STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215039	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care Center	415 South Market Street Havre DE Grace, MD 21078

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment. This was evident for 7 (#3, #4, #6, #123, #12, #34, #50) of 13 residents reviewed for MDS accuracy during the recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a comprehensive, federally mandated assessment tool used to evaluate a resident's functional, cognitive, and health status to create individualized care plans, monitor quality of care, and support reimbursement for Medicare and Medicaid certified facilities. 1) On 01/21/2026 at 3:07 PM, a review of Resident #3's physician order dated 12/14/2025 for siderails: 2 1/4 padded bed rails for seizure precautions. On 01/22/2026 at 8:05 AM, a review of the Minimum Data Set (MDS) 5-day assessment for Resident #3, completed on 12/16/2025 and locked on 12/29/2025, revealed a discrepancy. Specifically, Section P0100, titled Restraints and Alarms, had a designated section for Bed rail with options: 0. Not used, 1. Used less than daily, 2. Used daily, and -Not assessed. The chosen response was 0. not used. However, a subsequent review of Resident #3's Treatment Administration Record (TAR) for December 2025 indicated that the siderails were signed off as being used during every shift. 2) On 01/22/2026 at 11:20 AM, in review of Resident #4's physician order dated 11/14/2025 for siderails: 2 1/4 rails up for use of bed controls every shift. On 01/22/2026 at 11:39 AM, a review of the Minimum Data Set (MDS) admission assessment for Resident #4, completed on 11/20/2025 and locked on 11/21/2025, revealed a discrepancy. Specifically, Section P0100, titled Restraints and Alarms, had a designated section for Bed rail with options: 0. Not used, 1. Used less than daily, 2. Used daily, and -Not assessed. The chosen response was 0. not used. However, a subsequent review of Resident #4's Treatment Administration Record (TAR) for November of 2025 indicated that the siderails were signed off as being used during every shift. 3) On 01/22/2026 at 9:12 AM, in review of Resident #6's physician order dated 9/2/2025 for side rails: 2 1/4 rails for bed controls and to assist with positioning. Every shift, they may use 4 rails as requested. On 01/22/2026 at 9:10 AM, a review of the Minimum Data Set (MDS) quarterly assessment for Resident #6, completed on 10/27/2025, and locked on 11/04/2025, revealed a discrepancy. Specifically, Section P0100, titled Restraints and Alarms, had a designated section for Bed rail with options: 0. Not used, 1. Used less than daily, 2. Used daily, and -Not assessed. The chosen response was 0. not used. However, a subsequent review of Resident #6's Treatment Administration Record (TAR) for October of 2025 indicated that the siderails were signed off as being used during every (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift. On 01/22/2026 at 12:08 PM, during an interview with Staff #11 and Staff #12 (MDS Coordinator Nurses), it was confirmed that, according to the RAI manual, siderails are considered a restraint and should have been coded as used daily. On 01/22/2026 at 12:36 PM, the concern was shared with the Director of Nursing. 4) On 01/23/2026 at 11:32 AM, a review of Resident #123's Minimum Data Set (MDS) admission assessment, completed on 01/05/2026 and locked on 01/12/2026, revealed a discrepancy. Specifically, Section M0100, titled Determination of Pressure Ulcer/Injury Risk, had a designated section A for the question of whether the resident has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing device with the options Yes or No. The chosen response was No. However, a subsequent review of Resident #123's revealed a progress note dated 01/05/2026 at 1:06 PM; Resident #123 noted an open area to the sacrum measuring 1.2 cm (centimeters) x 0.7 cm with granulation tissue. On 01/28/2026 at approximately 1:10 PM, during an interview with Staff #11 and Staff #12 (MDS Coordinator Nurses), it was confirmed that the acquired wound Resident #123 sustained on 01/05/2026 should have been documented as yes in the admission Minimum Data Set (MDS). On 01/28/2026 at approximately 2:00 PM, the Director of Nursing (DON) was made aware of the concerns. 5) A review of Resident #12's medical record on 01/20/2026 at 11:24 AM revealed an MDS completed on 1/7/2026. Section P0100. Physical restraints indicated that bed rails were not used. On 1/20/2026 at 11:26 AM, further record review confirmed a physician order was written on 11/12/2025for siderails: 2 - 1/4 rails up for use of bed controls. On 1/20/2026 at 11:28 AM, A review of the Treatment Administration Record (TAR) for January 2026 revealed that the resident was being monitored for the use of padded side rails every shift for injury prevention/history of seizures. 6) On 1/20/26 at 11:30 AM, a review of Resident #34's medical record revealed an MDS completed on 10/30/2025, which indicated in Section P0100. Physical restraints, that bed rails were not used. The surveyor noted on 1/20/26 at 11:34 AM, a physician order written on 2/13/2021 for siderails: 2 - 1/4 rails up for use of bed controls. Further review of Resident #43's medical records on 1/20/2026 at 11:45 AM, revealed in the Treatment Administration Record (TAR) for January 2026, Resident #43 was monitored for the use of side rails every shift for bed controls. 