STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Turtle Creek Rehabilitation and Wellness Center	3000 McComas Avenue Kensington, MD 20895

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to 1) ensure that Personal Protective Equipment (PPE) was available for staff to provide Enhanced Barrier Precautions (EBP), and 2) ensure the clean area of the laundry room, including clean linens and laundry staff, were protected from exposure to wastewater from the washing machines. This was evident 1) for two (Residents #9 and #73) of 2 residents reviewed for EBP, and 2) during an observation of the laundry room, and this deficient practice had the potential to affect all residents.The findings include:1). Resident #73 had a medical history that included but was not limited to: acute osteomyelitis of the right lower extremity, complete traumatic amputation of two or more right lesser toes, atherosclerosis of native arteries of the extremities with gangrene, cellulitis of the right lower extremity, and moderate protein-calorie malnutrition. Resident #9 had a medical history that included, but was not limited to, hemiplegia and hemiparesis following cerebral infarction, type 2 diabetes, stage 4 pressure ulcer, dysphagia, adult failure to thrive, and vascular dementia. Resident #9 also has a G-tube (feeding tube) and was under hospice care. On 4/13/26 at 9:30 AM, Resident #9's room door and Resident #73's room door were observed with Enhanced Barrier Precaution signs posted. However, no PPE for staff use was observed on the supply racks, one of which was located outside the resident's room, and one was located immediately inside the room. On 4/14/26 at 10:40 AM, during an interview with Staff #6, the Geriatric Nursing Assistant (GNA) assigned to the resident's care, they walked with the surveyor to Resident #9's room and Resident #73's room to confirm that each resident was to be on EBP and its intended purpose; however, no PPE was available for staff use, as Staff #6 confirmed. On 4/17/26 at 3:45 PM a summarized review of the facility's EBP policy, revised in April 2026, revealed that EBP required gown and glove use during high contact resident care activities that included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: any skin opening requiring a dressing. On 4/21/26 at 2:30 PM, during an interview with the Director of Nursing, she acknowledged the concern regarding the deficient practice of not providing EBP supplies to Residents #9 and #73. 2). An observation of the facility's laundry room was conducted on 4/13/26 at 9:47 AM. The facility had and was utilizing 3 washing machines. Behind them was a canal-like concrete structure where the 3 washers, including a utility sink with a leaking faucet, drained into. The floor and the base of the washers were wet and the wetness was traced back from the canal. The wet area extended about 2.5 (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ft in front and about 5 feet to the left side of the washer. On 4/13/26 at 9:54 AM, The laundry tech (Staff #8) who was in the laundry room during the observation reported that there was a problem with the drain in the canal causing the wastewater to overflow as observed. She stated, It's not draining fast enough so it overflows. Staff #8 reported that she had to step onto the wet floor whenever she needed to access the washers. Also, she knew it was dirty water so she would have to remove or clean her shoes she went home and she indicated that the problem started a couple of weeks ago and that management was already aware of the situation. The Nursing Home Administrator (NHA) was interviewed on 4/13/26 at 10:14 AM. During the interview, the NHA reported that he was aware that there was a concern with the laundry room that the maintenance staff was working on but would clarify with the Maintenance Director (Staff #10) and report back to the surveyor. On 4/13/26 at 10:26 AM, the NHA accompanied Staff #10 to meet with the surveyor. Staff #10 confirmed the problem with the drain for the washing machines. Staff #10 reported that a contract had been submitted and was in the process for approval in March 2026, but since the facility had a change of ownership, he was not sure when the contractors would start the rebuild of the laundry room for the drainage system. The NHA confirmed that they don't have a date for the job to be done. Staff #10 reported that as a temporary mitigation of the issue, he installed an electronic pump to drain the wastewater collecting in the canal to the septic system. The concern was discussed with the NHA and the Maintenance director that the temporary mitigation they had put in place was ineffective as it was observed that the wastewater was overflowing and posed a significant risk for cross contamination with clean linens. Both staff acknowledged the concern.

