that the following staff were responsible for the care of 43 Residents during the 11pm-7am shift : LPN #15, GNA #20, and GNA #21. Surveyors noted that 3 out of 3 staff responsible for direct supervision and care of the D Unit were all observed to be sleeping. On 6/4/26 at 4:04AM surveyors shared concerns and conducted an interview with the facility's Registered Nurse Supervisor (RNS) #22 who confirmed they were the supervisor in charge of the building, and stated: I try to do rounds, but I can't be there all the time. When surveyors shared concerns with RNS #22, they acknowledged the concerns and stated: Yes, I do understand. On 6/4/26 at 4:54AM this surveyor in the presence of the survey team, shared concerns with the facility's Administrator who acknowledged and confirmed understanding of the concerns. The facility (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator informed surveyors that the involved facility staff would be addressed prior to leaving their shift. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. Prior to surveyor exit from the facility, the facility Administrator provided the following documentation which was reviewed by the surveyor: -Sign in sheet dated 6/4/26 for facility staff education conducted regarding sleeping on duty being strictly prohibited -Corrective action forms dated 6/4/26 noting suspension each of GNA #20, GNA #21 and LPN #15 -Education sheets signed each by GNA #20, GNA #21, and LPN #15. 2. On 6/1/2026 at 10:30AM, during an initial tour of the A wing nursing unit, Resident #171's motorized bed's power cord was observed plugged into a black standard electrical power strip instead of a wall outlet. On 6/5/2026 at 2:07PM, during an interview with the Director of Maintenance (DOM) #16, the Surveyor expressed the concern that Resident #171's motorized bed power cord was plugged into a standard electrical power strip and not directly into the wall outlet. DOM #16 informed the Surveyor that during room rounding, the maintenance staff inspect beds for safety, including power cords. During a follow-up observation with DOM #16, the resident's motorized bed power cord was removed from the standard electrical power strip and plugged directly into the wall outlet. DOM #16 confirmed that motorized bed power cords must be plugged directly into the wall outlet.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review it was determined the facility failed to ensure staff followed professional nursing standards for medication administration. This was evident for 1 (#127) out of 2 Residents reviewed for hospitalization during the facility's recertification survey. The findings include: Review of Resident #127's medical record by the surveyor on 6/4/26 at 6:37AM revealed there was no evidence found to be present in the medical record to show the following medications had been administered according to active medical orders for the Resident to receive them on 5/27/26 at 6:00PM: -Debrox Solution 6.5% Instill 5 drop in both ears two times a day for ear wax for 7 days -Metoprolol Tartrate Oral Tablet 25mg Give one tablet by mouth two times a day related to essential primary hypertension . On 6/5/26 at 9:48AM the surveyor shared concerns with and conducted an interview of the facility's Director of Nursing who reported to the surveyor that they could not give an answer as to why there was no documentation surrounding the 5/27/26 6:00PM medication administration and that they assumed the medications were given, but not signed off. The DON further reported to the surveyor during the interview that they reviewed the Resident's medical record and no further documentation for a reason as to why medications were not signed off could be found. The DON confirmed there were no holidays or leaves of absence of the Resident during the time in which the medications were to be administered on 5/27/26. The DON further stated to the surveyor during the interview: I know that if it's not documented, it is considered not done. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit.