STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215054	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towson Rehabilitation and Healthcare Center	509 East Joppa Road Towson, MD 21286

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, it was determined the facility failed to appropriately assess and determine the clinical appropriateness of self-administration of medications. This was evident for 1 (Resident #14) of 1 resident reviewed for medication self-administration during the recertification/complaint survey.The Findings include: On 02/09/2026 at 9:33 AM, during an observation, Resident #14 was observed in his/her room, lying in bed. On the bedside table to Resident #14's left, the following items were noted: one bottle of Tylenol 500 mg tablets, one bottle of Tylenol PM, and one bottle of TUMS.On 02/09/2026 at 9:36 AM, during an interview, Staff #4 (Registered Nurse) described the facility's medication procedure, stating that medication bottles should not be kept at the bedside. Staff #4 confirmed that Resident #14 had medication bottles at the bedside and stated, I am going to remove the medications and call Resident #14's complainant to get the medications. On 02/10/2026 at 12:39 PM, a review of Resident #14's medical record included an admission assessment from December 15, 2025. This assessment, under the Self-medication administration section, indicated NO to the question, Does the resident WANT to self-administer his/her own medications? Further review of Resident #14's medical record lacked a physician's order for Tylenol PM, authorization for self-administration of Tylenol 500 mg or TUMS, or a care plan confirming the resident's capacity for self-administration.On 02/10/2026 at 1:35 PM, during an interview with the Director of Nursing (DON), the DON confirmed the process for medication at the bedside. For a resident to self-administer medication, a physician's order is required, an assessment must be completed, and the medication must be kept locked up in the bedside table. This information would be documented on the medication administration record and included in the care plan. The concern regarding this process was shared with the DON at the time of the interview.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with facility staff and review of medical records, it was determined that the facility failed to ensure that physicians and resident representatives (RPs) were notified of changes in resident conditions. This was evident for 1 (Resident #101) out of 3 residents reviewed for skin conditions (non-pressure related) during the facility's recertification/complaint survey. The findings include:On 2/10/26 at 10:35 AM in an interview with Licensed Practical Nurse (LPN #17) she stated that Resident #101 had a new wound on his/her left toe. On 2/17/26 at 9:50 AM review of Resident #101's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction, peripheral vascular disease, epilepsy, and type 2 diabetes mellitus. Further review revealed a Weekly Skin Check dated 2/11/26 that documented No New Skin Alterations; however, the assessment also documented Left great toe wound: cleanse with normal saline, pat dry, apply silver alginate, cover with dry bordered dressing every other day, Tuesday-Thursday-Saturday-Sunday. Monitor for s/s (signs and symptoms) of infection. Continued review revealed a Weekly Skin Check dated 2/4/26 that documented Skin is intact.On 2/17/26 at 10:08 AM the surveyor requested documentation of when the facility first became aware of the wound on Resident #101's left toe. On 2/17/26 at 11:24 AM in an interview with the Director of Nursing (DON) she stated the first documentation on Resident #101's left toe was from the Weekly Skin Check on 2/11/26 and provided a copy of the 2/11/26 Weekly Skin Check. During the interview, the surveyor stated the Weekly Skin Check prior to this one dated 2/4/26 documented Skin is intact and this one dated 2/11/26 documented No New Skin Alterations. The DON stated, the nurse should have documented New Skin Impairment Noted as this was newly identified. On 2/17/26 at 11:46 AM review of Resident #101's medial record revealed an order, Appraise and observe every shift for changes in physical and mental condition. Notify Provider if observed. Every shift. with an order date of 8/1/25. Further review revealed on Resident #101's TAR (Treatment Administration Record) for 2/10/26 a check mark for each shift that the order was completed; however, failed to reveal that the provider was notified of the physical changes (left toe wound) in Resident #101's physical condition. On 2/17/26 at 12:15 PM the surveyor asked what the Doxycycline Hyclate Oral Tablet 100 MG was ordered for. On 2/17/26 at 12:36 PM in an interview with the DON, she stated it was ordered for his/her left great toe and provided a copy of an updated order to reflect that. The surveyor stated there was a wound treatment order for Resident #101's left great toe wound dated 2/10/26, showing the facility was aware of the wound on 2/10/26. The surveyor shared that there was an order for appraising and observing for physical changes and to notify the provider if observed and requested evidence that the provider was notified on 2/10/26 when the wound was first observed. On 2/17/26 at 1:36 PM in an interview with the DON she stated, I didn't see any documentation that the provider was notified on 2/10/26. The surveyor shared this was a concern. The DON verbalized and acknowledged understanding of the concern.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure a baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP) and documented in the medical record. This was evident for 2 (Resident #51 and #3) out of 41 residents reviewed during the facility's recertification/complaint survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to the resident and/or RP and there must be evidence in the medical record that it was provided. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission.On 2/10/26 at 10:43 AM review of Resident #51's medical record revealed he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP and/or evidence from the medical record that a copy was given to the resident and/or RP.On 2/10/26 at 12:51 PM review of Resident #3's medical record revealed he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP and/or evidence from the medical record that a copy was given to the resident and/or RP.On 2/10/26 at 1:03 PM in an interview with the Director of Nursing (DON) when asked to describe the facility's BLCP process, she stated, They get a BLCP when they're admitted . We give them a copy within 48-72 hours. When asked where it was located, she stated, They don't print it out separately. They add to the BLCP as the comprehensive care plan and write a progress note it was given to the resident and/or RP. The surveyor requested a copy of the BLCP and evidence from the medical record that it was provided to the resident and/or RP for Resident #51 and Resident #3. On 2/10/26 at 1:35 PM in an interview with the DON, she stated, Those 2 we don't have evidence. Most of the time they [facility staff] write a progress note they [resident and/or RP] received it. Well, that's the policy that they're supposed to write a note. When asked if there was a copy of the BLCP summary for either resident she stated, I didn't see anything in medical records. The surveyor shared this was a concern and the DON acknowledged understanding of 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with facility staff, it was determined that the facility failed to ensure that physician orders were carried out accurately to ensure patient safety and quality care. This was evident for 1 (Resident #3) out of 5 residents reviewed for unnecessary medications during the facility's recertification/complaint survey.The findings include:The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's functional, medical, psychosocial and cognitive status. It is administered to all residents at admission, quarterly, annually, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident. MDS assessments must be accurate to ensure each resident receives the personalized and resident specific care they need.Brief Interview of Mental Status (BIMS) is a standardized test used to assess a resident's cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. On 2/11/26 at 8:19 AM review of Resident #3's medical record revealed he/she was admitted to the facility on [DATE] with diagnoses including, but not limited to, schizophreniform disorder, bipolar disorder, generalized idiopathic epilepsy, type 2 diabetes mellitus (DM) with foot ulcer, and unspecified intellectual disabilities. Further review revealed his/her MDS dated [DATE] documented a BIMS of 5 indicating severely impaired cognition. Continued review revealed an order for Insulin Aspart Injection Solution 100 UNIT/ML (milliliter) inject subcutaneously before meals for DM2. The order was written to obtain a fingerstick (to obtain blood glucose or blood sugar levels) before meals. On 2/11/2026 at 8:51 AM review of Resident #3's MAR (Medication Administration Record) revealed the following:-11/5/25 at 8:00 AM and 12:00 PM blood sugar (BS) was documented as NA with a chart code of 2. According to the Chart Codes, a 2 meant Drug Refused. -11/12/25 at 5:00 PM BS was documented as NA with a chart code of 9. According to the Chart Codes, a 9 meant Other/See Nurses Note. -11/14/25 at 5:00 PM BS was documented as NA with a chart code of 2.-11/17/25 at 5:00 PM BS was documented as X with a chart code of NI. According to the Chart Codes/Follow Up Codes, NI meant No insulin required. -12/19/25 at 7:30 AM BS was documented as NA with a chart code of 2.-12/19/25 at 12:00 PM BS was documented as NA with a chart code of 9.-12/28/25 at 7:30 AM BS was documented as NA with a chart code of 2.-1/26/26 at 5:00 PM BS was documented as NA with a chart code of 9.-1/29/26 at 8:00 AM and 12:00 PM BS and insulin were blank. There was no BS or insulin or documentation of any form for this date and times. -1/30/26 at 12:00 PM BS was documented as NA with a chart code of 9.On 2/13/26 at 1:58 PM in an interview with the Director of Nursing (DON) when asked for residents diagnosed with intellectual disabilities, what was the facility's expectation if they refused a medication, she stated, We're going to encourage. We're going to let the doctor know. We're going to let the RP know. Those contacts should be documented as a change in condition or progress note. During the interview when asked for residents diagnosed with intellectual disabilities, what was the facility's expectation if they were sleeping during medication administration, she stated, You could wait a little bit within the timeframe and come back later and see if they're still sleeping. If it's getting too late, you should attempt to wake the patient up. Additionally, the DON stated, No, it would not be acceptable to mark sleeping and not administer the medication. On 2/17/26 at 7:46 AM in an interview with the DON, a dual observation was conducted of Resident #101's November and December 2025 and January 2026 MARs. When asked what NA meant, she stated, What I get is the NA was put in because they didn't get a BS, so they just put 'NA' instead of just putting some kind of documentation explaining. When asked if for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each shift where NA was documented should the nurse have obtained a BS, she stated, Yes they should have gotten a BS. When asked if a resident sleeping was a legitimate/acceptable reason to not obtain the resident's BS, she stated no. When asked if for the shifts documented that Resident #101 refused, was there any documentation that the provider was notified, she stated, I didn't see any documentation. The surveyor shared these were concerns and the DON acknowledged understanding of the concerns.On 2/17/26 at 11:28 AM in an interview with the DON regarding Resident #3's Nov-Jan MAR and insulin, when asked why on 1/29/25 at 8:00 AM and 12:00PM the BS and insulin boxes on Resident #3's MAR, she stated, It probably means they didn't do it, but I have to verify.On 2/17/26 at 12:36 PM in an interview with the DON she stated, The boxes (1/29/26 at 8:00 AM and 12:00 PM) were blank because there was no documentation. During the interview when asked if the expectation was for nurses to carry out physician orders and document, she stated, Yes, the expectation is that the nurses are documenting the BS, that insulin was administered, and the amount of insulin administered. The surveyor shared this was a concern. The DON acknowledged and confirmed understanding of the concern.