STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215029	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chevy Chase	8700 Jones Mill Road Chevy Chase, MD 20815

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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 observations, resident and staff interviews, it was determined that the facility failed to ensure the residents were treated with dignity. This was evident for 2 residents (#109 and #121) out of 54 residents during this recertification survey. The findings include: 1) While making observations on the Chesapeake Unit on 4/16/25 at 8:44 AM Staff # 17 a Certified Nurse Assistant (CNA) was observed feeding the resident in their room. The CNA was observed standing at the bedside above the resident's right side feeding the resident forkfuls of food and a substance that was in the resident bowl. There was a chair in the room on the left side of the resident bed. The CNA was asked at this time is there any reason why she is standing above the resident assisting with feeding. She stated that the resident had psychological issues and that the chair is too wide to fit in the area where she was standing. The GNA was made aware that standing over the resident to assist with feeding and not sitting in a chair at the level of the resident is a dignity issue. She said she was not aware. She continued to stand and feed the resident. The unit nurse supervisor (Staff # 16) who was in the hallway at this time, was made aware of the concern. He stated that all staff are to sit down with the residents when providing feeding assistance. The Nurse immediately went to the resident room and provided education to the CNA. The Administration team was made aware of all concerns at the exit conference on 4/28/25 at 2:45 PM. 2) Medical record review revealed Resident #109 had the following but limited medical history of muscle spasm, congestive heart failure, fluid overload, and left leg below the knee amputation. Resident #109 was assisted with ADLs, and could transfer self in and out of bed with 1-person physical assist; toileting required extensive assistance, and the resident was wheelchair ambulatory. On 4/17/25 at 9:08 AM, Resident #109 was observed in his/her room sitting on the bedside commode next to his/her bed. Resident #109 asked the surveyor to come back in a few minutes when s/he was finished. At 9:35 AM, the surveyor returned to speak with the resident. Resident #109 stated that there was a lack of respect in this facility, and that s/he was left on the bedside commode for 2 hours before s/he got assistance back to bed one night. Resident #109 also stated that s/he felt like they treat him/her inhuman. (continued on next page)

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 4/22/25 at 9:05 AM, the Administrator and Director of Nursing (DON) were interviewed about Resident #109's care. The surveyor asked if they knew Resident #109 and if they were aware of the resident being left on the bedside commode for 2 hours one night. The Administrator and DON stated that they were not aware of this and would have a discussion with the resident. On 4/22/25 at 11:28 AM, the DON came back to the surveyor to inform the surveyor that the resident stated that the event did occur, however, s/he did not know the exact date that it occurred, only that it was 2 o'clock in the morning. Resident #109 stated that s/he had told their nurse. The DON stated that she would speak with the evening manager about educating the staff on leaving residents on the bedside commode too long and the rights of the residents.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that facility staff failed to ensure a resident had access to their call light. This deficient practice was identified in 1 resident (#106) out of 1 residents reviewed for accommodations during the survey. The findings include: On 04/16/25 at 10:21 AM, the surveyor entered room [ROOM NUMBER] and observed Resident # 106 resting in bed. During the observation, the surveyor noted that the resident's call light (system that allows residents to alert staff when they need help) was missing. The surveyor located Licensed Practical Nurse (LPN) #31 and requested assistance in finding the call device. The LPN #31 searched the area around the resident's bed and located the call device wrapped around the arm of a chair positioned to the right side of the bed's head. The device was not within the reach of the resident. The surveyor asked LPN #31 what staff are expected to do before exiting a resident's room. LPN #31 stated that the call device should always be within the resident's reach and that staff are expected to ensure the resident has access to the call device prior to leaving the room. On 04/23/25 at 11:30 AM, review of medical records for Resident #106 under the task section showed instructions to 'keep call light within reach at all times.' The surveyor reported the observation to the Administrator #1.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 6) An initial tour of the facility was conducted on 4/16/25 at 7:50 AM. While screening residents on the Chesapeake Unit, residents #52 and #18 told the surveyor that the facility was without hot water for 3 days. At this time the surveyor checked the residents' water in the bathroom. The water was turned on for greater than five minutes and did not get warm. Resident #52 was asked how s/he takes a bath or shower, and the resident stated, I do what I have to do and have been taking a bath with cold water because there was no hot water. Further observations were made of the water in room [ROOM NUMBER] and the water was turned on. The water was cold for more than five minutes and it did not get warm. The residents in the room were asked if they had hot water and the residents stated, no, the water had been cold for 3 days. At this time the surveyor approached the nurse supervisor #16 and asked about the water. The nurse stated that the Administration was aware of the water concern and was looking into the issue. During a subsequent observation at 8:44 AM, resident #52 was observed walking in their room from the bathroom. The resident told the surveyor that s/he just finished taking a cold bath. The resident stated that the water was not hot. On the same date at 8:55 AM an interview was conducted with the Administrator, and she stated that she was aware that the Chesapeake Unit did not have hot water in the afternoon of the previous day (4/15/25) and that the facility had a call into a company to get the issue resolved and that they are awaiting someone to be dispatched to the facility. The Administrator was made aware that multiple residents complained of not having hot water for 3 days that was prior to her report of the concern beginning on the previous day. The survey team asked the Administrator to provide documentation of previous temperature logs for the Chesapeake unit as well as current temperatures for the unit. The Administrator and the Maintenance manager returned to the survey team at 10:00AM and provided the team with copies of the temperatures for the unit as follows. 3/28/25 the temperature varied from 103, 104, 105, 106, 108, 110 up to 115. 4/4/25 temps were 106-114. 4/10/25 the temps were 104-115. 4/14/25 the temps were 107-114. Current temperatures for 4/16/24 were as follows: room [ROOM NUMBER] was 68 degrees Room # 84 was 66 degrees room [ROOM NUMBER] was 68 degrees (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] was 65 degrees room [ROOM NUMBER] was 66 degrees room [ROOM NUMBER] was 65 degrees room [ROOM NUMBER] was 68 degrees room [ROOM NUMBER] was 68 degrees. The Administrator stated that they are currently rerouting showers to be done on the Annapolis unit. She stated that the Plumber was scheduled to come to the facility this date. The Administrator provided updated correspondence to the survey team on 4/18/25 at 9:20 AM regarding when the company would resolve the issue. She stated that the Plumber came in and looked at the valve and was waiting for a part. In the interim, residents were being transferred to another unit to shower. Residents who required assistance with baths the water was warmed prior to their bed bath. The plumbing company came into the building on 4/28/25 to work on water concerns. The Administrator stated that the water issue would be resolved this date and hot water would be restored. 