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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 record reviews, observations, and interviews, it was determined that the facility failed to treat residents with respect and dignity during mealtime. This was evident in one of two dining observations during the recertification survey.The findings include:1a) Record review for Resident #10 showed that he/she had a limited range of motion in both upper extremities and required full assistance from staff with his/her self-care needs, including eating.An observation of breakfast at the Potomac Unit on 4/14/26 at 8:23 AM showed staff #12, a nursing assistant, feeding Resident #10 in the Resident's room. Resident #10 was lying in bed while staff #12 stood by the left side of the bed. The observation also noted 2 chairs in the Resident's room, and staff #12 continued to stand while feeding Resident #10.During an interview with staff #12 on 4/14/26 at 8:40 AM, she stated she was unaware that feeding a resident while standing was a dignity concern. In an interview on 4/21/26 at 1:00 PM, the director of nursing (DON) reported that staff were expected to sit at eye level when assisting residents with eating and to avoid standing to maintain dignity. The DON also added that staff would be educated regarding the concern.1b) A meal observation at the Chesapeake unit on 4/14/26 at 9:05 AM showed staff #13, a nursing assistant, standing over Resident #41, who was lying in bed while assisting him/her in eating breakfast. In a follow-up interview, the surveyor asked Staff #13 what was expected of her while assisting with residents' feeding. Staff #13 stated that she preferred to stand whenever she assisted with feeding Resident #41. A medical record review for Resident #41 showed that the Resident had a history of stroke with right-sided weakness and required full assistance from staff for his/her care needs.During an interview on 4/22/26 at 9:26 AM, the vice president of clinical operations stated that staff were expected to sit while feeding residents to respect residents' dignity.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that the facility failed to ensure that advance directives were discussed with residents and/or responsible representatives when new orders for life-sustaining treatment were implemented. This was evident for 1 (Resident #58) out of 5 residents reviewed for advance directives.The findings include:The Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form that includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. Section 1 includes orders to perform CPR or Not Perform CPR. The No CPR section includes three options: A-1 Intubate; A-2 Do Not Intubate, but comprehensive efforts may include limited ventilatory support by CPAP or BiPAP; or Option B, No CPR, Palliative and Supportive Care, do not intubate or use CPAP or BiPAP.A review of Resident #58's medical record on [DATE] at 10:44 AM showed that the Resident had resided in the facility since [DATE]. Resident #58's cognitive status was moderately impaired, as evidenced by a BIM score of 12 on a nursing admission assessment dated [DATE]. Further review included an assessment by Resident #58's attending provider, which noted that the Resident lacked capacity to make medical decisions due to a Dementia diagnosis. The review also showed an advance directive naming the Resident's son as the decision-maker for Resident #58.A continued review of Resident #58's electronic health record included a MOLST signed on [DATE] that indicated Attempt CPR in the event of cardiac and/or pulmonary arrest and stated that the provider discussed the MOLST with the Resident's health care agent. The MOLST was labeled VOIDED by the facility; however, there was no documentation on the form itself indicating it was voided.A follow-up review of the current active MOLST for Resident #58, completed on [DATE], revealed an order for NO CPR in the event of a cardiac and/or pulmonary arrest. The review lacked documentation that the provider discussed the change in the MOLST orders for Resident #58 with the Resident and/or his/her representative. In an interview on [DATE] at 12:12 PM, the director of nursing reviewed Resident #58's medical record and confirmed that the Resident's current MOLST order had not been discussed with the Resident's representative.During an interview on [DATE] at 1:31 PM, an attending provider for Resident #58 reported that, when a resident lacked capacity, it was required to discuss a change to the Resident's MOLST order with the representative; however, she had missed discussing the change in Resident #58's MOLST order with his/her representative. The provider added that she would take care of it right away after the surveyor's intervention.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and interview it was determined that the facility failed to ensure the resident and the resident's representative were provided the written notice of transfer when the resident was transferred to the hospital. This was found to be evident for one (Resident #4) out of one resident reviewed for hospitalization.The findings include: Review of Resident #4's medical record revealed the resident's diagnosis included, but was not limited to, a mental disorder. The resident had an identified representative listed as an emergency contact. On 12/30/25 the resident was sent to the hospital for treatment and was admitted . On 4/21/25 further review of the resident's medical record failed to reveal documentation to indicate the required transfer notice information was provided to the resident or the resident's representative related to the 12/30/25 transfer. On 4/21/26 at 1:52 PM the Director of Nursing (DON) was interviewed about information provided to the resident and the representative at time of hospital transfer. The DON reported that the bed hold policy is provided and they notify the representatives that their loved one is being sent to the hospital. When asked specifically about the transfer notice, the DON responded that that the eInteract Transfer goes with the resident. She also reported that she did not think social worker provided anything other than the bed hold notice. According to the regulation the resident and the resident's representative should be provided with a notice of transfer in writing. This notice is required to include: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. Review of the eInteract Transfer form revealed it did not include the required transfer notification information but was a summary of information provided to the hospital regarding the resident's representative information, primary care provider and list of documents being sent that were needed to provide care for the resident. On 4/21/26 at 1:59 PM interview with Corporate Nurse #9 revealed that she was aware of the need to provide a transfer notice that included appeal information. Surveyor informed corporate nurse that review of the medical record failed to reveal documentation that a written transfer notification was provided for the December discharge to the hospital. On 4/21/26 at approximately 3:00 PM Corporate Nurse #9 confirmed they cannot find a notice of transfer for this resident but indicated they have a paper form they use for this notification. Corporate Nurse #9 reported that staff sometimes cannot find the paper.