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on a record review and interviews, it was determined that the facility failed to ensure that residents received appropriate treatment to maintain vision abilities. This was evident for 1 (Resident #64) of 2 residents reviewed for communication and sensory problems during the recertification/complaint survey process.Findings Included:On 02/09/2026 at 1:00 PM: During an interview, Resident #64 reported experiencing visual impairment, a need to see an ophthalmologist, and that this request had not been fulfilled. The resident reported that the glasses at bedside did not work and special glasses were needed.On 02/11/2026 at 9:56 AM: Staff #22 (unit manager) was interviewed regarding the ophthalmologist process. She explained the standard procedure: after resident notify the the nurse of their concern, the nurse notifies the resident's healthcare practitioner for an assessment order, the order is placed in the computer, the unit secretary schedules the appointment, and the appointment is noted on the calendar. She stated she was unsure if the facility had an in-house ophthalmologist but would check.On 02/11/2026 at 10:32 AM: A review of the admission Minimum Data Set (MDS) assessment, completed on 8/26/2025, indicated the resident's vision (with glasses or visual appliances) was adequate.On 02/11/2026 at 10:45 AM: A review of progress notes revealed the following: 8/18/2025 (PCP Note): Vision was documented as WNL (Within Normal Limits - No abnormalities noted); 9/15/2025 (Nutrition Note): Resident #64 required setup/clean-up assistance related to vision loss; On 10/16/2025 (PCP Note): A note regarding a vision problem stated, Ophthalmology follow-up appointments should be scheduled as necessary. Ensure regular monitoring and evaluation by an ophthalmologist to address any concerns. Follow-up intervals depend on individual needs, medical conditions, and treatment; 02/10/2026 (Provider Note): Documented the patient's verbalization of Dry eyes, and new orders were written for artificial tears.On 02/11/2026 at 11:18 AM: In a follow-up interview, Staff #22 reported that the facility utilized one specific in-house ophthalmology company, and appointments were dependent on insurance qualification; otherwise, residents were sent to an outside ophthalmologist.On 02/11/2026 at 11:20 AM, in an interview with Geriatric Nursing Assistant (GNA#23), when asked she reported that Resident #64 was partially blind and required assistance with care.On 02/11/2026 at 11:38 AM, in an interview, the License Practical Nurse (LPN #17) reported the resident had glasses at the bedside that he/she reported did not work, but the resident had not specifically told the LPN about current vision issues. The LPN noted the resident was able to see her from a far distance down the hallway.On 02/11/2026 at 11:48 PM, in an interview, the Nurse Practitioner (NP#24) explained that the resident reported difficulty seeing and requested eye wash. NP #24 reported that she could not prescribe eye wash without an ophthalmologist assessment and had been attempting to schedule an appointment but was unsure about insurance coverage. Documented evidence supported the facility's awareness of the vision issues but showed a failure to obtain an ophthalmologist visit. NP #24 was notified that these findings were a concern.On 02/11/2026 at 12:05 PM, in an interview, the Director of Nursing (DON) was notified of the concern. She reported that the resident was being reviewed for an ophthalmologist assessment but was unsure of the conclusion. She was notified that there was no documented evidence to support that the facility had appropriately assessed and/or treated the resident's vision impairment issues.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and staff interviews, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, as evidenced by the failure to timely 1) implement physician orders pertaining to wound consultations or wound treatment, and 2) implement recommended wound care treatments following wound consultations. This was evident for 3 (Resident #14, #5, and #16) of 4 residents reviewed for wounds during the recertification/complaint survey.The Findings include: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 02/10/2026 at 3:09 PM, a review of Resident #14's progress notes revealed a late entry from 01/04/2026, at 1:05 PM. This entry documented a scheduled skin check during which a new skin impairment was noted: redness on the sacrum area. However, the notes lacked any further description of the skin impairment.On 02/10/2026 at approximately 3:16 PM, a continued review of Resident #14's medical record revealed a physician order dated 01/5/2026 for an in-house wound team consult.On 02/10/2026 at 3:19 PM, a further review of Resident #14's medical record revealed a wound consult dated 01/13/2026. This consult documented a stage 3 cluster wound in the coccyx region. The wound measured 1.00cm in length, 5.50cm in width (LXW 5.50cm), and 0.20cm in depth, with 40% slough and 60% granulation. However, the wound consult