4) On 04.16.25 at 08:15 AM the surveyor initiated an observation tour of the unit Arcadia and the following maintenance issues were identified inside resident rooms: a) room [ROOM NUMBER]A/B: no chair for guests was present, the linoleum was warped and cracked outside the bathroom door and missing paint on the wall near the room entry door. b) room [ROOM NUMBER]A/B: there were scratches on the wall paint behind the resident's headboard. c) room [ROOM NUMBER]A/B: the bedside cabinet was missing the top drawer handle. The toilet paper holder was missing in the bathroom, a plastic bag was tied through the toilet paper roll to a towel holder. d) room [ROOM NUMBER]A/B: the wall behind the resident's headboard had areas of paint missing and there was a non-fitting plastic cover over the top of the toilet. e) room [ROOM NUMBER] A: toilet paper was observed on a roll with plastic bag tied to handle rail safety bar across from the toilet, the toilet roll holder was missing the tension bar piece that would hold the bath tissue. There was an blue uncovered, unprotected water shutoff valve on the right side of the sink, located near the floor. During an interview with the unit nurse manager, staff #19 she confirmed the locked unit had a census of 32 residents at the time of the observation on 04.16.25 at 09:00 AM. On 04.17.25 at 09:10 AM, the unit manager, staff #19 stated that all disrepair or maintenance concerns are reported to the maintenance department via the TELS system. These observations were discussed with the maintenance director during an observation tour of two units with another surveyor on 04.18.2025 that began at 11:39 AM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04.28.25 prior to the exit conference, the administrator verified that the maintenance concerns had been shared with her by the maintenance director.5) During the initial observation of unit Annapolis and Garden View on 04/16/25 at 7:59 AM, the surveyor entered the shower room and observed a basin placed on top of a trash can, wheelchair pedals placed in front of the trash can, and a mop and broom leaning against it. Next to the toilet, a clear plastic bag and trash were noted on the floor. A brown substance was present on the toilet seat. The tub in the shower room contained a bedside commode bin, a bra, a black sock, a hanger, and a seat cushion. Towels were also noted on the floor. On 04/16/25 at 8:03 AM, the surveyor entered a room labeled as the clean utility room and observed a used clear glove placed on top of a black bin. Next to the back cabinet, the surveyor noted a wall with incomplete paint and an area of the floor missing tile. A box containing papers was observed on the floor, and behind the door, six staff jackets and a fanny pack were hanging. On 04/16/25 at 8:06 AM, the surveyor entered the soiled utility room. Upon entry, a sink full of standing dirty water was observed. The surveyor opened the cabinets to the right of the sink and found soiled shelves, five empty soiled flower vases, a clear plastic bag, a rod, and two telephones. The Administrator #1 and Director of Nursing #2 were both made aware of the observation on 04/16/25 at 8:38AM. During an interview with the Housekeeping Director #21 on 04/18/25 at 1:22 PM, she stated that floor technicians are responsible for pulling trash from common areas (dining room, clean and dirty utility rooms, shower rooms) and from resident rooms, and housekeeping staff are responsible for cleaning this area throughout the shift. When asked about monitoring cleaned areas, the Housekeeping Director #21 reported that she was responsible for rounding. The surveyor informed the Director of Housekeeping of the observed conditions in the residents' shower room and the clean and dirty utility rooms. She acknowledged the observation and stated that overseeing both housekeeping and laundry services can be challenging. Based on observation and interview, it was determined that the facility failed to maintain a homelike environment for the residents as evidenced by failure to 1) keep the utility rooms, and resident shower room clean and organized; 3) ensure that residents were provided with hot water during the survey. This was evident during multiple observations made on the Arcadia Unit and throughout the facility. The findings include: 1) On 04/16/25 at 08:43 AM, an initial observation of the Arcadia unit in rooms [ROOM NUMBERS] revealed a toilet paper roll in the bathroom that was hung by a trash bag and tied around a handrail. On 04/17/25 at 08:22 AM, a follow up observation revealed the same concern in both room [ROOM NUMBER] and 23, where their toilet paper rolls were hung by a trash bag. 2) On 04/16/25 at 08:43 AM, an observation in room [ROOM NUMBER] revealed the bottom drawer of the (A-bed) nightstand, which failed to reveal it properly fit in the dresser or had a hand knob. On 04/17/25 at 08:22 AM, a follow up observation was made, which revealed the same concern. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 04/16/25 at 09:03 AM, an initial observation of the Arcadia Unit in the bathroom between 18 and 19, failed to reveal a door knob on either side of the bathroom doors, which exposed a hole on both bathroom doors. On 04/17/25 at 08:06 AM, an interview with the Arcadia Unit Manager / Registered Nurse (Staff #19) revealed the staff used an online platform, TELS to report maintenance concerns. On 04/18/25 at 11:13 AM, an interview with the Director of Maintenance (Staff #5) revealed he was unaware of any maintenance concerns on the Arcadia Unit. On 04/18/25 at 11:46 AM, the surveyor and the Director of Maintenance (Staff #5) completed a walk through on the Arcadia Unit, and reviewed the concerns noted above from examples 1 through 3.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on administrative record review and interviews with facility staff it was determined the facility failed to ensure the safety of a resident after the resident reported allegations of staff abuse for Resident #146, and failed to ensure a thorough investigation was conducted for a Facility Reported Incident (FRI) regarding Resident #165. This was found to be evident for 2 of 19 residents reviewed for abuse during the survey. Findings include, 1) MD00204470 was reviewed on 4/18/25 12:00 PM for allegations of staff abuse. The abuse was unsubstantiated. A review of the facility's investigation revealed a discipline in which staff (#34) received a written warning about the following infraction: Employee (# 34) who is a nurse, was directed to leave the facility immediately and was on off duty due to an allegation of abuse made by Resident #146. The employee was told to leave the building by the Administrator and DON on 4/8/24 at approximately 12:30PM. The employee was found on another unit documenting on a resident at 2:12 PM and did not leave the building until after about 2:20 PM. Employee (#34) wrote a response stating that they were holding keys and did not give report and was waiting to do narcotic count. An interview was conducted with the NHA on 4/21/25 at 12:15 PM and she was asked to explain the facility's procedure when investigating an employee for allegations of resident abuse and she stated the following: The alleged perpetrator was asked to leave the building immediately, however, this employee did not leave and remained in the building. The Administrator was asked how the facility can keep residents safe from retaliation from their alleged perpetrator, and she stated the employee should have been escorted out of the building, and that this employee was not, he was told to leave. The NHA stated that the abuse allegation was unsubstantiated, however, this employee was later terminated for insubordination. All concerns were discussed with the administration team at the exit conference on 4/28/25 at 2:45 PM. 2) On 04/23/25 at 11:09 AM, review of facility documentation for MD00212656 revealed that Resident #165's representative made the facility aware of an allegation Resident #165 had made regarding Geriatric Nursing Assistant (Staff #39). At the same time, review of the facility documentation revealed that Resident #165 indicated to their representative that Staff #39 was rough with her/him during repositioning/ morning care and that Staff #39 turned the resident on their right side during care which they did not want to be turned on. On 04/23/25 at 11:12 AM, further review of the facility documentation for MD00212656 revealed a document titled, Abuse- Investigation Statement which failed to reveal indication that the allegation was addressed (if Staff #39 was rough during Resident #165's repositioning/ morning care and/or if the staff member had turned the resident on the side they did not want to be turned on). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at 11:13 AM, further review of the facility documentation failed to reveal indication that the staff was interviewed or made a statement regarding the specific allegation made. On 04/24/25 at 10:29 AM, the surveyor reviewed the concern with the Nursing Home Administrator (Staff #1). Staff #1 said they would look into it and see if they had any further documentation to provide that would address the specific allegation made. On 04/24/25 at 12:35 PM, Staff #1 indicated they had no further documentation to provide that would indicate what the surveyor requested.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to include the resident comprehensive care plan goals with the required documentation during a transfer. This was evident for 1 (Resident #86) of 2 residents reviewed for hospitalization. The findings include: On 04/21/25 at 07:42 AM, a review of Resident #86's medical record revealed that the resident was hospitalized on [DATE]. On 04/22/25 at 08:38 AM, an interview with Registered Nurse/ Unit Supervisor (Staff #16), revealed that resident comprehensive care plan goals were not sent with residents upon transfer. On 04/22/25 at 08:45 AM, an interview with Licensed Practical Nurse (Staff #7) revealed that resident comprehensive care plan goals were not sent with residents upon transfer. On 04/22/25 at 11:19 AM, the surveyor reviewed the concern with the Director of Nursing (Staff #2).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that facility staff failed to ensure written notification of transfer were provided to the resident and responsible representative upon a transfer. This was evident for 1 (Resident #86) of 2 residents reviewed for hospitalization. The findings include: On 04/21/25 at 07:42 AM, a review of Resident #86's medical record revealed that the resident was hospitalized on [DATE]. On 04/22/25 at 08:38 AM, an interview with Registered Nurse/ Unit Supervisor (Staff #16), revealed that resident representatives were verbally notified of resident transfer and reasoning, but that it was not written notification. On 04/22/25 at 08:45 AM, an interview with Licensed Practical Nurse (Staff #7) revealed that resident representatives were verbally notified of resident transfer and reasoning, but that it was not written notification. On 04/22/25 at 11:19 AM, the surveyor reviewed the concern with the Director of Nursing (Staff #2).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and interviews with facility staff it was determined the facility failed to ensure accuracy when coding a resident Minimum Data Set (MDS). This was found to be evident for 1 (Resident # 107) of 6 residents reviewed for accidents during the survey. Findings include: The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. The Matrix is used to identify pertinent care categories for :1) Newly admitted residents in the last 30 days who are still residing in the facility and 2) All other residents. The facility is responsible for completing this form. Column # 10 is to be completed if the resident has a Fall (F), Fall with injury (FI), Fall with Major injury (FMI). Review of the facility's matrix on 4/16/25 at 12:45 PM revealed resident # 107, column # 10 for Falls indicated F, and FI. Review of the MDS Quarterly Assessment with an Assessment Reference Date (ARD) of 1/5/25 revealed under section J1900 (B) number of falls since admission or prior assessment-injury was coded one (1) for injury. Section J0300 Pain assessment interview is coded (0) No. Continued review revealed, a nurse note with a date of 10/6/24 at 6:34 AM indicating that during morning routine check-ups, writer noted Resident # 107 sitting on the floor. Assessment done and pain score 0/10 indicating no pain. No physical injury noted. Further review of the resident falls care plan revealed the last update was on 5/8/23. Review of nurse progress notes and pain assessments revealed the resident did not have pain on the following assessments dates: 10/6/24 Day (D) Shift, 10/7/24, Day shift and 10/8/24 Day shift. The Medication Administration Record (MAR) for pain evaluation was marked zero (0) for each of the above dates. Further review of a physician note dated 10/7/24 revealed the resident indicated pain in the arm and an x-ray was ordered to rule out fracture. The results of the x-ray were negative for fracture. An interview was conducted with the NHA on 4/22/25 at 10:40 AM and she stated that the resident did not have a fall with injury and that the documentation on the matrix was incorrect. An interview was conducted with the MDS Coordinator (Staff # 22) on 4/22/25 at 11:08 AM and she was asked if the resident had a fall with injury. She stated that the resident had a fall on 10/6/25 and it was captured on the 1/5/25 assessment. She stated that if the resident has pain, it will be coded as an injury. The surveyor informed her that according to the assessment that was done after the fall, the resident did not c/o pain and there was no injury. She confirmed that the MDS was coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All concerns were discussed with the Administration team during the exit conference on 4/28/25 at 2:45 PM.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chevy Chase	8700 Jones Mill Road Chevy Chase, MD 20815

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and interviews, it was determined that the facility failed to develop a care plan to manage bowel and bladder incontinence for a resident. This deficient practice was evident for 1 (#106) resident reviewed for comprehensive care plans during the survey. The findings include: On 04/17/25 at 8:20 AM, a review of Resident #106's medical records indicated that the resident is incontinent of bowel and bladder. Further review of medical records failed to show that a care plan was developed to address bowel and bladder incontinence. During an interview with Director of Social Worker (SW) #3 on 04/22/25 at 10:46 AM, the surveyor asked who was responsible for auditing resident's medical records to ensure residents' care plans accurately address plan of care. The SW #3 explained that an interdisciplinary team meets quarterly and annually to review each resident's plan of care, and the nurse unit manager is responsible for ensuring the nursing portion of the plan is up to date. On 04/17/25 at 11:05 AM, a review of Resident #106's Minimum Data Set (MDS) section bowel continence indicated that the resident is always incontinent of bowel. Review of section urinary continence also reflected the resident is always incontinent of bladder. On 04/17/25 at 11:10 AM, during an interview with Nurse Unit Manager (UM) #18, the surveyor informed the UM #18 that the resident had been identified as incontinent of both bowel and bladder since admission, however, a review of the quarterly care plans revealed that no plan of care had been developed to address the incontinence. Both the surveyor and the UM #18 reviewed the resident's medical records, and he acknowledged that a care plan should have been created. After surveyor intervention, on 04/22/25, a care plan was initiated to address the resident's bowel and bladder incontinence.