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews, it was determined that the facility failed to ensure that a Pre-admission Screening and Resident Review (PASARR) was completed for 1 (Resident #59) of 1 Residents reviewed for PASARR. The findings include: PASARR is a federally mandated program implemented by the Maryland Department of Health to ensure individuals with serious mental illness, intellectual disabilities, or related conditions are not inappropriately placed in Medicaid-certified nursing facilities or long-term care. On 04/13/26 at 2:45 PM, the medical record for Resident #59 revealed they had a medical history that included, but was not limited to: non-ST-elevated myocardial infarction (NSTEMI), delusional disorders, bipolar disorder, encephalopathy, paranoid personality disorder, unspecified psychosis, and type II diabetes. On 04/14/26 at 9:44 AM, there was no indication of a Level I PASARR screening having been completed for Resident #59. The PASARR completed was for a recent hospitalization and a 30-day exemption for a short-stay nursing facility admission. There was no evidence that a Level I PASARR evaluation was completed to screen for a Level II beyond the 30-day exemption dated 12/14/2025. Resident #59 was admitted from Holy Cross Hospital with medical diagnoses of schizoaffective disorder, bipolar type, and non-ST-elevated myocardial infarction. Further review of Resident #59's medical record revealed an original admission date of 11/16/2022, and frequent hospitalizations where Resident #59 is documented to call 911 themselves on their personal device to be transported by emergency medical services out of the facility for a multitude of reasons since their time of admission to the facility. On 04/15/26 at 11:55 AM, during an interview with Staff #4, the Social Services Director, the surveyor inquired about the facility's PASARR process. Staff #4 stated that the PASARR process was multifactorial with staff involvement, and could not clearly define a facility-specific process. When asked for a facility policy on the PASARR process, Staff #4 provided the surveyor with a printout from the Maryland Department of Health's (MDH) website, a current printout from the code of federal regulations (CFR), and a PowerPoint presentation that was provided by MDH for community providers in November 2023, and stated they would refer to their corporate consultant for facility-specific information. On 04/16/26 at 10:41 AM, Staff #4 was unable to provide a facility-specific policy related to PASARR. Resident #59's PASARR evidence provided by Staff #4 has an end date of 12/14/25 for a 30-day approval. However, there is no indication that a Level I screening evaluation was completed at the facility for the resident to remain long-term, as indicated by their census status. They continued to reside at the facility as of that date, 04/16/26. On 04/16/2026 at 12:10 PM, during an interview with Staff #4, the surveyor inquired about the status beyond the 30-day exemption for the resident's Level I PASARR screening to determine if a Level II evaluation was ever needed. Staff #4 stated that they would need to consult with their regional support to provide an answer. On 04/17/26 at 11:25 AM, Staff #4 confirmed there was no additional evidence that Resident #59 had a Level I PASARR evaluation accurately completed beyond the initial 30-day exemption that was provided, dated 12/14/2025, to determine if a Level II evaluation would be needed. During the interview, Staff #4 acknowledged that they completed and submitted a Level I PASARR screening for a Level II evaluation determination with the facility's new name and identification number as of 04/17/26, indicating Resident #59 had medical diagnoses that included, but weren't limited to: delusional disorder, unspecified psychosis, and encephalopathy. On 4/21/26 at 2:30 PM, during an interview with the director of nursing, the director acknowledged the concern regarding the deficient PASARR practice for Resident #59.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed 1) failed to review and revise a resident's care plan, and 2) to ensure interdisciplinary care plan meetings were held to address residents' care needs after the completion of the Minimum Data Set assessment. This was found to be evident for 1) one resident (Resident #6) of five reviewed for advance directives, and 2) two residents (Resident #108 and #51) of four residents reviewed for neglect. The findings include:1). MOLST stands for Medical Orders for Life-Sustaining Treatment. It is an actionable medical document used for patients with serious, advanced illnesses to stipulate specific preferences for end-of-life care—such as intubation, resuscitation, and feeding tubes—that are recognized across various healthcare settings, including hospitals, nursing homes, and emergency care. A review of Resident #6's medical records was conducted on [DATE] at 12:09 AM. The review revealed that the resident's most recent MOLST form which was dated [DATE], indicated to attempt cardiopulmonary resuscitation (CPR) if cardiac and/or pulmonary arrest occurs. However, Resident #6's care plan initiated on [DATE] and revised on [DATE], indicated the resident's code status as do not resuscitate (DNR) as it was related to his/her MOLST. Also, a review of the resident's current medical record revealed an active DNR order dated [DATE]. The nurse (Nurse #14) who was currently assigned to Resident #6 care was interviewed on [DATE] at 1:42 PM. During the interview, Nurse #14 confirmed that Resident #6 had conflicting information regarding code status and when asked what she would do if the resident's heart stopped, she answered, I wouldn't provide CPR and indicated that her decision was based on the resident's current care plan and medical orders. Nurse #14 then reported that she would discuss the finding with the Nurse Practitioner (Staff #15). The surveyor accompanied Nurse #14 to discuss the findings with Staff #15 on [DATE] at 1:56 PM. Staff #15 reported that the resident was full code and had the capacity to make medical decisions. She also confirmed the finding of conflicting information regarding the resident's code status and reported that the