was completed 9 days after the initial physician order for the wound consult.On 02/11/2026 at 11:25 AM, a review of Resident #5's progress notes indicated a change in condition dated 09/17/2025 at 11:02 AM. The reported change was a skin wound or ulcer. The physician was informed and recommended the following treatment for the sacrum pressure ulcer: cleanse with normal saline solution (NSS), pat dry, apply Medihoney to the wound bed, followed by calcium alginate, and cover with a border foam dressing.On 02/11/2026 at 11:12 AM, a continued review of Resident #5's wound consult dated 09/19/2025 indicated a Stage 3 wound on the left buttock, acquired 09/17/2025, measured 1.00 CM x 2.00 CM x 0.20 CM (2.00 CM^2), with 100% granulation. Recommendations included daily and as-needed normal saline cleansing, medical-grade honey, and bordered foam.On 02/11/2026 at 11:34 AM, further review of Resident #5's treatment administration record for September 2025 revealed a physician order, dated 09/20/2025, for wound care to the left buttock pressure ulcer. The order specified to Cleanse with NSS, pat dry, apply medihoney to wound bed, and cover with border foam dressing every day shift. This physician order, however, was implemented 3 days after the wound was first identified and a physician treatment was given (on 09/17/2025).On 02/11/2026 at 11:48 AM, during an interview, the Director of Nursing (DON) confirmed that wound orders to include wound consults/physician orders should be implemented right away. The DON described the facility's wound identification process: a nurse evaluates the wound (including size, drainage, pain, and description) and calls the primary physician for treatment. The concern was shared with the DON at this time regarding timely completion of wound consults and implementation of physician orders for wounds.2) On 02/17/2026 at 8:57 AM, a review of Resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#16's physician order dated 01/20/2026 for the left dorsal foot (arterial ulcer) was reviewed: Cleanse with NSS, pat dry, apply Xeroform 4x4 and an ABD pad, and wrap with rolled gauze every other day for wound care and as needed for soilage. Monitor for infection. Offload in Prevalon boots as tolerated every day shift.On 02/17/2026 at 9:01 AM, a continued review of Resident #16's wound consult dated 02/10/2026 for the left dorsal foot specified: daily cleanse with soap and water, pat dry, apply Xeroform, cover with dry gauze/Kerlix, secure with tape, and maintain a Prevalon boot while in bed, per the surgeon's request and facility protocol.On 02/17/2026 at 9:19 AM, further review of Resident #16's February 2026 treatment record showed a wound care order for a left dorsal foot arterial ulcer (cleanse with NSS, apply Xeroform, 4x4, ABD pad, wrap with rolled gauze, monitor, and offload in Prevalon boots every other day) that started on 01/22/2026. However, this order was not updated, despite a 02/10/2026 wound consult that provided new, daily treatment orders.On 02/17/2026 at 10:00 AM, during an interview with the Director of Nursing (DON) regarding the wound consultation process. The DON stated that recommendations from wound consults are to be implemented immediately or, at the latest, by the following day. This process involves the DON and managers reviewing the recommendations, making necessary changes, informing the physician, modifying orders, and completing all required documentation. The concern was shared with the DON during this time.

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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 observations, interviews, and medical record review, the facility failed to provide necessary respiratory care, specifically the care of the oxygen nasal cannula. This was evident for 1 (Resident #12) of 1 resident reviewed for oxygen during the recertification/complaint survey.The findings include: On 02/09/2026 at 9:30 AM, during an observation, Resident #12 was lying in bed with oxygen at 2 liters via a nasal cannula. The oxygen tubing was not dated, and the oxygen concentrator did not have a humidifier attached.On 02/10/2026 at 9:00 AM, during an interview, Staff #7, a Licensed Practical Nurse (LPN), was asked about oxygen administration. Staff #7 (LPN) stated that a physician's order is required to change the nasal cannula, the oxygen tubing is changed every 24 hours, and staff also date the humidifier bottle. Staff #7 (LPN) confirmed the oxygen tubing was undated and no humidifier was in use. Staff #7 (LPN) reviewed Resident #12's orders with the surveyor present, which included a physician order dated 11/20/2025 for Oxygen 2 liters via nasal cannula as needed but lacked physician orders that detailed respiratory equipment care. On 02/10/2026 at 9:11 AM, during an interview with Resident #12 with Staff #7 (LPN) present, Resident #12 shared that his/her nose gets dry from the oxygen.On 02/10/2026 at 9:15 AM, during an interview, Staff #12, Registered Nurse (RN Unit Manager), described the oxygen administration process. She stated that oxygen therapy requires a physician's order that must include specific instructions for the care of the respiratory equipment, such as orders for the oxygen tubing and humidifier to be changed and dated weekly on Wednesdays. She expected an order for the weekly oxygen tubing change and humidifier to be in place. At this time the concern was shared with the unit manager.On 02/10/2026 at approximately 1:44 PM, a continued review of Resident #12's treatment administration record revealed a physician's order, dated 02/10/2026, for weekly, Wednesday night-shift changes and dating of oxygen tubing/water bottles, and washing of the filter, if applicable. However, prior to surveyor intervention, there were no respiratory care instructions for oxygen equipment for the preceding three months (November 2025, December 2025, and January 2026).On 02/10/2026 at 1:40 PM, during an interview, the Director of Nursing (DON) confirmed that a physician's order is required for the care of respiratory equipment, including oxygen tubing changes (weekly or as needed) and the humidifier. The DON acknowledged that physician orders for the respiratory care of oxygen equipment were only initiated after the surveyor's intervention. The concern was shared with the DON at this time.