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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. Based on record reviews and interviews it was determined that facility staff failed to ensure that resident records were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This deficient practice was evident for 3 (#66, #86, #101) residents out of 4 residents reviewed for care plan meetings and quarterly assessment during the facility survey. The findings include: 1.) On 04/16/25 at 10:41 AM, during an interview, Resident #66, reported that they have not participated in care plan meetings. During an interview with the Director of Social Work (SW) #3 on 04/18/25 at 09:50 AM, she stated that resident care plan meetings are conducted within 14 days of admission, quarterly, annually, and upon change in medical condition. She also reported that invitations to the meetings are sent to the residents and their families. The surveyor requested documentation verifying that comprehensive and quarterly care plan meeting were held, and invitations notices were provided for 2024 and 2025. On 04/18/25 at 12:44 PM, the SW #3 provided the surveyor with care plan meeting notes dated 6/7/23, but no meeting invitation. Additional documents included care plan meeting notes dated 8/28/24, a care plan invitation dated 8/8/24, and care plan invitations dated 11/13/24 and 4/23/25. The SW #3 stated she was unable to provide proof that a care plan meeting was conducted on 11/2004 and acknowledged that she is behind on completing resident care plans. 2.) On 04/17/25 at 12:28 PM, an interview with Resident #86 revealed he/she had concerns regarding her/his routine care plan meetings not being quarterly. On 04/18/25 at 09:50 AM, an interview with the Director of Social Services (Staff #3) revealed that the expectation was for care plan meetings was that resident care plans were revised to be quarterly. During the same interview, the surveyor requested Resident #86's care plan meeting documentation for 2024. On 04/18/25 at 12:26 PM, Staff #3 provided documentation for a care plan meeting for 7/11/24, and informed the surveyor that she was only able to provide documentation for the one (7/11/24) care plan meeting. 2a.) On 04/22/25 at 9:00 AM, review of complaint intake MD00202691 revealed a concern that Resident #86 was supposed to be in rehabilitation services. On 04/22/25 at 09:27 AM, an interview with the Director of Rehabilitation Services (Staff #23) revealed that residents were screened quarterly for rehabilitation services along with the care plan revision. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the same time, further interview with Staff #23 revealed that Resident #86 was screened for rehabilitation services on 8/8/2023, was put into rehabilitation services, and was discharged on 8/30/23. On 04/22/25 at 09:27 AM, during the same interview, Staff #23 indicated that the resident had not been screened again for rehabilitation services until 4/11/24. On 04/22/25 at 11:55 AM, the surveyor reviewed the concern with the Nursing Home Administrator (Staff #1). 3.) On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management, starting on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy. On 4/22/25 at 9:47 AM, the surveyor interviewed with the Director of Rehab (DOR #23) and the OT therapist (OT #40) regarding resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for the resident, DOR #23 and OT #40 were unable to answer. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR was unable to provide an answer. They stated that they would return with the necessary information. On 4/22/25 at 11:44 AM, the Admin was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing. On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for Resident #101 to get the discharged recommendations from OT therapy. OT #40 stated that she would complete Resident #101's quarterly evaluation today and enter the recommendations and orders from OT into the system for nursing to follow-up.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interview with facility staff, it was determined that the facility failed to: 1) implement wound and skin care orders for a resident admitted after a surgical amputation and identified pressure ulcer; 2) provide services as order by the physician; and 3) maintain professional standards of practice when documenting a resident's showers. This was identified for 4 of 4 (#160, #106, #66, #108) residents reviewed for orders and documentation during the survey. The findings include: 1. Review of the medical record on 4/25/25 at 12:13 PM for Resident #160 revealed admission to the facility with diagnosis including aftercare following surgical amputation, gangrene and peripheral vascular disease. The hospital discharge summaries provided in the resident's medical record stated that prior to admission to this facility, Resident #160 was admitted to the hospital for a gangrenous infection of the left first toe. The podiatry team completed multiple debridement's and then finally an amputation of the toe to prevent the infection from spreading. Resident #160 was admitted to the facility according to an admission summary with 22 staples to the amputated toe site on the left foot. Resident #160 was screened by the wound physician on 8/26/24. He verbalized wound care orders. On 4/28/25 at 9:31 AM staff #27, the wound care physician was interviewed. He reviewed his notes and returned at 9:36 AM. He stated that he only saw the resident on 8/26/24 and had made recommendations at that time. He was asked why he didn't see Resident #160 again after that and he stated that he is given a list when he comes in to the facility of who to see and checks the list off as he goes. He further stated that he is just a consultant and sees who the facility requests him to see. At 9:40 AM staff #28 the Regional Clinical Consultant was notified that for Resident #160, no wound care orders for the amputation or the identified heel wound identified on admission could be found. Staff #28 was also notified that Resident #160 was admitted to the hospital for a follow-up procedure a month after admission to the facility for another surgical procedure. Those admission assessments were requested. At 1:38 PM on 4/28/25 this surveyor met with the facility DON regarding the status of the concerns for Resident #160. She was unaware and had not been notified of the concerns from staff #28 and had not looked for information to relay to this surveyor. Prior to exiting the facility, the DON provided nursing notes from the wound care nurse that documented wound care measurements for the heel and that care was provided weekly for Resident #160. The ongoing concern was presented to the DON at this time that during Resident #160's month long stay, there were no treatment orders put in for either the monitoring of the surgical site of the amputation or the wound care of the heel and therefore there was no place for staff to sign off that either were completed consistently.2) On 04/16/25 at 10:37 AM, during the initial screening of Resident #66, the surveyor noted a past medical history of cerebrovascular disease. The resident was observed not wearing Thrombo-Embolic Deterrent Stockings (TEDS). A review of the medical records revealed that the resident was ordered for TEDS to be applied at 9:00AM and removed at 9:00PM daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/18/25 at 10:54 AM, revealed that Resident #66 was not wearing TEDS. A review of the medical record did not indicate that the resident refused to wear the TEDS, and there was no evidence that the physician had been notified of a refusal. On 04/21/25 at 11:50AM, during a follow up observation, the surveyor noted that Resident #66 was not wearing TEDS. On 04/21/25 at 11:54 AM, the surveyor asked Nurse Unit Manager (UM) #18 about staff expectation regarding physician orders. The UM #18 stated that staff are expected to review orders prior to providing treatment or services and follow the written instructions. If staff are uncertain about the orders, they are expected to speak with a supervisor. The surveyor informed UM #18 of the observations made for Resident #66 and that there was no documentation explaining why the resident was not wearing TEDS. The UM #18 stated that he would review the residents medical records for supporting documentation; however, no documentation was provided by the end of the day. On 04/22/25 at 9:09AM, the surveyor informed the Administrator #1 of observations related to Resident #66 and pending documentation from the UM #18. The Administrator stated that they were not able to locate any documentation confirming that the resident refused to wear TEDS. The Administrator stated that nursing staff will receive education on following physician's orders and nursing documentation. 