Social Worker should have updated Resident #6's medical record when the MOLST was changed. A subsequent review of Resident #6's medical record was conducted on [DATE] at 2:32 PM. The review revealed a note from the social worker (Staff #4) that indicated the most recent care plan meeting/conference was held on [DATE] at 2:15 PM where the code status was reviewed and indicated as a DNR. On [DATE] at 9:49 AM, the Director of Nursing (DON) was interviewed and reported that she was already aware of the concern with Resident #6's conflicting code status information and that an audit was started to review medical records of random residents to ensure they are updated and accurate. Resident #6's medical record was reviewed with the DON and revealed that the current care plan still indicated DNR. The DON then updated the care plan and acknowledged that it should have been reviewed and updated on [DATE] when the new MOLST was done. 2.a) The Minimum Data Set (MDS) is a federally mandated assessment that nursing home staff use to collect information about each Resident's strengths and needs. This information is then used to make (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care planning decisions for the Resident. Maryland state regulations require the nursing home to hold the care planning conference not later than 7 calendar days after completing the assessment but may hold the conference sooner if agreed to by the resident, a family member, or a resident's representative. On [DATE] at 12:20 PM an interview with Social Worker #4 revealed that she had identified an issue with failure to have care plan meetings when they were due and had initiated a quality assurance/performance improvement plan in either December or January. On [DATE] a review of Resident #108's electronic health record revealed that an MDS assessment was completed in November, and a Care Conference Note revealed a meeting took place on [DATE]. Further review of the medical record revealed an MDS assessment with an assessment reference date (ARD) of [DATE] but no Care Conference Note was found to indicate a meeting had occurred after the [DATE] assessment. On [DATE] at 4:35 PM the surveyor reviewed with the Director of Nursing the concern that the facility failed to have a care plan meeting after the [DATE] MDS assessment. 2.b) A review of Resident #51's medical records was conducted on [DATE] at 11:51 AM. The review revealed that a quarterly assessment was completed on [DATE]. However, the last care conference note had an effective date of [DATE] created by the Social Worker (Staff #4). In an interview with Staff #4 on [DATE] at 11:57 AM, she reported that care plan meetings are held on Wednesdays and Thursdays and that her timeframe was to have one within 7 days prior to and 7 days after the resident's ARD of comprehensive and quarterly assessments. Staff #4 confirmed that her understanding of the regulation with regards to care plan meetings was that she had 7 days before or after the MDS ARD dates. A review of Resident #51's medical record was conducted with Staff #4 on [DATE] at 12:06 PM. She confirmed the resident's most recent MDS assessment had an ARD of [DATE]. Staff #4 was asked if she had or scheduled a care plan meeting based on that MDS assessment. She reported that she met with the resident's guardian on [DATE] and wrote a progress note about it but did not write it as a care conference note. She also reported that she was trying to schedule a care plan meeting with the guardian, however he could not make that date and she stated, I need to have the guardian present for the care plan meeting. Further review of Resident #51's medical record with Staff #4 revealed the progress note she wrote on [DATE] that described her talking to the resident regarding a concern with his/her behavior. There was no indication on the note that the guardian was present nor was there any indication that the resident's care plan was reviewed and/or discussed. The concern was discussed with Staff #4 that the regulation does not require the residents, guardian and family members to attend the care plan meeting, however the facility is still required to hold a care plan meeting within 7 days after a comprehensive or quarterly MDS assessment is completed. Staff #4 verbalized understanding and acknowledged the concern.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and staff interviews, it was determined that the facility failed to ensure physician-ordered medications were administered as prescribed, including the correct medication, dose, and timing, for 3 (Resident #3, Resident #38, and Resident #55) of 3 Residents observed during the medication administration observation. This deficient practice has the potential to affect all residents receiving medications on all nursing units.The findings include: On 4/15/26 at 9:25 AM, LPN #3 was observed to have prepared medications for Resident #38, which included: Levetriacetam 750 mg, Divalproex sodium 500 mg, and Lactulose 30 mL. These medications were left unlabeled by LPN #3 and placed in a non-resident-specific drawer. LPN #3 then proceeded to administer medications for Resident #3, demonstrating a failure to ensure medications were administered to the intended resident in accordance with physician orders.On 4/15/26 at 9:50 AM, LPN #3 prepared a Magnesium 500 mg for administration to Resident #3. Upon review, the physician's order was for: Magnesium Oxide 400 mg (240 mg elemental magnesium) once daily. LPN #3 demonstrated a failure to administer medication in accordance with the physician's order for the correct medication and the correct dose, and LPN #3 acknowledged the discrepancy after surveyor intervention and removed the medication.On 4/15/26 at 10:00 AM, during medication administration for Resident #55, a hard stop alert in the eMAR (electronic Medication Administration Record) indicated a late dose of gabapentin. LPN #3 did not initially acknowledge or administer the medication. After the surveyor's intervention, LPN #3 reviewed the eMAR and identified the missed medication for Resident #55.These observations are separate from the calculated medication error rate and reflect failure to implement physician orders as written.On 4/21/26 at 2:30 PM, during an interview with the director of nursing, the director acknowledged the concern regarding the deficient practice related to professional standards.