7) On 1/20/2026 at 11:50 AM, a review of Resident # 50's medical record revealed an MDS completed on 11/14/2025, indicated in Section P0100. Physical restraints, bed rails were not used in bed. Further record review of Resident #50's medical record on 1/20/26 at 11:55 AM, revealed a physician order written on 11/3/2025 for siderails: 2 - 1/4 rails up for use of bed controls. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/20/2026 at 12:00 PM, a review of Resident #50's Treatment Administration Record (TAR) for January 2026 revealed Resident #50 was being monitored for the use of side rails every shift for bed controls. The MDS Coordinators (Staff # 11 and Staff # 12) were interviewed on 01/22/2026 at 12:08 PM and they verified that the MDS should have been coded as A. bed rail 2. Used daily. The Director Of Nursing (DON) was made aware of the concern on 1/22/2026 at approximately 1:30 PM.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on clinical record review, observation, and interviews with the facility staff it was determined the facility failed to properly assess a resident for bedrails as evidenced by: not assessing a resident for entrapment risk, reviewing risks and benefits with the resident/representative, or obtaining informed consent prior to installation. This was evident for 5 Residents (# 34, # 50, #3, #4, and #6) of 5 residents observed having siderails in use during the facility's recertification/complaint survey. The findings include:Bed rails are adjustable bars attached to beds. While they can aid mobility and safety, they can also act as a restraint, preventing exit, and pose an entrapment risk if incorrectly installed. Proper evaluation of resident needs is essential before installation to maximize benefit and prevent risk. A side rail is a specific type of bed rail mounted on the sides. Entrapment occurs when a resident is caught or entangled in or around the bed rail, potentially causing injury, impairment, or death. 1) On 1/20/2026 at 11:01 AM, during the screening process of the annual survey, the surveyor observed Resident # 34 lying in bed with a 1/4 bedrail raised at head of the bed. On 1/20/2026 at 11:05 AM, Resident # 34 stated during an interview that he/she cannot easily and voluntarily release the bed rails. On 1/20/2026 at 2:00 PM, a review of Resident # 34's medical record revealed that Resident # 34 had a Brief Interview of Mental Status (BIMS) of 13 and diagnoses that included a history of falling, unspecified dementia, muscle weakness, and hemiplegia affecting left nondominant side. In addition, there was an order written on 2/13/2021 for siderail: 2 - 1/4 rails up for use of bed controls. There was no consent for the use of the bedrail and no assessment documented. 2) On 1/20/2026 at 11:10 AM, Resident # 50 was observed in bed with 1/4 bedrail raised on each side of the bed. Resident # 50 was unable to demonstrate use of the controls on the bedrails. A review of Resident # 50's medical record on 1/20/2026 at 2:05 PM revealed that Resident #50 have diagnoses that included unspecified dementia, muscle weakness, other abnormalities of gait and mobility, and other lack of coordination. There was an order written on 11/3/2025 for siderails: 2 - 1/4 rails up for use of bed controls. There was no consent from the responsible party or assessment for the use of the bedrails in the medical record. On 01/21/2026 at 3:25 PM, during an interview, the Director of Nursing (DON) stated that the use of two siderails required a physician's order and are primarily for residents repositioning and assistance with bed control. The DON confirmed that no specific assessment is performed prior to the use of siderails. During a follow up interview on 01/22/2026 at 7:51 AM with the Director of Nursing (DON), she stated that the facility does not have a formal bedrail policy, and all purchased beds complied with entrapment measurement guidelines and are checked by maintenance. However, the DON could not provide the manufacturer guidelines for the purchased beds or documentation of maintenance checks. On 1/22/2026 at 12:36 PM, the Director of Nursing was made aware that siderails can lead to entrapment and not having consent for side rails and no assessment for the use of side rails is a concern. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 01/20/2026 at 1:11 PM, during an observation, Resident #3 was lying in bed with one 1/4 bedrail raised on each side of the bed and blue padding inside the rails. On 01/21/2026 at 3:07 PM, a review of Resident #3's medical records revealed a 12/15/2025 physician order for Siderails: 2 1/4 padded bed rails for seizure precautions. However, the medical record contained no documentation of a bedrail assessment or any additional details concerning the use of bedrails. On 01/22/2026 at 8:09 AM, during an interview with Resident #3, he/she stated that he/she did not request the side rails; they came with the bed. 4) On 01/20/2026 at 10:00 AM, during the initial tour and observation, Resident #4 was sitting on the side of the bed with 2 1/4 side rails raised on each side of the bed. On 01/22/2026 at 11:20 AM, a review of Resident #4's medical record revealed a physician order dated 11/14/2025—Side Rails: 2 1/4 rails up for use of bed controls every shift. However, the medical record contained no documentation of a bedrail assessment or any additional details concerning the use of bedrails. 