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews with facility staff, review of pertinent documentation and medical record reviews, it was determined that the facility failed to ensure providers responded to the monthly pharmacy review reports and took action to address the recommendations. This was evident for 2 (Resident #3 and # 8) of 6 residents reviewed for unnecessary medications during the facility's recertification/complaint survey.The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. 1) On 2/11/26 at 7:49AM in an interview with the Director of Nursing (DON) when asked about the facility's MRR process, she stated the pharmacist comes usually about the 3rd week of the month, she sends them, we [myself and the Unit Managers (UMs)] print them off to distribute to the physicians, we get them back, see what kind of order there is and make sure the orders are completed. I have a book I keep them in and we now put them in the resident's medical record. We started about 2 months ago. If there are any order changes, we do a change in condition so the family would know. During the interview when asked how the report was sent, she stated it was emailed to the Regional, herself and the UMs. When asked whose responsibility it was to print the MRRs, she stated, There is not one designated person, but since I've been here, I have printed them off and have them ready for clinical meeting. When asked about the process for the provider, she stated, We have a Nurse Practitioner (NP) and we're physically handing the printed MRRs to the her. Then, she physically hands them back to the UMs or myself. When asked the timeline for the provider to address the MRRs, she stated, 7-10 days. When asked who was responsible for discontinuing orders and/or putting in new orders, she stated the UMs. Additionally, she stated it was the facility's expectation that the provider checked one of the boxes (agree, disagree, other) and if they disagreed, the provider was to write a rational for why they disagreed. She also said the expectation was that the provider signed and dated the MRR. The surveyor requested MRRs from the past 6 months for Resident #3. On 2/11/26 at 9:12 AM review of the facility's Medication Regimen Reviews policy revealed, Physician Response 1. Upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. On 2/11/26 at 9:48 AM the DON provided MRR's dated 8/22/25, 9/21/25, and 11/16/25 MRR's for Resident #3. The recommendations were as follows: -8/22/25 Oxycodone HCl Oral Tablet 5mg (milligrams) Give 1 tablet by mouth two times a day for lower extremity pain. CMS (Centers for Medicare/Medicaid Services) encourages healthcare providers to co-prescribe naloxone for residents on narcotics. The resident is on a routine narcotic. Please consider adding naloxone -9/21/25 Uzedy Subcutaneous Suspension Prefilled Syringe 100 mg/0.28ml (milliliters) Inject 100mg subcutaneously one time a day every 2 months starting on the 20th for 1 days(s) for Schizophreniform disorder. Resident is due for gradual dose reduction (GDR) in an attempt to find the lowest (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effective dose. Please consider a trial dose reduction. If the medication cannot be reduced at this time, please check the appropriate rationale below related to the GDR being clinically contraindicated at this time and make a brief clinical rationale note that benefits outweigh the risks.The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility.An attempted GDR is likely to result in impairment of function or increased distressed behaviors.Other: (Please state below) -11/16/25 Cefepime HCl Intravenous Solution Reconstituted 2 gm Use 2 grams intravenously every 8 hours for wound infection. Please provide stop date for antibiotic therapy.Please add probiotic while on antibiotic therapy. On 2/11/26 at 10:02 AM review of Resident #3's medical record revealed the following for each recommendation: -8/22/25: The provider had checked agree and signed and dated the MRR and the resident had an active order for oxycodone; however, he/she did not have an active order for naloxone.-9/21/25: The provider has checked disagree and signed and dated the MRR; however, the provider did not check one of the 3 boxes the pharmacist's recommendation asked to be checked if they disagreed with the recommendation. Furthermore, the provider did not provide a brief clinical rationale note as to why they disagreed with the pharmacist's recommendation. -11/16/25: The provider checked other and wrote, Pt (patient) has stop date of 12/3/25. The first part of the recommendation was addressed and acted upon; however, the second part regarding probiotics was not responded to on the MRR report. On 2/11/26 at 11:57 AM in an interview with the DON the surveyor shared they had requested 6 months of MRRs for Resident #3 and had received MRRs for August, September and November 2025. The surveyor made a second request for the MRRs for October and December 2025 and January 2026. The DON stated, I'll check for these. On 2/11/26 at 1:16 PM in an interview with the DON stated there was no recommendations for Resident #3 for December 2025 and that the resident was in the hospital during the January 2026 review, so a MRR was not conducted because all his/her medications were discontinued. When asked about the October 2025 MRR, she stated, He/She did have one and it looks like it was missed. The surveyor requested a copy and shared this would be a concern. The DON verbalized understanding of the concern. On 