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to have an effective system in place to ensure residents only had one active Maryland Order for Life-Sustaining Treatment (MOLST). This was evident for 1 (Resident #6) of 5 residents reviewed for advanced directives. The findings include:The Maryland Orders for Life-Sustaining Treatment (MOLST) form is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. It was designed to ensure that healthcare providers throughout Maryland have a uniform system of communicating a resident's end-of-life wishes in the event of cardiac or respiratory arrest. Cardiopulmonary Resuscitation (CPR) is the act of attempting to revive someone once their heart or breathing have stopped.A review of Resident #6's electronic health record on [DATE] at 12:09 PM revealed a MOLST dated [DATE], that indicated do not attempt CPR if cardiac and/or pulmonary arrest occurs. The resident's facesheet and current medical orders also indicated a do not resuscitate (DNR) order dated [DATE]. No other MOLST was found in the resident's electronic health record.On [DATE] at 12:25 PM, Resident #6's hard chart was reviewed and revealed another MOLST dated [DATE], that indicated attempt CPR if cardiac and/or pulmonary arrest occurs. A floor nurse (Nurse #16) was interviewed on [DATE] at 12:28 PM. Nurse #16 explained the process when a resident suddenly experiences a cardiac and/or pulmonary arrest. She reported that the resident's code status should be quickly checked and can be found in the electronic health record and/or hard chart and stated, the record on PCC (point click care- electronic health record that the facility was utilizing) should match the hard chart.The nurse (Nurse #14) who was currently assigned to Resident #6 care was interviewed on [DATE] at 1:42 PM. During the interview, the resident's medical record was reviewed and Nurse #14 confirmed that Resident #6 had conflicting information regarding code status as the hard chart had the MOLST that indicated to attempt CPR, and PCC had a different MOLST and medical orders that indicated DNR. When asked what she would do if the resident's heart stopped, she answered, I wouldn't provide CPR, I'll go with what's indicated in PCC.Nurse #14 then reported that she would discuss the finding with the Nurse Practitioner (Staff #15). The surveyor accompanied Nurse #14 to discuss the findings with Staff #15 on [DATE] at 1:56 PM. Staff #15 reported that Resident #6 was full code and had the capacity to make medical decisions. She also confirmed the finding of 2 active and conflicting MOLST information. Staff #15 reported that the Social Worker should have updated the resident's medical record when the MOLST was changed.A subsequent review of Resident #6's medical record was conducted on [DATE] at 2:32 PM. The review revealed a note from the social worker (Staff #4) that indicated the most recent care plan meeting/conference was held on [DATE] at 2:15 PM where the code status was reviewed and indicated as a DNR.On [DATE] at 9:49 AM, the Director of Nursing (DON) was interviewed and reported that she was already aware of the concern with Resident #6 having 2 active MOLST with conflicting code status information and that an audit was started to review medical records of random residents to ensure they are updated and accurate. She also reported moving forward, the resident's hard chart will also be reviewed during care plan meetings.Cross reference F657

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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 record reviews, interviews, and observations, it was determined that the facility failed to provide activities based on the resident's comprehensive assessment. This was evident for 1 (Resident #51) of 4 residents reviewed for neglect. The findings include:The concerns related to Complaint2795585 included a report that staff was mistreating Resident #51 by showing other residents more attention. On 4/14/26 at 10:08 AM, Resident #51 was observed in room, watching TV.On 4/17/26 at 12:10 PM, a review of Resident #51's most recent comprehensive assessment with a reference date of 7/15/25 section F, indicated that it was very important for the resident to do things with groups of people and to go outside to get fresh air when the weather is good.On 4/17/26 at 12:15 PM, Resident #51's care plan for activities included interventions such as, encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities; and invite resident to scheduled activities.A review of April 2026 activities and activity participation was conducted on 4/17/26 at 12:17 AM. The review failed to show documentation that the resident attended or was offered and refused to attend group and/or outdoor activities.The Activity Director (Staff #7) was interviewed on 4/17/26 at 12:22 PM. During the interview, Staff #7 reported that Resident #51 usually prefers to do independent activities in his/her room. Staff #7 was asked if he or activity staff document the refusal when group and outdoor activities are offered to the resident. He reported that refusals are documented and group activities are done daily. A review of Resident #51's medical record was conducted with Staff #7, and he confirmed that there was no documentation to indicate that the resident had attended or refused to attend group and/or outdoor activity for April and March 2026. The concern was discussed with Staff #7 that the facility failed to provide activities to the resident based on the comprehensive assessment and individualized care plan. Staff #7 verbalized understanding and acknowledged the concern.

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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 medical record review and interview it was determined that the facility failed to ensure lab tests that were required to determine if a specific medication needed to be administered were obtained. This was found to be evident for one (Resident #40) out of five residents reviewed for unnecessary medications.The findings include:Review of Resident #40's medical record revealed the resident has leukopenia, which is a lower than normal white blood cell (WBC) count. A low white blood cell count leaves a resident vulnerable to infections.The resident had an order, in effect from 11/20/25 through 2/21/26 for Zarxio to be administered once every 14 days for leukopenia when the WBC (white blood count) is less than 4. The resident had an order from 9/26/25 until 4/17/26 for a CBC (complete blood count - which includes WBC) every two weeks on Tuesdays and to fax the results to the pharmacy for neupogen delivery. Neupogen and Zarxio have the same active ingredients. Review of the lab results revealed the resident had a WBC of 2.7 on 2/12/26 and the Zarxio was administered. On 2/22/26 the order for the Zarxio was changed from being given every 14 days to being given every 7 days when the WBC was less than 4. This order had a start date of 2/22/26. No documentation was found to indicate the order for the CBC testing was changed in February when the order for the Zarxio was increased to weekly. Review of the Medication Administration Record (MAR) revealed the Zarxio was