5) On 1/20/2026 at 8:20 AM, an observation of Resident #6 lying in bed with the upper and lower sections of the quarter-length side rails raised on both sides. On 1/22/2026 at 8:24 AM, during an interview with Staff #6, Registered Nurse (RN), it was verified that all four siderails were up on Resident #6's bed. The nurse stated that a physician's order and assumed a safety assessment would be required for the use of siderails. On 01/22/2026 at 9:12 AM, in review of Resident #6's physician orders dated 9/2/2025 for side rails: 2 1/4 rails for bed controls and to assist with positioning. Every shift may use 4 rails as requested. However, the medical record contained no documentation of a bedrail assessment or any additional details concerning the use of bedrails. On 01/21/2026 at 3:25 PM, during an interview, the Director of Nursing (DON) explained the facility's process for siderail use. The DON stated that while four siderails are not used, two siderails are occasionally used. The use of two siderails requires a physician's order and is primarily for resident repositioning and assistance with bed control. The DON confirmed that no specific assessment is performed prior to the use of siderails. On 01/22/2026 at 7:51 AM, the Director of Nursing (DON) informed the surveyor that the facility does not have a formal bedrail policy. The DON asserted that all purchased beds comply with entrapment measurement guidelines and are checked by maintenance. However, the DON could not provide the manufacturer guidelines for the purchased beds or documentation of maintenance checks. On 01/22/2026 at 10:06 AM, during an interview, Staff #10 (Rehab Director) stated therapy does not complete any evaluations for side rails; the side rail is already in place on the beds. The only time therapy would evaluate is if the bottom rails are requested, and she stated she has not had a request for an evaluation for siderails in years. On 1/22/2026 at 12:36 PM, the Director of Nursing was made aware of the concern.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined the facility failed to maintain a restraint-free environment as evidenced by ensuring least restrictive measures were attempted prior to utilizing restraints. This was identified for 2 (Resident #4 and #6) of 2 residents reviewed for restraints during the recertification/complaint survey. The findings include:1) On 01/20/2026 at 10:02 AM, during initial tour and observation, an alarm activated when Resident #4 got out of bed. At 10:07 AM, Resident #4 was observed standing in the doorway, appearing anxious due to the alarm's sound. The resident commented to staff (unknown) at the nearby medication cart, Don't you get tired of that sound, to which the staff member replied, Sometimes. At 10:09 AM, a different staff member came to the door, stating, I am going to turn the alarm off, and Resident #4 responded, Thanks, it is enough to drive you nuts.On 01/22/2026 at 11:15 AM, a review of Resident #4's admission record revealed Resident #4 was admitted to the facility on [DATE]. On 01/22/2026 at 11:17 AM, record review revealed a physician's order for a bed alarm, dated 11/14/2025, stipulating its use for Resident #4's safety during all shifts. However, Resident #4's medical record failed to document any prior interventions that were attempted or evaluated before the implementation of the bed alarm, nor was there evidence of an ongoing evaluation for the continued necessity of the bed alarm. On 1/22/2026 at 8:24 AM, during an interview with Staff #6, Registered Nurse (RN), Regarding alarms, it was stated that the facility utilizes bed or chair alarms for residents identified as a fall risk. These alarms are in place to alert staff when a resident is attempting to get out of bed or a chair.On 01/21/2026 at 3:28 PM, during an interview the Director of Nursing (DON) confirmed the alarm process: bed/chair pressure alarms are used for residents at risk for falls and if ambulatory or impulsive the facility uses bed/chair alarms, with no other assessment performed.2) On 1/20/2026 at 8:20 AM, an observation was made of Resident #6 lying in bed with the upper and lower sections of the quarter-length side rails raised on both sides. On 01/22/2026 at 9:12 AM, in review of Resident #6's physician orders dated 9/2/2025 for side rails: 2 1/4 rails for bed controls and to assist with positioning. Every shift may use 4 rails as requested. However Resident #6's medical record lacked evidence of documentation of any prior interventions that were attempted or evaluated before the implementation of the use of 4 siderails, nor was there evidence of an ongoing evaluation for the continued necessity of the siderails.On 1/22/2026 at 8:24 AM, during an interview with Staff #6, a Registered Nurse (RN), it was confirmed that all four siderails were raised on Resident #6's bed. The nurse indicated that both a physician's order and assumed a safety assessment would be required for the use of siderails. On 01/21/2026 at 3:25 PM, during an interview, the Director of Nursing (DON) explained the facility's process for siderail use. The DON stated that while four siderails are not used, two siderails are occasionally used. The use of two siderails requires a physician's order and is primarily for resident repositioning and assistance with bed control. On 01/22/2026 at 10:06 AM, during an interview, Staff #10 (Rehab Director) stated therapy does not complete any evaluations for side rails; the side rail is already in place on the beds. The only time therapy would evaluate is if the bottom rails are requested, and she stated she has not had a request for an evaluation for siderails in years.On 01/22/2026 at 11:04 AM, the Director of Nursing (DON) provided the surveyor with the facility's physical restraint policy. This policy states the facility's goal is to maintain an environment free of restraints. Furthermore, the section titled Alternatives encouraged emphasizes that the facility will prioritize non-restraint methods-such as environmental changes, increased supervision, and behavioral strategies-to manage resident risk.On 01/22/2026 at 12:36 PM, the concern was shared with the DON regarding restraints and she shared the facility was going to work on reducing.