3) During an interview with the Administrator #1 and Director of Nursing (DON) #2 on 04/21/25 at 8:16 AM, the surveyor asked about the expectation of nursing staff prior to administering blood pressure medication. The DON #2 stated that staff are expected to review the resident's Medication Administration Record (MAR) for instructions and administer the medication according to the provider's orders. On 04/21/25 at 08:48 AM, a review of Resident #106's MAR revealed an order for clonidine Oral Tablet 0.3 milligram (mg) tablet to be administered through a Percutaneous Endoscopic Gastrostomy (PEG) tube every 8 hours for hypertension, with instructions to hold the medication if the systolic blood pressure (SBP) was less than 110 or if the heart rate(HR) is less than 60. Further reviews showed that the medication was administered outside of the ordered parameter on the following dates: 3/4/25=SBP 107 3/11/25=SBP 106 3/22/25=SBP 108 3/25/25=SBP 108 3/30/25=SBP 109 4/6/25=SBP 108 4/15/25=SBP 104 4/14/25=SBP 101 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/21/25=SBP 103 A review of the medical records failed to show documentation that the nurse notified the physician when the resident's blood pressure was outside the ordered parameters for the medication. On 04/21/25 at 12:19 PM, the surveyor informed the Administrator #1 that blood pressure medication had been administered for Resident #66 outside of the ordered parameters, and that there was no documentation indicating that the physician had been notified. On 04/22/25 at 9:09AM, the Administrator stated that they were not able to locate documentation confirming that the physician was notified of the resident's SBP. The Administrator #1 stated that nursing staff will receive education on following physician's orders and nursing documentation. 4) On 04/17/25 at 10:39 AM, review of complaint MD00212813 revealed a concern regarding Resident #108 receiving showers between October 2023 and December 2023. On 04/17/25 at 10:42 AM, review of Resident #108's medical record revealed an order with a start date of 10/03/2023, which indicated for the resident to receive a shower on Tuesdays and Fridays. On 04/17/25 at 10:43 AM, review of Resident #108's Treatment Administration Record (TAR) from October 2023 through December 2023 revealed 8 days (Tuesday 10/10/2023, Tuesday 10/24/2023, and Tuesday 10/31/2023, 11/07/2023, 11/17/2023, 12/08/2023, 12/22/2023, and 12/29/2023) which the order was documented as N (No), but failed to reveal why the resident had not gotten a shower. On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (Staff #2) revealed that when staff document N for a shower, the expectation was for staff to document why the resident had not received a shower. On 04/17/25 at 10:43 AM, review of Resident #108's TAR revealed 2 days (11/24/2023 and 12/12/2023) which the shower order failed to be documented on. On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (DON) revealed that the expectation of staff was to document every shift based on orders, including shower documentation on the TAR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews, observations, and record reviews it was determined that facility staff failed to assist residents who are dependent on staff for activities of daily living (ADLs) such a bathing. This deficient practice was evident for 1 (#66) of 5 residents reviewed for ADL care during the survey. The findings include: During an interview with Resident #66 on 04/16/25 at 10:37 AM, he/she stated they had only received one shower during the month of April 2025 but reported receiving daily bed baths from staff. The resident stated they would prefer more showers in the shower room. On 04/21/25 at 09:05 AM, during an interview with the Director of Nursing (DON) #2, she stated that staff are expected to provide showers to residents as ordered and should not substitute a bed bath in place of a shower. If a resident refuses a shower, staff are expected to document the refusal in the medical records. On 04/21/25 at 1:48, a review of Resident #66's treatment administration record (TAR) revealed an ordered for showers Mondays and Thursdays. Further reviews showed that the resident received a bed bath on Thursday 04/3/25, Monday 04/07/25, Thursday 04/10/25, with no documentation of a bed bath or shower on Monday 04/14/25. Review of geriatric nursing assistant (GNA) documentation for April 2025 indicated that the resident received daily bed bath, except on 4/3/25 it was documented that the resident received a shower. There was no documentation explaining why the resident did not receive scheduled showers. On 04/22/25 at 09:13 AM, the surveyor informed DON #2 that Resident #66 reported receiving one shower in April, although resident's preference was twice a week. The DON #2 stated that she would follow up with staff regarding resident's schedule shower day.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, staff interviews, and record review, it was determined that the facility failed to ensure that residents with a limited range of motion receive appropriate treatment and services to prevent further decrease in range of motion. This was evident for 1 out of 1 resident observed for limited range of motion during this survey. The findings include: Contracture management is a variety of techniques aimed at preventing or improving limited joint movement due to shortening of muscles, tendons, or surrounding tissues. These methods include physical therapy, splinting, medication, and in some cases, surgery. Early intervention and consistent management are crucial for maximizing functional outcomes. Review of medical record revealed Resident #101 was a long-term care resident who has the following but is limited to medical history: morbid obesity, protein-calorie malnutrition, and a PEG tube. Resident #101 was bed-bound with a limited ROM to all extremities. On 4/17/25 at 12:13 PM, Resident #101 was observed in bed resting comfortably. The surveyor observed that the resident's right hand was in contracture. On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management, started on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy. On 4/22/25 at 9:47 AM, the surveyor interviewed the Director of Rehab (DOR #23) and the Occupational Therapist (OT #40) regarding Resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for this resident completed. OT #40 was unable to provide an answer. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR #23 was unable to provide an answer. They both stated that they would return with the necessary information. On 4/22/25 at 11:44 AM, the Administrator (Admin #1) was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin #1 stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing. On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for Resident #101 to get the discharge recommendations from OT therapy. OT #40 stated that she would complete Resident #101's quarterly evaluation today and enter the recommendations and orders from OT into the system for nursing to follow-up.