scheduled to be given on Sundays, starting on 2/22/26. No documentation was found to indicate the medication was administered on 2/22/26, no nursing notes were found for 2/22/26 to indicate why the medication was not administered that date, or if the primary care provider was notified. No documentation was found to indicate the CBC was obtained when due later in February. Review of the March MAR revealed documentation that the Zarxio was administered on 3/1/26 but staff documented NA for not applicable in the space on the MAR to document the WBC result. The most recent WBC count found in the medical record prior to 3/1/26, was the result from the 2/12/26 CBC, which was more than two weeks prior. The next CBC results found in the medical record were dated 3/5/26 and revealed a WBC of 3.9. This would indicate the Zarxio should be administered. Further review of the MAR failed to reveal documentation to indicate the Zarxio was administered when scheduled on 3/8/26. No corresponding nursing note was found to indicate why the medication was not administered on 3/8/26.Further review of the March MAR revealed staff documented a 9 indicating see nurse's note when the Zarxio was scheduled to be given on 3/15/26. The corresponding nursing note revealed the lab was contacted for the results of a 3/13/26 WBC and were informed that the results were not in yet. Staff documented: Zarxio was not given.The surveyor requested from the Director of Nursing on 4/17/26 at 2:04 PM the CBC results since January. Review of the CBC results provided failed to reveal documentation to indicate a CBC was drawn on 3/13/26 as indicated in the 3/15/26 nursing note. A report was provided that indicated a CBC was drawn on 3/20/26 with a WBC result of 4.0. Review of the March MAR failed to reveal documentation in the space provided to document when the Zarxio was scheduled to be given on 3/22/26. When scheduled on 3/29/26 staff documented 9. Review of the corresponding nursing note revealed: Zarxio was not administered due to the resident's most recent lab result on 3/20/26 showing a WBC count of 4.0.Review of the MAR for April revealed that when scheduled to be given on 4/5/26 staff wrote 4.0 in the space to document the WBC and a 9 indicating see nursing note. On 4/22/26 the DON confirmed there was no nursing note for 4/5/26. The Zarxio was not administered when scheduled on 4/12/26, the corresponding nursing note revealed Resident WBC 4.0.On 4/17/26 no documentation was provided to indicate a CBC was obtained since 3/20/26. Blood was drawn for labs on 4/6/26, but these did not include a CBC.On 4/22/26 at 9:15 AM surveyor reviewed with Corporate Nurse #9 the concern regarding the failure to ensure the CBCs were obtained as ordered and the failure to ensure the Zarxio was administered as ordered. Corporate Nurse #9 acknowledged the deficient practice and reported that there was no change in the lab order when the Zarxio order was changed in February, and that she had spoken to the provider and obtained a new order for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly labs.Further review of the medical record on 4/22/26 revealed an order, dated 4/17/26 for CBC weekly on Monday and to fax the results to the pharmacy for Zarxio delivery. There was also an updated order for Zarxio, dated 4/17/26 to be administered every Wednesday for leukopenia when WBC is less than 4.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure residents at risk for developing pressure injuries receive appropriate services for treatment and prevention. This was evident for 1 (Resident #45) of 4 residents reviewed for pressure injuries. The findings include:Resident #45 had been a resident of the facility since early 2018. On 4/13/26 at 11:10 AM, the resident was observed in bed equipped with an air mattress. The control unit for the air mattress was located at the foot of the bed and was observed to be set at 550 lbs.A review of Resident #45's medical record was conducted on 4/13/26 at 1:32 PM. The review revealed the resident's most recent weight was 252.4 lbs. taken on 4/3/26. Current orders included for nursing to check air mattress to be set per manufacturers guidelines and check for proper placement and function every shift.The Braden Scale is a widely used healthcare tool to assess a patient's risk of developing pressure injuries/ulcers. Scores range from 6 to 23, with lower scores indicating higher risk. Resident #45's scored 11.0 that was indicated as a high risk in the Braden scale done on 3/15/26.On 4/15/26 at 1:53 PM, the nurse (Nurse #17) who was currently assigned to care for Resident #45 was interviewed. Nurse #17 reported that the order to check the air mattress meant to ensure that it was plugged into the electrical outlet, inflated with no leaks, no beeping sound and/or alerts for any malfunction.Nurse #17 was then invited to observed Resident #45's bed with the surveyor on 4/15/26 at 1:58 PM. Nurse #17 confirmed that the air mattress weight setting was set at 550 lbs. and indicated that it should be changed since the resident's weight was in the 250 lbs. range. Nurse #17 reported that it was the responsibility of maintenance staff to ensure weight settings and cycle time were appropriate to the residents.The Director of Nursing (DON) was interviewed on 4/15/26 at 2:09 PM. During the interview, the DON confirmed that the air mattress was maintenance staff's responsibility. She was asked how maintenance staff were informed of the setting specific to the resident, and she answered, I'm not sure.The Maintenance Director (Staff #10) was then interviewed on 4/15/26 at 2:18 PM. During the interview, he reported his department's process when an air mattress is requested for a resident. He indicated that he or his staff installs the air mattress in the room requested and then sets to static to inflate fully to ensure there are no leaks. But as far as the specific weight setting and cycle time, he reported that it was the nursing department's responsibility. He also reported that air mattress requests are given to him through verbal orders/communication and indicated that he does not get resident specific information like their names and/or their weight.The findings were reviewed and the concern was discussed with the Nursing Home Administrator (NHA) on 4/15/26 at 2:34 PM that no one in the facility was checking to ensure air mattress settings were appropriate to the resident utilizing them. The NHA stated, looks like we dropped the ball. There is a disconnect with the process with air mattress. The NHA verbalized understanding and acknowledged the concern.On 4/16/26 at 9:10 AM, the NHA reported that a facility wide audit was conducted to ensure air mattresses were set up appropriately to the resident and that staff education was being done as well.