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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 review and interviews, the facility failed to develop and implement a person-centered care plan to meet and address the residents' medical and physical needs. This was evident for 2 (Resident #2 and Resident #125) of 40 care plans reviewed during the recertification/complaint survey process.Findings Included:A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment (MDS) and prepared by an interdisciplinary team.1) On 01/20/2026 at 09:18 AM, the surveyor observed Resident #2 receiving oxygen (O2) with no date observed on the O2 tubing to indicate when the O2 tubing was last changed.On 01/21/2026 at 2:30 PM, a review of the physician orders dated 01/17/2026 revealed Supplemental Oxygen 2 Liters via nasal cannula to maintain O2 saturation of 90%.On 01/23/2026 at 2:52 PM, a review of Resident #2's care plan revealed no documented evidence of that respiratory care plan was developed to ensure a resident-specific treatment was a part of the treatment plan.On 01/23/2026 at 3:40 PM, the Director of Nursing (DON) interview confirmed that care plans should be initiated by day 21, done quarterly, or updated for a significant change in status (lasting > 7 days). The DON explained that care plans must address interventions, Activities of Daily Living (ADL) needs, goals, preferences, and all active diagnoses/issues such as oxygen usage. The DON was informed that the facility failed to develop a respiratory care plan and the surveyor's findings was acknowledged.2) On 01/21/2026 at 9:43 AM, during the initial pool phase, the surveyor observed oxygen (O2) at Resident #125's bedside; however, the oxygen was not in use at time. The O2 tubing was on top of the oxygen concentrator machine (which was on the floor), not stored in a sanitary environment and the attached humidifier was dated 01/13/2026.On 01/21/2026 at 09:46 AM, in an interview with RN #27, she stated the resident used 2 liters via nasal cannula O2 as needed (PRN) for anxiety.On 01/22/2026 at 1:57 PM, the Assistant Director of Nursing (ADON) was notified of Resident #125's O2 tubing storage and a second observation of the resident's O2 tubing was made with the ADON.On 01/23/2026 at 2:49 PM, a review of Resident #125's care plan revealed the facility failed to develop a respiratory care plan to address the residents' needs.On 01/23/2026 at 3:00 PM, a review of Resident #125's medical records showed an order for Oxygen 2 Liters per minute via Nasal Cannula PRN which was started 3/14/2025 but discontinued on 12/27/2025; however, the O2 was still being used by the resident.On 01/23/2026 at 3:40 PM, the DON was notified that the facility failed to develop a resident-specific care plan and she acknowledge the surveyor's findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interviews, it was determined that the facility failed to provide documented evidence that the residents' care plans were reviewed and revised by an interdisciplinary team to address the resident's medical and physical needs after a change in health status. This was evident for 1 (Resident #2) of 40 care plans reviewed during the recertification/complaint survey process.Findings Included:A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment (MDS) and prepared by an interdisciplinary team.Restorative Care is a supportive service that usually follows rehabilitation to maintain function and prevent further decline, focusing on incorporating skills into daily life.1) On 01/23/2026 at 1:40 PM, the surveyor observed Resident #2 wearing a brace on the left upper extremity as she sat in the chair next to the bedside. On 01/28/2026 at 3:54 PM, a review of Resident #2's medical records revealed orders to wear hinged elbow brace, remove brace for hygiene. Elbow motion 40 to 100 degrees okay to progress 10 degrees in 2 weeks; 1/16/26 Sling to Left Upper Extremity (LUE) to remain in place at all times with the exception of providing ADL care; 1/16/2026 Non-weight bearing to the LUE; and on 1/16/2026 physical therapy (PT) recertification order revealed continue with skilled PT services 3-5 x week for 30 days.On 01/29/2026 at 10:00 AM, a review of Resident #2 care plan revealed no documented evidence to support that the facility revised the care plan to address the resident-specific needs and interventions related to the LUE brace usage and maintenance.On 01/29/2026 at 10:00 AM, in an interview with the Director of Nursing (DON), she was asked if the facility provided any restorative care services to aid with maintaining the resident independence and function, and she explained that it was done through physical therapy and the PT staff also leaves instruction on the unit when necessary.On 01/29/2026 at 10:48 AM, in an interview with the DON, she stated that Resident #2's care plan was reviewed and she acknowledged and verbalized that the care plan did not address the LUE brace. She explained that the floor staff was educated on the removal and replacement of the brace; however, there was no documentation to suggest that staff education was provided.2) On 01/20/2026 at 9:21 AM, in an interview with Resident #2 it was revealed that resident had a bed sore on his/her sacrum.On 01/28/2026 at 1:45 