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record reviews, and interviews, it was determined that facility staff failed to ensure a resident who is incontinent of bowel/bladder received appropriate treatment and services. This deficient practice was evident for 1 (Resident #106) of 1 resident review for incontinent care during the survey. The findings include: On 04/17/25 at 8:20 AM, a review of Resident #106's medical records indicated that the resident had a stage 4 sacral pressure ulcer, was incontinent of bowel and bladder, and needed assistance with personal care. Further review of treatment administration records, physician orders, and resident care plan failed to show that treatment, or services were in place to address bowel and bladder incontinence. During an interview with Director of Social Worker (SW) #3 on 04/22/25 at 10:46 AM, the surveyor asked who was responsible for auditing resident's charts to ensure residents are receiving appropriate services and treatment. The SW #3 explained that an interdisciplinary team meets to review each resident's plan of care, and the unit manager is responsible for ensuring the nursing portion of the plan is accurate. On 04/17/25 at 11:10 AM, during an interview with Nurse Unit Manager #18, the surveyor informed them of the missing treatment and services to manage the resident's incontinence. The UM #18 stated that a plan should have been in place to address the residents incontinence. Both the surveyor and UM #18 reviewed the resident's medical chart and were unable to locate services or treatment addressing the incontinence. The UM #18 acknowledged that a plan should have been developed and state they would update the medical records to ensure treatment and services were addressed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and record reviews, it was determined that facility staff failed to ensure daily staff postings were complete for the residents and visitors. This deficient practice was evident on 5 out of 5 units review for daily staff postings during the survey. The findings include: On 04/23/25 at 8:41 AM, during an interview with Staff Scheduler #38 she reported that facility staff posting forms are displayed at the nursing station daily on all 5 units and she was responsible for collecting and storage of the forms. The surveyor reviewed the facility's staff posting records for multiple dates in April 2025 and identified that several daily staffing sheets were missing dates, nurse to resident ratios, titles of nursing and nursing assistant staff, current dates, shift supervisor, actual hours worked, and unit census. The surveyor asked about the missing information and the Staff Scheduler #38 stated that she was not aware the missing information was required and relies on unit managers to complete the staff posting forms. On 04/23/25 at 9:45 AM, during an interview with the Administrator #1, the surveyor revealed the observations made of the facility's staff posting forms. The surveyor stated that Staff Scheduler #38 indicated that she was not aware of the requirement for the staff postings. The Administrator #1 stated that the scheduler was aware and she would follow-up and provide education.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure that an antipsychotic medication was ordered with adequate monitoring. This was evident for 1 (Resident #16) of 5 residents reviewed for unnecessary medications. The findings include: On 04/18/25 at 10:53 AM, review of Resident #16's medical record revealed an active order for Bupropion (an antidepressant) to be administered once a day, with a start date of 3/24/2025. An antidepressant is a medication used for mental health. The medication can cause side effects that could be serious and monitoring can help identify side effects. On 04/18/25 at 10:54 AM, further review of the residents medical record failed to reveal an order for antidepressant monitoring until 4/16/2025. On 04/21/25 at 09:07 AM, an interview with the Director of Nursing (Staff #2) revealed that the expectation was for side effect monitoring to be ordered when an antipsychotic (like Bupropion) was ordered for a resident.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and interview it was determined the facility failed to ensure residents were served their preferred hot drink beverage at breakfast. This omission of serving the resident the drink item listed on their meal ticket impacted 3 (Resident #131, #105, #26) out of 5 residents reviewed. The findings include: On 04.21.25 at 08:13 AM the surveyor interviewed and observed the breakfast meal in the presence of the charge nurse who was also working as the unit manager and the medication nurse on the Arcadia unit. The two dietary food carts were delivered to the unit at 08:15 AM by the dietary aide. During an interview with the unit manager, the surveyor was informed that there were currently seven (7) residents who required maximum assistance with feeding at meal times by the unit manager. On 04.21.25 at 08:25 AM, the unit manager called the dietary department to request the cart with the coffee, tea, and condiments. The cart with the coffee, tea, and condiments arrived within five minutes (08:30 AM) on 04.21.25. The unit manager assisted the staff with the distribution of the resident trays. Only two GNA's were scheduled to work this 7A-3PM day shift with a census of 32 residents and the GNA assignment consisted of 16 residents for each GNA. Other facility staff members were pulled from throughout the facility to assist with the delivery of the food trays to the residents in the Arcadia dining room, some of those staff members included the GNA, Medical Records Clerk, and Transportation aide. The following residents were present in the dining room on the Acadia unit and were randomly selected by the surveyor for the breakfast meal/dining room observations which occurred at 08:40 AM on 04.21.25. Coffee was listed on the dietary ticket for: 1. Resident # 131, however no coffee was served with the resident's meal. 2. Resident # 105, however no coffee was served with the resident's meal. 3. Resident # 26, however no coffee was served with the resident's meal. These dining room observations were reviewed with the DON and the administrator on 04.21.25 at 10:15 AM and 10:30 AM.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview with facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures on 1 unit of 32 residents who eat food prepared by the facility out of 4 units of within the facility. The findings include: On 04.25.25 at 11:45 AM the surveyor toured the facility kitchen with one other surveyor, the regional food service director, staff #14, the facility food service manager, staff #15, and the registered dietician, staff #13. The surveyor requested the facility food service manager, staff #15 assist with setting up a test tray for Garden View unit for the lunch meal. The two surveyors were informed while in the kitchen observing the tray line set up for the unit that the lunch menu consisted of the following food items for a regular diet: fish cakes, herbal rice, blended mixed vegetables. The temperatures were: fish cake: 164 degrees, herbal rice: 163 degrees, mixed vegetables: 170 degrees, the pureed meat was 185 degrees, the pureed blended vegetables was 190 degrees, super-mashed potatoes were at 191, mashed potatoes were 201 degrees. The temperature of the cold drink refrigerator was listed at 30 degrees. The whole milk 4 oz. container temperature was 41.4, the cranberry juice temperature in the 4 oz. container was 45 degrees, and the coffee temperature was 161 degrees. The whole milk and the cranberry juice were replaced with milk and cranberry juice obtained from the juice refrigerator and those temperatures 41 degrees. The substitute meal choices for residents on a regular diet were hot dog, hamburger, and cold lunchmeat sandwiches. Both surveyors observed the temperature testing of the hot dog and the temperature was 157 degrees while in the kitchen. At 12:04 PM on 04.25.25 the surveyors followed the food cart allocated for Garden View along with the