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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 medical record review and interview it was determined that the facility failed to ensure urology appointments for monthly suprapubic catheter changes were scheduled in a timely manner. This was found to be evident for one (Resident #40) out of two residents reviewed for urinary catheter care.The findings include:Supra pubic catheters require a surgical procedure in which a small incision is cut through the abdomen to allow for insertion of a tube into the bladder. The tube remains in place to allow for continuous drainage of urine into a drainage bag. Review of Resident #40's medical record revealed the resident was admitted to the facility in 2025. The resident has a suprapubic catheter, with orders in effect from 9/3/25, to change the supra pubic catheter monthly at the urologist office. Review of the medical record revealed documentation that the resident was seen by the urologist for a supra pubic catheter change on 10/9/25 with a recommendation to follow up in 4 weeks for a catheter change. Review of a 10/9/25 nursing progress note revealed the resident's next appointment was scheduled for 11/6/25.Further review of the medical record revealed a nursing note, dated 11/6/25, which stated: Resident returned from follow up appointment with report that the scheduled appointment did not take place due to the absence of the doctor. Appointment to be rescheduled tomorrow.Further review of the medical record failed to reveal documentation to indicate the resident was seen by the urologist again until 12/29/25.Further review of the medical record revealed the resident was seen by the urologist on 12/29/25. A nursing note dated 12/29/25 revealed a recommendation to continue monthly supra pubic catheter changes. Further review of the medical record failed to reveal documentation to indicate attempts were made to schedule follow-up urology appointments in January or February 2026. On 3/9/26 there was an order put in for a follow-up urology consult on 3/19/26 at 10:40 AM.On 3/19/26 there was a Care Plan Note written by the Unit Nurse Manager #5 that the resident refused to go to the appointment and wanted it to be rescheduled due to not wanting to get up at 8 am to get ready for the appointment. The note indicated that the nurse practitioner was made aware of the missed appointment.On 4/13/26 at 12:21 PM Resident #40 expressed a concern to surveyor about a recently missed urology appointment for the suprapubic catheter change. The resident also expressed concern about the scheduling of the appointment by the unit manager. On 4/13/26 at 12:34 the Unit Nurse Manager #5 approached the surveyor and reported the urology appointment had been scheduled twice and the resident refused.On 4/15/26 an order was put in the medical record for a follow-up urology appointment on 4/23/26. Further review of the medical record failed to reveal documentation of attempts to reschedule the urology appointment prior to 4/15/26.On 4/16/26 at 9:48 AM the Unit Nurse Manager #5 was interviewed in regard to the process for scheduling appointments outside of the facility. She reported that the unit managers are responsible for scheduling appointments and that the process involved obtaining an order from the physician, checking for insurance coverage, calling the offices to schedule the appointment and then arranging transportation. When asked about documentation of these appointments, the Unit Manager reported once the appointment is scheduled they put an order in the medical record, so they don't forget the appointment, and they add it to a calendar. In regard to Resident #40, the Unit Nurse Manager #5 indicated she had attempted to reschedule the appointment prior to this week but was told no appointments were available until June. The Unit Nurse Manager confirmed she had not scheduled an appointment in June. She went on to report the urology office recently contacted her about a cancellation and the resident now has an appointment next Thursday in the afternoon. On 4/17/26 at 1:00 PM the surveyor asked the Director of Nursing (DON) what her expectation is if a resident needs to be seen monthly, but the next available appointment is several months away. The DON indicated the staff should document the call, let the provider know and talk to the office to see if they can schedule sooner. She confirmed that she would have expected staff to schedule the appointment and then work on getting an earlier appointment.On 4/21/26 at 11:41 AM surveyor (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed the concern with the Corporate Nurse #9 that no documentation was found to indicate the urologist office was contacted in January or February regarding the scheduling the supra pubic catheter change and that the resident had expressed a concern that the UM had not scheduled the appointment in a timely manner. Corporate Nurse #9 indicated she would check to see if there was a note about scheduling the appointment.On 4/21/26 at 12:39 PM Corporate Nurse #9 confirmed that there was no additional documentation found regarding the scheduling for the urology appointment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record reviews and interviews, it was determined that the facility failed to ensure pain management was provided to a resident requiring such services according to professional standards of practice. This was evident for 1 (Resident #6) of 2 residents reviewed for pain management. The findings include:Resident #6 had been a resident of the facility since mid-2019. The medical record indicated that the resident was cognitively intact.Resident #6 was interviewed on 4/13/26 at 11:52 AM. During the interview, the resident reported that s/he was in severe pain and that the facility had run out of his/her pain medication. The resident stated, they have a box upstairs for emergency if you run out but they won't do that for me.A review of Resident #6's medication orders was conducted on 4/16/26 at 1:37 PM. The review revealed that the resident was on a routine narcotic pain medication (Oxycodone 5 MG capsule every 6 hours) for chronic pain scheduled at 12 AM, 6 AM, 12 PM and 6 PM. The administration record for April 2026 revealed that the resident missed doses on 4/12/26 at 6 AM, 4/12/26 at 12 PM, 4/12/26 at 6 PM, 4/13/26 at 12 AM, 4/13/26 at 6 AM and 4/13/26 at 6 PM. A one-time order for Oxycodone 5 MG tablet was administered on 4/13/26 at 12:07 by the charge nurse (Nurse #17).Nurse #17 was interviewed on 4/16/26 at 3:34 PM regarding Resident #6's routine narcotic pain medication. Nurse #17 reported that the resident was not given the routine narcotic pain medication from 4/12/26 at 