PM, a review of Resident #2's medical records revealed that on 1/6/2026 the skin assessment revealed that the resident had an actual skin impairment on the left inner buttocks and treatment included cleanse with normal saline medihoney/alleyn; on 1/16/2026 a right Inner buttocks wound was identified and treatment included Medihoney/Allevyn dressing; on 1/21/2026 the Resident's skin assessment revealed Moisture Associated Skin Damage (MASD) on the left and right buttocks and treatment included cleanse w/ normal saline solution apply acquacel AG; cover with foam daily pressure reducing mattress turn every 2 hours, gel cushion in chair, house shake three times per day and multivitamin. On 1/28/2026 a suspected deep tissue injury was identified on the sacrum.On 01/28/2026 at 2:57 PM, a review of Resident #2's medical records revealed that on 12/03/2025 the resident was identified as at risk for pressure ulcer development related to urinary incontinence, gait/balance issues and a care plan was developed; however, there was no documented evidence to support that the care plan was reviewed and revised to include the treatments and interventions related to an actual skin impairment as documented. The facility failed to ensure that an active wound care plan was in place to ensure that the resident's needs were addressed as required.On 01/28/2026 at 3:38 PM, the DON confirmed that the Care plan identified risk but failed to address the active wound care needs. She verbally confirmed that care plan should have been updated to reflect the current treatment needs and interventions after a new wound was identified.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to ensure that the resident had the opportunity to participate in an activity program and failed to provide documentation of participation in desired activity. This was found to be evident for 1(Resident # 34) of 5 residents reviewed for activity during the recertification/complaint survey.The Findings include:During the survey investigation process on 01/20/2026 at 12:38 PM, Resident # 34 stated that he/she missed BINGO twice because no one assisted him/her to BINGO.A record review was conducted on 1/22/2026 at 09:53 AM that revealed an Activities- Initial Review for Resident # 34 was conducted on 7/20/2017. Documented in section A. past activity interests were [Resident #34] enjoys fishing, hunting, and card games; section D. limitations/special needs: question 5. Assistance should be provided to get resident to the activity- yes. Question 6. If any of the above are answered yes, please describe the accommodation that should be made to encourage/promote activity participation - Transportation assistance to and from activities is needed.An interview was conducted on 01/22/2026 10:00 AM with the Activities Director (AD), Staff # 24, who stated that the activity staff is responsible for bringing the residents down to activities, such as BINGO, but the Administrator had asked others to assist, such as nursing, admin staff and managers; anyone can assist with transport to activities. When surveyor asked if Resident # 34 attended BINGO, the AD stated that BINGO is offered on Mondays and Thursdays and that Resident # 34 attends BINGO. The surveyor requested documentation that Resident # 34 participated in BINGO within the past 30 days.On 01/22/2026 at 11:06 AM, the AD provided documentation for Resident # 34 participation in activities within the last 30 days with the following dates and times:12/19/25 - Happy Hour 2:30 PM 12/31/25 - New Years Eve Party - 2:45 PM 1/8/26 - Birthday Party - 12:30 PM1/9/26 - Catholic Mass - 2:00 PM, Happy Hour - 2:45 PM1/2/26 - Active participation in Group - documented at 3:59 PM1/12/26 - Catholic Mass - 2:00 PM1/21/26 - Active participation 1:1 at 12:29 PMThe surveyor asked AD if there were any documentation for participation in BINGO, and the AD stated that the activity staff failed to document when resident attended BINGO. The surveyor informed the AD that if participation is not documented, then Resident # 34's claim of not getting assistance to BINGO cannot be refuted. AD agreed and stated that the activities staff will do a better job with documentation of attendance to daily activities and assisting residents to activities.On 1/22/2026 at 12:02 PM, the Director of Nursing was made aware of the concern about resident's activities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, it was determined the facility failed to ensure that a resident received treatment and care in accordance to professional standards of practice, as evidenced by failing to: 1) properly manage a bowel regimen that led to persistent constipation, and 2) appropriately assess, evaluate, and modify interventions for a newly developed pressure ulcer. This was evident for 1 (Resident #123) of 8 residents that were reviewed during the recertification/complaint survey.The findings include: According to the Mayo Clinic, constipation is a problem with passing stool. Constipation generally means passing fewer than three stools a week or having a difficult time passing stool.According to the Centers for Disease Control (CDC), pressure ulcers (bed sores, pressure sores, or decubitus ulcers) are wounds from unrelieved pressure on the skin, per the CDC. They are staged by severity: Stage 1 is persistent skin redness; Stage 2 is partial thickness loss (abrasion, blister, shallow crater); Stage 3 is full thickness loss exposing subcutaneous tissue (deep crater); and Stage 4 is full thickness loss exposing muscle or bone. An unstageable ulcer involves full-thickness skin and tissue loss where the extent of damage is obscured by slough or eschar.The standard of practice for the care of pressure ulcers is for the facility staff to conduct weekly assessments and document findings that include the location, measurement, stage, and characteristics of a pressure ulcer. This information provides facility staff with information to determine whether the pressure ulcer is healing or worsening at future assessments and to evaluate which treatment plan would be most effective to heal the pressure ulcer. 