dietary aide. The clinical facility staff on the unit did not start serving the trays until 12:09 PM. The charge nurse stated that lunch is normally served from 12 noon through 12:30 PM. The staffing for the unit was 1 RN, 1 LPN, and two GNA's. Staff #14 accompanied the surveyors and agreed to test the food temperature of the test tray on the unit. The surveyors observed the registered dietician, staff #13 assisting with serving the trays to the residents. At 12:19 PM there were three trays left to be served. At 12:21 PM the test tray temperatures was as followed: fish cake patty 127 degrees, herbed rice: 128 degrees, blended mixed vegetables was 135.2, apple juice in the 4 oz container was 54.2 degrees. The food temperature testing completed on the unit was performed by staff #14, the regional dietary manager who acknowledged the facility failed to ensure that some of the test tray food items identified were delivered at the proper temperature for both hot food and cold food items. On 04.28.2025 at 08:30 AM the administrator stated that she was aware of the results of the test tray temperatures from 04.25.25. This potential deficiency was reviewed during the exit interview on 04.28.25 at 1:30 PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of administrative documents, and interviews it was determined that the facility failed to: 1) store food items at the appropriate temperature, repair broken kitchen equipment, place dry food items in appropriate storage containers, and to remove food items that were not stored at an appropriate temperature, and 2) ensure that the resident's meal matched the items listed on the resident's meal ticket. These was evident during 2 of 3 facility observations and for 2 (#35, #81) of 2 residents reviewed for food preparation during the survey. The findings include: 1) On 04/16/25 at 07:34 AM the surveyor initiated the tour of the kitchen dietary aide, staff # 26 opened the kitchen door without a nametag present on his/her uniform. Walk-in refrigerator #1 had temperature of 42 degrees Fahrenheit per log completed by staff#37. Freezer #1 had a temperature of -5 Fahrenheit degrees based on outside thermometer and documented on the AM temperature log sheet dated 4/16/25 and signed by staff #37. Refrigerator #2 was the juice refrigerator which housed milk and fruit juices. The whole milk cartons had an expiration date 04.16.25. The surveyor was informed that all the milk cartons would be served to residents or disposed of the same day. Refrigerator number # 3, labeled Back Room, the temperature outside the refrigerator read 51 degrees Fahrenheit. When the door of refrigerator #3 was opened by the surveyor, the shelves and the food containers were warm to touch. The contents within the refrigerator were applesauce, grape jelly, soy sauce, mayonnaise and iced tea. Refrigerator # 3 temperature was not in compliance with the food safety storage procedures. Refrigerator #4 labeled back room, appeared to be unplugged and the outside temperature was 65 degrees. Within the interior of refrigerator #4 were dry goods, such as pasta, noodles, large cans of tomato sauce, grape jelly, and bread. The surveyor observed that refrigerator #4 was being used as a storage unit for dry goods and was not operational as a refrigerator. On 04.16.25 at 10:05 AM the surveyor met with the registered dietician, staff #13, the regional dietary manager #14, and the facility dietary manager, staff # 15 to tour the kitchen area again and to review the original concerns found by the surveyor. Staff #14, regional dietary manager explained that the delivery dates for food items are Tuesday and Thursday. Also, stated the whole milk cartons dated 04.16.25 would by utilized by the end of evening meal. The dietary manager #15 stated that he was unaware that refrigerator # 3 labeled back of kitchen refrigerator was not functional: the temperature log for 04.16.25 was written as 41 degrees Fahrenheit. The outside manual temperature read as 51 degrees. The dietary manager, staff # 15 proceeded to throw away the contents of the refrigerator # 3 with guidance of the dietary regional manager #14 and the registered dietician #13. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refrigerator #4 which was labeled as the back room of kitchen refrigerators per the dietary manager, staff #15 was not functional and the facility staff were using it a storage area for the 3 day emergency /menu /supply storage of dry goods such as pasta, spaghetti noodles, tomato sauce, and fresh loaves of bread. All the items in Refrigerator #4 were labeled appropriately. On 04.25.25 at 11:45 AM the surveyor toured the facility kitchen and was informed by the regional dietary manager, staff #14 that the kitchen's ice machine was not operational. The regional dietary manager, staff #14 stated the kitchen was reliant on the units to assist with providing the residents with ice with meals. Also, the surveyor discussed the status of the two broken refrigerators in the kitchen. Staff #14 also stated that she would provide the surveyor with documentation of the work orders related to the pending for kitchen equipment. On 04.28.25 at 1:05 PM staff #14 presented the surveyor with copies of work orders for the proposed repair of the kitchen equipment. These potential deficiencies were discussed during the exit conference to facility and regional administrative staff on 04.28.25 as well. 2) On 04/16/25 at 8:22 am, during the initial screening of Resident #35 and Resident #81 in room [ROOM NUMBER], the surveyor observed that Resident #35's meal ticket indicated an order for 6 ounces of coffee, two packets of sugar, 8 ounces of whole milk, one salt and pepper packet, however, these items were missing from the resident's meal tray. The surveyor also observed Resident #81's meal tray and noted that the resident did not receive 6 ounces of coffee, and instead of 8 ounces of whole milk, 8 ounces of skim milk was served. On 04/16/25 at 8:24 am, the surveyor asked geriatric nursing assistant (GNA) #6 about the process for ensuring that a resident's meal tray matches the items listed on the meal ticket. The GNA #6 stated that it is the GNA's responsibility to verify that the meal tray matches the meal ticket. The surveyor showed GNA #6 that the meal trays for Resident #35 and Resident #81 did not match their meal tickets. The GNA #6 acknowledged that items were missing from the tray and stated that she would provide the missing items. Both the Administrator #1 and Director of Nursing #2 were made aware of the observation on 04/16/25 at 8:38 AM.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record reviews and interviews it was determined that the facility failed to provide an accurate facility assessment for direct care staff to resident ratios. This deficient practice was discovered during the survey. The findings include: On 04/16/24 at 1:46 PM the surveyor received a copy of the facility assessment from Administrator #1. On 04/24/25 at 7:40 AM, a review of the facility assessment revealed the facility assessment was completed in June 2024 and reviewed by the quality assurance committee in July 2024. Further review of the facility assessment revealed a staffing template that contained the facility's staffing for both licensed nurses and direct care staff separated by skilled rehab units and long-term care units. The surveyor asked the Administrator to explain the overall staffing plan described in the assessment. The Administrator stated that she was unable to explain the staffing plan at that time and would need to review the facility assessment before providing an explanation. On 04/24/25 at 7:45 AM, the administrator informed the surveyor that the staffing plan described in the facility assessment was incorrect. The Administrator then provided the surveyor with a hand-written staffing to resident ratio for all units. The information provided did not correspond with the nurse and direct care staffing ratios documented on the facility's assessment.