2/11/26 at 1:23 PM the DON provided a copy of Resident #3's 10/26/25 MRR which the provider had not responded to. In an interview with the DON, she confirmed that the MRR report was not completed by the provider (no check for agree, disagree, other and no signature or date) nor was any action taken to address the recommendation. The surveyor shared this was a concern and the DON confirmed understanding of the concerns. On 2/17/26 at 7:33 AM in an interview with the DON, she stated The provider put the rationale for disagreeing in his psychiatry note, but I talked to him yesterday and told him he needed to put the rationale on the MRR report (for Resident #3's 9/21/25 MRR). During the interview she stated, Naloxone was ordered, but he/she went to the hospital, and it dropped off, so the NP put it back on. When asked if prior to surveyor intervention, the resident should have had a current, active order for Naloxone, the DON stated, Yes, the facility did still want him/her to have Naloxone since he/she's prescribed narcotics (for Resident #3's 8/22/25 MRR). Additionally, the DON stated, I spoke with the NP, and she didn't feel he/she needed a probiotic. So, I did tell her that she needs to complete the MRR report and address it in some kind of way (for Resident #3's 11/16/25 MRR). When asked about the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/26/25 MRR for Resident #3, the DON stated, I looked at that and don't see where the provider addressed that one, which I'll get him to do today. The surveyor shared the concern that this MRR was not addressed and almost 4 months later still had not been addressed. The DON acknowledged understanding of the concern. 2) During an interview on 2/11/26 at 7:49AM with the Director of Nursing (DON), when asked about the facility's MRR process, she stated the pharmacist conducted monthly medication record review and emailed the reviews to the Regional staff, the DON and the Unit Managers. The physician or facility Nurse Practitioner are given the medication reviews for reconciliation, and a copy is given back to the DON or the Unit Managers to be placed in an MRR binder. When asked for the timeline for the provider to address the MRRs, the DON stated, 7-10 days. The DON also stated that the facility's expectation is that the provider would check one of the boxes (agree, disagree, other) and if they disagreed, the provider would write a rational for why they disagreed and that the provider signed and dated the MRR. On 2/12/2026 at 8:39 AM, the DON provided the Medication Regimen Review (MRR) for August 2025 – December 2025 for Resident #8, which revealed the following: The MRR dated 10/26/2025 had a psychiatry recommendation for Olanzapine tablet dispersible 10 MG give 1 tablet by mouth at bedtime for Paranoid Schizophrenia, ordered on 6/19/2025. It stated that the resident is due for a gradual dose reduction to find the lowest effective dose. Please consider a trial dose reduction. The form was blank for agree, disagree, and other. There was no response noted and no signature and date noted. The MRR dated 1/19/2026 had a physician recommendation for Trazadone HCL tablet 50 MG Give 1 tablet by mouth at bedtime for depression/insomnia (take one tablet at bedtime) ordered on 10/2/2025. The recommendation was that if an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat a psychiatric disorder, it must be reviewed for a possible gradual dose reduction in an effort to find the lowest effective dose. If a dose reduction is deemed clinically contraindicated at this time, please state the rationale below and the risk vs. benefit of continuing the drug at the current dose. The signed and dated form was checked off as disagree, but there was no written response to the brief clinical rationale note if disagree. On 2/12/2026 at approximately 10:00 AM, the physician's progress notes for Resident #8 failed to address a disagree reason for the Trazadone 50 MG tablet GDR. In addition, there was no indication that the medication regimen review recommendations for Olanzapine 10 MG tablet were completed. On 2/12/2026 at 10:32 AM, the DON was made aware that there was a concern regarding the reconciliation of the MRRs. The DON 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 observations, record review, and interview with facility staff, it was determined that the facility failed to ensure the medication error rate was less than 5%. This was evident for 2 medication errors out of 37 opportunities which resulted in a medication error rate of 5.41%. The findings include: A Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:1. The prescriber's order;2. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or3. Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils.1) On 2/11/26 at 9:13 AM the surveyor observed Licensed Practical Nurse (LPN #11) prepare medications to administer to Resident #32. The medications included Methadone and LPN #11 stated she was going to administer 75 mgs (milligrams) of Methadone and passed the Methadone container to the surveyor. At that time the surveyor noticed that the bottle was labeled 74mgs. At 9:26 AM LPN #11 stated she had finished dispending the medications and was about to enter Resident #32's room to administer the medications. The surveyor asked LPN #11 to read the dosage on the Methadone bottle, and she stated, Methadone 74 mgs. LPN #11 did not register that there was a discrepancy. The surveyor asked LPN #11 to read the Methadone dosage from the order. LPN #11 looked at her computer and stated Methadone 75mg; however, did not register there was a discrepancy. After surveyor intervention, when asked if the dosage on the Methadone container matched the dosage on the order, LPN #11stated, No, it doesn't match. I'm going to hold onto this and talk to my unit manager. The surveyor shared this was a concern and LPN #11 acknowledged understanding of the concern.Review of Resident #32's