1) On 01/20/2026 at 11:24 AM, during an interview with Resident #123, the complainant raised concerns regarding constipation and a new wound. On 01/23/2026 at approximately 12:40 PM, a review of the facility's bowel protocol revealed the following: The charge nurse checks the BM (Bowel Movement) list each shift. If a resident hasn't had a BM by day two, the nurse administers and documents that prune juice was given in the nurse's notes; if unsuccessful, the next shift gives milk of magnesia or a prescribed laxative. On the third day, the nurse administers a physician-ordered enema and documents it in the nurse's notes. If there is still no BM, the doctor must be notified for further orders. Results are checked and reported to the next shift until successful. On 01/23/2026 at approximately 12:30 PM, a review of the facility's bowel and bladder elimination report for Resident #123, revealed a significant gap in documented bowel movements. The report indicated no applicable size for a bowel movement from 01/09/2026 until 11:59 PM on 01/21/2026, which finally noted a medium bowel movement. This constituted an 11-day period without a recorded bowel movement.On 01/23/2026 at 12:27 PM, a review of Resident #123's physician orders revealed: -12/30/2025: Bowel routine as per policy.-01/18/2026: Fleet Enema (Sodium Phosphates): 1 application rectally every 24 hours as needed for bowel policy.-01/19/2026: Senna Plus (Sennosides-Docusate Sodium): 2 tablets by mouth in the evening for bowel regimen.On 01/23/2026 at 12:16 PM, a review of Resident #123's progress note dated 01/18/2026 at 4:14 PM revealed the last documented BM was on 1/9/26, and Milk of Magnesia (MOM) was given yesterday with no results. Fleet given today with no results thus far. Order obtained for Senna Plus QHS. However, this was 9 days after a documented bowel movement. On 01/23/2026 at 12:34 PM, a review of Resident #123's medication administration record (MAR) documented the administration of the following laxatives: Milk of Magnesia (MOM) on 1/11, 1/16, and 1/19; Fleets on 1/18; and Senna (2 tabs) on 1/12. However, the record lacked subsequent documentation to confirm that the facility's bowel protocol was followed.On 01/23/2026 at 12:21 PM, a review of the physician's note dated 1/19/2026 at 12:03 PM revealed the patient is in the bed resting except for intermittent constipation. Plan to continue with stool softener and to check abdominal x-ray.On 01/23/2026 at 12:22 PM, a review of progress note 1/20/2026 at 1:28 PM revealed Resident #123, complaining of chest pain and a history of constipation, was sent to the emergency room, and at that time the abdominal x-ray was still pending.On 01/23/2026 at 12:32 PM, a review of the discharge instructions dated 01/20/2026 from the hospital indicated constipation. On (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/23/2026 at 12:50 PM, during an interview with the Director of Nursing (DON) indicated the facility's protocol for bowel movement (BM) monitoring: staff documents daily BM checks in the task record for nurse review each day shift. If no BM occurs in three days, a bowel protocol is initiated (batch order on admission if the physician ordered). If interventions fail, the physician is notified for further constipation management. She acknowledged the concern regarding delayed follow-up, which was shared with her at this time. 2) On 01/23/2026 at 11:16 AM, a review of Resident #123's medical record revealed a progress note from 12/30/2025 at 2:42 PM indicated that the resident's skin was assessed with no open areas. Further review indicated a progress note dated 01/05/2026 at 1:06 PM; Resident #123 noted an open area to the sacrum measuring 1.2 CM (centimeters) x 0.7 CM with granulation tissue. On 01/23/2026 at approximately 11:45 AM, a review of Resident #123's Wound Evaluation Sheet revealed a sacral wound identified on 01/05/2026 (1.2 X 0.7 X 0.1 CM, scant yellow exudate, granulation) with no stage documented. A reassessment on 01/14/2026, 9 days later, showed the wound worsened (3 X 2.5 CM, unstageable, moderate serous drainage, 10% granulation, 90% slough). The medical record showed a care plan dated 01/12/2026 for a sacral pressure injury due to immobility post hip surgery, with interventions (air mattress, avoiding friction/bony prominences, not positioning on wound). However, these interventions were initiated 7 days after the wound developed and worsened.On 01/28/2026 at 10:27 AM, an interview was conducted with Staff #3 (Assistant Director of Nursing), ADON, who manages facility wounds. The ADON explained the in-house wound process: the nurse assesses the wound, notifies the physician and responsible party, initiates treatment, and notifies the ADON. The ADON then assesses the wound, evaluates treatment, completes a skin sheet, evaluates the need for support surfaces and nutrition, documents a progress note, and revises the care plan. Wound rounds are held on Wednesdays with the interdisciplinary team.On 1/23/2026 at 2:18 PM, a review of the progress note for Resident #123 