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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. Based on observations, staff interviews, and record review, it was determined that the facility failed to ensure that medical records were complete and accurately documented. This was evident for 2 residents (Resident #101, #108) out of 54 residents reviewed for medical records during the survey. The findings include: 1) On 04/17/25 at 10:42 AM, review of Resident #108's medical record revealed an active order with a start date of 10/03/2023, which indicated for the resident to receive a shower on Tuesdays and Fridays. On 04/17/25 at 10:43 AM, further review of the resident's medical record revealed an active kardex task which indicated the resident was to receive a shower on Mondays and Thursdays. On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (Staff #2) revealed that a resident's kardex task regarding showers should reflect the resident's shower order. 2) On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was bed-bound with limited ROM to all extremities and was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management. Services started on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy. On 4/22/25 at 9:47 AM, the surveyor interviewed with the Director of Rehab (DOR #23) and the OT therapist (OT #40) regarding resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for the resident. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR was unable to provide an answer. They stated that they would return with the necessary information. On 4/22/25 at 11:44 AM, the Admin was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing. On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for resident #101 to get the discharged recommendations from OT therapy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that facility staff failed to keep isolation cart stocked with personal protective equipment (PPE) for enhanced barrier precaution (EBP) residents. This deficient practice was evident for 2 out of 5 units observed during the survey. The findings include: On 04/16/25 at 7:34am, during the initial observation on the units Annapolis and Gardenview, the surveyor observed the following: 1. An EBP sign was posted on the door of room [ROOM NUMBER], however, no isolation cart was present. 2. An EBP sign was posted on the door of room [ROOM NUMBER]. Upon review of the isolation cart, the surveyor noted that gloves were missing. 3. An EBP sign was posted on the door of 38. A review of the isolation cart revealed that gloves were missing, and a resident's medication Santyl was located inside the cart. 4. An EBP sign was posted on the door of room [ROOM NUMBER]. Review of the isolation cart revealed missing gloves. On 4/16/25 at 7:46 am, during an interview with Licensed Practical Nurse (LPN) #7, she states the isolation cart should contain isolation gowns, gloves, mask, and hand sanitizer. The surveyor asked LPN #7 to review the isolation cart outside room [ROOM NUMBER]. The nurse acknowledged that the cart was missing PPE. The surveyor also informed LPN #7 of the resident's medication found in the isolation cart. Both the Administrator #1 and Director of Nursing #2 were made aware of the observation on 04/16/25 at 8:38AM. On 04/28/25 at 10:18 am, during a follow up observation of isolation carts for all units, the surveyor noted that isolation gowns were missing from the carts outside room [ROOM NUMBER]. A second observation conducted at 12:34 pm revealed that the gowns were still missing. The surveyor asked LPN #7 to review the isolation cart, and she acknowledged the observation. The administrator was made aware of the observation on 4/28/25 at 12:38pm.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, review of administrative documents, and interviews it was determined that the facility failed to repair broken kitchen equipment, These factors were found evident to be true during three of multiple observations facility observations of the kitchen made during the survey. The findings include: 1) On 04/16/25 at 07:34 AM the surveyor initiated the tour of the kitchen dietary aide. Refrigerator number # 3, labeled Back Room, the temperature outside the refrigerator read 51 degrees Fahrenheit. When the door of refrigerator #3 was opened by the surveyor, the shelves and the food containers were warm to touch. The contents within the refrigerator were applesauce, grape jelly, soy sauce, mayonnaise and iced tea. Refrigerator # 3 temperature was not in compliance with the food safety storage procedures. Refrigerator #4 labeled back room, appeared to be unplugged and the outside temperature was 65 degrees. Within the interior of refrigerator #4 were dry goods, such as pasta, noodles, large cans of tomato sauce, grape jelly, and bread. The surveyor observed that refrigerator #4 was being used as a storage unit for dry goods and was not operational as a refrigerator. On 04.16.25 at 10:05 AM the surveyor met with the registered dietician, staff #13, the regional dietary manager #14, and the facility dietary manager, staff # 15 to tour the kitchen area again and to review the original concerns found by the surveyor. Staff #14, regional food service director. The facility dietary manager #15 stated that he was unaware that refrigerator # 3 labeled back of kitchen refrigerator was not functional: the temperature log for 04.16.25 was written as 41 degrees Fahrenheit. Refrigerator #4 which was labeled as the back room of kitchen refrigerators per the dietary manager, staff #15 was not functional and the facility staff are using it a storage area for the 3 day emergency /menu /supply storage of dry goods such as pasta, spaghetti noodles, tomato sauce, and fresh loaves of bread. All the items in Refrigerator #4 were labeled appropriately. On 04.25.25 at 11:45 AM the surveyor toured the facility kitchen and was informed by the regional dietary manager, staff #14 that the kitchen's ice machine was not operational. The regional dietary manager, staff #14 stated the kitchen is reliant on the units to assist with providing the residents with ice with meals. Also, the surveyor discussed the status of the two broken refrigerators in the kitchen. Staff #14 also stated that she would provide the surveyor with documentation of the work orders related to the pending for kitchen equipment. On 04.28.25 at 1:05 PM staff #14 presented the surveyor with copies of work orders for the proposed repair of the kitchen equipment. These potential deficiencies were discussed during the exit conference to facility and regional administrative staff on 04.28.25 as well. 2) On 04/16/25 at 09:31 AM, an anonymous complaint revealed that staff often say the ice machine is broken when residents request for ice water. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25 at 08:39 AM, an observation of the main dining room of the long term care unit revealed it was not administering ice when the surveyor attempted to test the machine. On 04/18/25 at 11:13 AM, an interview with the Director of Maintenance (Staff #5) revealed that staff were able to use an online platform called, TELS to report maintenance concerns. He was unaware of a concern regarding the main dining room ice machine. On 04/18/25 at 12:18 PM, an observation during a walk through with the Director of Maintenance (Staff #5) revealed the main dining room ice machine was not administering ice.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and interview, it was determined that the facility failed to ensure a resident's mattress properly fit the bed frame. This was evident for 1 (Resident #108) of 1 resident bed observed during a random observation of the Annapolis Unit. The findings include: On 04/18/25 at 11:42 AM, an observation of Resident #108 in bed revealed that his/her mattress was hanging over the bed frame approximately 8 inches on the right side of the bed. On 04/18/25 at 12:19 PM, the surveyor and the Director of Maintenance observed Resident #108's mattress hanging over the right side of the bed frame. He indicated that the mattress was too big for the bed frame.