6AM until 4/13/26 at 6 PM, including 4/13/26 at 12 PM, because it was not delivered by the pharmacy. She stated, the capsule form of the medication was not available at the pyxis (Pyxis is an automated medication dispensing system) that's why we did not use it.The Director of Nursing (DON) was interviewed regarding pain management on 4/17/26 at 10:20 AM. During the interview, the DON explained that when there is a concern with medication delivery from the pharmacy, nurses can check the pyxis to see if the medication is available there. Once they confirm availability, nurses should inform the providers to get an order, then the pharmacy will send them a code so they can get the supply from the pyxis. The DON was asked to provide the list of medications kept in stock in the pyxis.On 4/17/26 at 1:21 PM, the DON provided the list of medications kept in the pyxis. The list included 8 counts of Oxycodone 5 MG tablet, 8 counts of Oxycodone 10 MG tablet, and 8 counts of Oxycodone/Acetaminophen 5/325 MG tablets. The DON was asked, prior to Resident #6 reporting the concern to the surveyor, is there any documentation that the nursing staff tried to access the supply from the pyxis and she stated, I don't know, it wasn't brought to my attention. The DON was also asked if the provider was informed that Resident #6's routine narcotic pain medication was not delivered and she answered, No. The concern was discussed with the DON that pain management was not provided to the resident, as there was no documentation to indicate efforts from nursing staff to access available medication from emergency supply, until the resident had reported the concern to the surveyor. The DON verbalized understanding and acknowledged the concern.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and staff interviews, it was determined that the facility failed to ensure medications were administered in accordance with physician orders and accepted standards of practice. This deficient practice resulted in a medication error rate of 17.24% (5 errors out of 29 opportunities), exceeding the allowable 5% error rate.The findings include:On 4/15/26, a medication pass observation identified 5 medication errors out of 29 opportunities (17.24%).On 4/15/26 at 2:25 AM, a Licensed Practical Nurse (LPN) #3 was observed to have partially dispensed medications for Resident #38 prior to completing the administration for another resident. The medications included: Levetiracetam 750 mg, Divalproex sodium DR 500 mg, and Lactulose 30 mL. These medications were unlabeled and placed in a non-resident-specific drawer within the medication cart. LPN #3 then proceeded to administer medications to Resident #3, leaving three of Resident #38's medications unsecured and not identifiable for the intended resident. Constituting three errors.On 4/15/26 at 9:50 AM, LPN #3 obtained and dispensed a ?house stock' supplement of Magnesium 500 mg for Resident #3. Upon review, LPN #3 removed the incorrect medication after the surveyor intervened and obtained the correct dose. Constituting as one error.On 4/15/26 at 10:00 AM, during medication administration for Resident #55, LPN #3 received a hard stop alert in the electronic medication administration record (eMAR) for a late medication, Gabapentin. LPN #3 did not initially acknowledge or administer this medication. After the surveyor's intervention, LPN #3 reviewed the eMAR and identified the missed dose. Constituting as one error.On 4/21/26 at 2:30 PM, during an interview with the director of nursing, they acknowledged the concern related to the deficient practice with medication administration.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure complete and accurate hospice documentation was maintained and readily accessible for 1 (Resident #9) of 1 Residents reviewed for Hospice Care.The findings include:Resident #9 had a medical history that included, but was not limited to, a terminal diagnosis of cerebral atherosclerosis and had been receiving hospice care services since 7/4/2025 from Heartland Hospice.On 4/15/26 at 1:13 PM, a record review revealed that Resident #9's electronic medical record contained hospice-related documentation limited to a care plan conference dated 10/7/25, covering benefit period dates 10/2/25 through 12/20/25. There was no evidence of additional hospice care documentation in the medical record, in the two available electronic formats, or on a hard copy.On 4/16/26 at 11:30 AM, during an interview with the Director of Social Services, SSD #4 stated that Heartland provided the facility with handwritten documentation of visits to the resident and that it was maintained in the resident's chart under the ?Hospice' tab at the nurses' station. During the interview, SSD #4 was notified by the surveyor that there was no such documentation that could be located in Resident #9's medical record.On 4/16/26 at 11:45 AM, during an interview with a Licensed Practical Nurse (LPN), LPN #5 stated that Heartland Hospice does not provide handwritten documentation; instead, it documents electronically via tablet and provides a verification signature line to facility staff, which conflicted with the information provided by SSD #4.On 4/16/26 at 12:20 PM, SSD #4 was informed of the surveyor's findings and the interview with LPN #5. During the interview, SSD #4 contacted Heartland Hospice to request copies of Resident #9's hospice documentation for nursing staff, applicable social service visits, and the hospice plan of care.On 4/16/26 at 1:22 PM, a review of the facility's agreement with Heartland Hospice revealed that both the facility and Heartland Hospice agreed to provide access to all records of the hospice services rendered. Heartland Hospice would be responsible for providing complete and timely medical records for each hospice patient. The records of hospice services were to be available and shared with the facility. Despite the agreement, there was no evidence that the facility had provided or maintained hospice visit documentation for Resident #9.On 4/16/26 at 2:32 PM, SSD #4 provided printed hospice documentation from Heartland Hospice that included certification period documentation dated 3/1/26 through 4/29/26, a comprehensive assessment and plan of care updated 3/24/26, and hospice physician orders dated 2/24/26. These documents were not previously maintained in Resident #9's medical record. These documents did not include summaries of visit notes provided by hospice nursing staff and did not support SSD #4's statement that handwritten documentation was provided to the facility by Heartland Hospice.On 4/21/26 at 2:30 PM, during an interview with the director of nursing, they acknowledged the concern regarding deficient hospice care documentation.