revealed a nutrition/dietary note dated 01/12/2026 at 11:11 AM. While this note indicated a nutrition follow-up for weight review, it failed to include any follow-up regarding the resident's nutritional status as it relates to the newly developed wound.On 01/28/2026 at 9:26 AM, during an interview with Staff #14 (Dietician), she discussed her role in managing resident wounds. She explained that she is typically notified by nursing staff, or she identifies wounds during Thursday wound rounds or weekly meetings. She stated that she was unaware of Resident #123's sacral wound and would have immediately assessed the resident if she had been notified.On 01/28/2026 at 10:51 AM, during an interview, the Director of Nursing (DON) expressed an expectation that Resident #123's new wound should have been evaluated sooner. Specifically, the DON questioned why the wound was not further assessed the immediate Wednesday on 01/07/2026 or prior following its identification, along with updated interventions, including those from the dietician. The concern was shared with the DON during this interview.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on surveyor observation, review of the medical record, and interview with facility staff it was determined the facility staff failed to provide necessary respiratory care services for residents by failing to change out an empty humidifier bottle, failing to maintain nasal cannula in a sanitary manner, and failing to administer oxygen as prescribed. This was evident for 3 (#138, #125, #3) out of 6 residents reviewed for Respiratory Care during the recertification/complaint survey.The Findings Include:1) On 01/21/2026 at 9:43 AM, a surveyor's observation revealed that Resident #125 had oxygen at bedside. The oxygen tubing was observed laying on top of the oxygen concentrator and not stored in a sanitary environment. It was also observed that the attached humidifier was dated 01/13/2026. At the time of the observation the resident was asked if he/she used oxygen and the resident stated that they used oxygen in the afternoons. On 01/21/2026 at approximately 09:46 AM, in an interview with RN#27, she stated that the resident used 2 liters via nasal cannula oxygen as needed for anxiety. On 01/22/2026 at 1:57 PM, the Assistant Director of Nursing (ADON) was notified that Resident #125 oxygen tubing was observed resting on top of the oxygen concentrator and stored in an unsanitary environment. A second observation of Resident #125's room was made with the ADON to verify the surveyor's observation. 2) During the survey screening process on 1/20/2026 at 12:25 PM, the surveyor noted that Resident #138 had a respiratory precaution sign on room door. After putting on Personal Protective Equipment (PPE) and entering room, the surveyor observed resident receiving oxygen through a nasal cannula at 2.5 liters. The oxygen humidifier bottle (a liquid that adds moisture to oxygen for enhancing comfort and preventing dryness in the respiratory system during oxygen therapy) was empty and had a label dated 1/7/2026. On 1/21/2026 at approximately 1:39 PM, a second observation noted that the humidifier bottle remained empty and the oxygen setting remained at 2.5 L/Min. An interview was conducted with Staff #7 on 1/21/2026 and when asked about oxygen administration process, staff #7 stated that once an order is written for oxygen, an oxygen concentrator is brought to the room with nasal cannula tubing and humidifier bottle. The oxygen is set to the desired amount, and the humidifier is labeled with a date it was attached to the concentrator. Staff #7 also stated that the humidifier is changed when it is empty and the oxygen tubing is changed every 30 days or as needed. The surveyor requested staff #7 to check the oxygen setting and the humidifier bottle in Resident #138's room. Staff #7 stated that she would. Record review on 01/22/2026 at 9:08 AM revealed the following: The care plan indicated that Guest is on contact/droplet monitoring isolation x 10 days for positive COVID-19 test. Date Initiated: 01/20/2026. Orders were initiated on 1/14/2026 for Oxygen 2L/min via Nasal Cannula every shift and check and change prefilled oxygen humidifier water bottle as needed. During a follow up observation on 1/22/26 at 1:39 PM surveyor noted that the humidifier bottle remained empty with the oxygen still at 2.5 Liters. The surveyor interviewed staff #23 and asked what the order for oxygen administration for Resident #138 was. Staff #23 checked the electronic (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record and verified that it was 2L/Min. when asked how often the humidifier bottle should be changed, staff #23 stated that it should be changed when empty. The surveyor requested that staff #23 go to resident's room and check the oxygen setting and humidifier bottle. On 1/22/2026 at approximately 2:00 PM, the Director of Nursing (DON) was made aware of the concern that the oxygen setting, and the empty humidifier bottle were not corrected even after surveyor's intervention. The DON acknowledged the concern and had no comments. 