medical record on 2/11/26 at 11:32 AM revealed a physician order dated 9/15/25 for Methadone HCl (hydrochloride) Oral Solution 5 MG/5ML (milliliter) Controlled Drug Give 75 mg by mouth two times a day for maintenance. On 2/11/26 at 2:58 PM in an interview with LPN #11 when asked about Resident #73's Methadone, she stated, I checked the paper that comes with the Methadone bottles. I looked in the new pack, and it was a 74/75mg split of 28 total doses; 14 were 74 mg and 14 were 75 mg. We tried to call the center, but it was closed so we talked to the Nurse Practitioner (NP) and the resident because he/she is alert. The resident said the center told him/her they were going to send a 74/75 split, so the NP updated that going forward he/she will get 75mg in the morning and 74mg at bedtime. For today, the NP put in a one-time order for 74 mg in the morning and evening because there are two doses left and they are both 74 mg. 2) On 2/11/26 at 10:28 AM the surveyor observed Registered Nurse (RN #13) administer medications to Resident #73. During the administration, RN #13 gave Resident #73 a dose of his/her Ellipta inhaler. After receiving his/her puff of the medication, Resident #73 took a sip of water. RN #13 failed to provide instructions to Resident #73 regarding rinsing his/her mouth with water and expectorating (spitting) after, and Resident #73 did not do so. Review of Resident #73's medical record on 2/11/26 at 1:23 PM revealed a physician order dated 1/24/26 for Anoro Ellipta Inhalation Aerosol Powder Breath Activated 62.5-25 MCG/ACT 1 puff inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease) Rinse mouth with water and expectorate after use.On 2/11/26 at 1:51 PM in an interview with RN #13, the surveyor shared the concern that Resident #73's order for the Anoro Ellipta inhaler had instructions to rinse mouth with water and expectorate after use, and the resident was not observed following those instructions. RN #13 acknowledged and verified understanding of the concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with facility staff and residents and review of the medical record, it was determined that the facility failed to ensure medications were stored properly. This was evident for 1 (Resident #51) out of 41 residents reviewed during the facility's recertification survey.The findings include:On 2/10/26 at 11:10 AM in an interview with the Nursing Home Administrator (NHA), who had just finished speaking with Resident #51, she stated, He/she's a hoarder and he/she's an admitted hoarder. He/she has a safety inhaler in his/her pocket. He/she always has one. The surveyor asked, The resident always has an inhaler? for clarification. The NHA replied, He/she had one just now when I was down there. When asked if there was medication in the inhaler, the NHA stated, I didn't really look. I guess I should have, but I saw a blue inhaler in his hand. When asked if residents should have medications at the bedside, she stated, If they have an order. I don't even know if he has an order to keep meds at the bedside. I'll check with [Director of Nursing's first name] to see if he/she has that order. On 2/10/26 at 11:26 AM in an interview with Resident #51, he/she verified and confirmed he/she had his/her rescue inhaler, albuterol with medication in it in his/her pocket but refused to show the surveyor. During the interview Resident #51 stated he/she was going to have his/her medication on him/her in case he/she could not breathe. Furthermore, he/she stated that he/she was not going to rely on some nurse down the hallway to give him/her his medication, he/she would decide when he/she needed it. On 2/10/26 at 1:01 PM review of Resident #51's medical record revealed he was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, heart failure, and other nonspecific abnormal finding of lung field. Further review revealed an assessment completed on 1/5/25 Atlas- NSG (Nursing): Admission/readmission Evaluation. In the Self Medication section, was the following question: Does the resident WANT to Self-Administer his/her own medications? and No was marked. Continued review revealed an order for Albuterol Sulfate HFA (hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) MCG (microgram)/ACT (actuation) (Albuterol Sulfate) 1 puff inhale orally every 4 hours as needed for Wheezing r/t (related to) COPD; however, failed to reveal an order for self-administration of any medication(s). Furthermore, in the Albuterol Sulfate order, the section titled, Administered By had 4 options: 1) Clinician, 2) Assisted Non-Clinical Staff, 3) Supervised Self-Administration, and 4) Unsupervised Self-Administration and on the order Clinician was selected. On 2/10/26 at 1:31 PM the above concerns were shared with the NHA who acknowledged understanding of the concerns.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record observation and interviews, it was determined that the facility failed to serve food at an appetizing temperature. This was evident during the completion of the kitchen facility task during the recertification/complaint survey. Findings Included:On 02/09/2026 at 9:12 AM: Resident #10 reported hot foods were not hot. Resident #12 reported that food was sometimes served hot and sometimes not, and the taste was poor.On 02/09/2026 at 12:46 PM, another resident, Resident #4, reported that food was being served cold and sometimes it is due to the wait for assistance with feeding.On 02/13/2026 at 08:50 AM, the Food Service Director was informed to provide a test tray (sample tray) on the last food cart for delivery to the unit during the lunch time.On 02/13/2026 at 12:30 PM, observation of the last food cart delivery to the Terrace unit began. Lunch tray service started at 12:36 PM. The surveyor observed staff deliver all resident trays before removing the last tray (test tray) from the cart.On 02/13/2026 at 12:44 PM: The surveyor pulled the test tray/sample tray