3) On 01/20/2026 at 9:29 AM, during an observation of Resident #3, the oxygen tubing that was connected to the oxygen concentrator was on the floor. On 01/22/2026 at 8:11 AM, during a second observation of Resident #3, the oxygen tubing was connected to the concentrator and stored unbagged on top of the unit. On 01/22/2026 at 8:12 AM, during an interview with Resident #3, he/she verbalized that he/she uses oxygen every night. On 01/21/2026 at 2:53 PM, in review of Resident #3's medical record, a Physician order dated 12/10/2025 for Respiratory: Oxygen 2 liters per minute via nasal cannula at bedtime for shortness of breath. On 01/22/2026 at 8:14 AM, during an interview with Staff #8 Registered Nurse (RN), verified that the oxygen tubing for Resident #3 was not stored in a bag, and indicated the requirement that oxygen tubing be bagged when not in use. On 01/22/2026 at 1:55 PM, during an interview with Staff #3 (Assistant Director of Nursing) ADON confirmed that proper storage for oxygen tubing, when not in use, requires placing it in a bag to prevent sanitary concerns. This concern was shared with the ADON during the interview.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based clinical record review and staff interview it was determined that the facility staff failed to ensure a resident reporting serious pain received a follow up assessment after receiving treatment for the pain to ensure effectiveness of the treatment. This was evident for one (Resident #46) out of three residents reviewed pain during the recertification/complaint survey.The findings include: A review of a facility reported incident (#2704171) was conducted on 1/20/26. A review of the resident's clinical record on the same day revealed that Resident #46 was ordered Tylenol extra strength 500 mg to be administered in the morning for pain. The resident reported pain on 12/30/25 that was rated as 8 out 10. The resident was administered the medication at approximately 9:00 AM but there was no evidence that staff went back to see if it was effective. The resident's physician added a medication order at 5:00 PM on the same day for Tylenol extra strength 500 mg one tablet every 8 hours for the diagnosis of pain. The resident received their first dose at 6:02 PM and had a pain level of 0 as a result. The Director of Nursing (DON) was interviewed on 1/23/26 at 3:40 PM. This surveyor informed her of the facility reported incident that prompted a review of pain levels and the administration of pain medication during the month of December 2025. She was then shown the Medication Administration Record (MAR) for December 2025 and the lack of a documented follow up to the pain level of 8 on 12/30/25. She said she would investigate. The DON returned to the conference room where the survey team was working on 1/23/26 at 4:45 PM. She informed this surveyor that she investigated the concern and was aided by the unit manager. They could not find evidence that a nurse followed up on the effectiveness of the pain medication.

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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 clinical record review and staff interview, it was determined that the facility failed to ensure a resident's blood sugar was properly monitored. This was evident for one (Resident #5) out of five residents reviewed for the unnecessary medication review task during the recertification/complaint survey.The findings include: This surveyor reviewed Resident #5's clinical record on 1/23/26. The resident's physician wrote an order on 10/10/25 for the resident to be administered Admelog (insulin) 100 units/ml 3 units to be injected every morning but to be held if blood sugar is below 70. The resident had their blood sugar checked on 1/11/26 at 7:00 AM. The blood sugar was 65 and the medication was held. The clinical record was reviewed and there was no evidence that the physician was notified to ensure adequate monitoring of the resident's blood sugar levels. Failure to notify the physician denied the physician the opportunity to intervene. The Director of Nursing (DON) was interviewed on 1/23/26 at 3:40 PM. She was shown the Medication Administration Record and informed that there was no evidence of the physician being informed. She said she would investigate and get back to the survey team. The DON returned on 1/23/26 at 4:45 PM. She said she investigated and confirmed that a call to the physician was not made but should have been made.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, resident interview, and staff interview, it was determined that facility staff failed to ensure a resident received routine dental services. This was evident for one (Resident #5) out of three residents reviewed for dental services during the recertification/complaint survey. The findings include: This surveyor interviewed Resident #5 on 1/22/26 at 9:41 AM. This surveyor asked if the resident has seen a dentist in the past 12 months and if the resident was having any mouth pain. The resident stated that they have not been to the dentist or had a dentist come to see them at the facility for over a year. The resident also reported no mouth or tooth pain. This surveyor interviewed the Unit Manager (#26) for Bay Lane unit on 1/22/26 at 12:05 PM. She said they assess residents for pain, discomfort, chewing and/or swallowing issues and will call the dentist when appropriate. She was unaware that the resident needed to go to the dentist since the resident has not been complaining or has stated a need to see a dentist. A review of the clinical record on 1/22/26 failed to discover any dental consult or dental visit. The Director of Nursing (DON) was interviewed on 1/23/26 at 3:35 PM. She was informed of the interview with the resident and the absence of a dental consult in the clinical record. The DON stated she would investigate. The DON returned on 1/23/26 at 4:45 PM. She was interviewed and stated that she could not find a record of the resident ever going to the dentist in either the physical clinical records of the electronic clinical record.