as served from the delivery cart.On 02/13/2026 at 12:53 PM: Test tray temperature results were recorded using two thermometers: Candied Sweet Potatoes measured 115.3 degrees/112.8 degrees; Fish measured 108.5 degrees/107.7 degrees; and Vegetables measured 108.1 degrees/105.0 degrees.On 02/13/2026 at 2:13 PM: The Director of Nursing (DON) was informed that the warm lunch test tray temperatures were low/abnormal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the kitchen tour and staff, it was determined that the facility failed to ensure that stored food items were labeled and were not expired. This was evident during the initial kitchen tour during the recertification/complaint survey. Findings Included:During the initial kitchen tour on 02/09/2026 at 7:44 AM, the following deficient practices were revealed:An initial observation of the kitchen staff revealed that one staff member, Staff #27 (the cook) was preparing breakfast; however, Staff #27 did not wear a hairnet as required.On 02/09/2026 at 7:54 AM, An observation of the refrigerators revealed the following conditions: Wholesome Farm Low-Fat Cottage Cheese (5 lbs): One open container was present. A second, un-opened container, both had a Best If Used By date of 1/30/2026; Prepared Cheese: A container was labeled with a prep date of 1/3/26 and a Used By date of 1/27/2026; Sysco Classic Sliced Strawberries (5 lb): An open container lacked an expiration date; Sysco Imperial Thickened Apple Juice (1.36 L): An open box container had a Best If Used By date of November 2025; Marinara Sauce: A large plastic container, identified by the cook as marinara sauce, lacked an open or expiration date/time; Fruit Cocktail: A plastic container lacked an open or expiration date; Chicken Gravy: A metal storage container with a white/cream sauce, identified as Chicken gravy by Staff#27 (cook), lacked an open or expiration date; Pre-Made Sandwiches: Staff identified grilled cheese, turkey and cheese, and peanut butter sandwiches; all were observed without dates or proper labels. A wilted head of lettuce had a Used By sticker date of 02/02/2026. Saran-wrapped, wilted, sliced raw red onions had a Used By sticker date of 1/26/2026.On 02/09/2026 at approximately 08:00 AM, in an interview with Staff #28, he stated that everyone is responsible for checking the date of each item to make sure they are used by the expiration date or thrown away if unused.On 02/13/2026 at 8:50 AM, in an interview with the food service director, he was informed of the surveyor finding as it relates to the above-mentioned concern.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, it was determined that the facility failed to maintain the medical records on each resident that was accurately documented. This was evident for 2 behavioral monitoring assessments reviewed in the January 2026 Medication Administration Record (MAR) during the recertification/complaint survey.Findings included:On 02/09/2026 at 1:00 PM, Resident #64 was observed to be irritable and easily agitated (stating he/she wants to leave the facility immediately) during the initial interview.On 02/17/2026 at approximately 11:04 AM, a review of Resident #64's Psychiatric services progress notes on 1/12/2026 revealed Resident presented today as frustrated, irritable, and angry. yelled at therapist, I want to leave here ASAP! The resident complained of sleep difficulty and fatigue. A psychiatric evaluation on 12/30/2025 indicated depression and Anxiety and the treatment plan included continue current treatment plan and routine monitoring of mood and behavior. Follow-up as clinically indicated.On 02/17/2026 11:22 AM, a review of Resident #64 physician's orders on10/3/2025 stated every shift for Behavior Monitoring Document: Frequency of episodes, interventions and outcomes. Intervention Codes:0=None, 1=Redirect, 2=Remove from situation/Ensure Rt. Safety, 3=Provide calm environment,4=Activity, 5=Reapproach, 6=Offer Food/Drink, 7=Toilet 8=Provide Comfort, 9=1:1 A review of January 2026 MAR revealed that there was no documented evidence of behavioral issues for two dates: January 1/8/2026 (evening shift) and 1/16/2026 (day shift) that noted behaviors were present but then no further documentation about the behaviors noted by staff. There was also no documented evidence of the interventions provided related to the behaviors indicated on the MAR. On 02/17/2026 at 11:35 AM, in an interview with the Director of Nursing (DON), she was asked about the above-mentioned findings, and she stated that she was not sure what the documentation on the medication Administration Record (MAR) indicated. She was asked to further investigate what behaviors were identified by staff on the above-mentioned dates and she reported back that the documentation didn't clarify their findings. The DON agreed that if the nurses identified that behaviors were observed then there should be additional description about what was observed and then what treatment was provided, if necessary. She was notified that the documentation was not accurately completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215054	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towson Rehabilitation and Healthcare Center	509 East Joppa Road Towson, MD 21286

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and medical record review it was determined the facility failed to: 1) ensure staff donned appropriate personal protective equipment (PPE) during wound care for resident who was on Enhanced Barrier Precautions and entering residents' room who was on Droplet Precaution, 2) use appropriate infection control practice when performing wound care. This was evident for 1 (GNA #5) out of 1 employee observed entering the Droplet Precautions room and 1 (LPN #26) out of 1 employee conducting wound care during the recertification survey. The findings include: Droplet Precautions are infection control measures designed to prevent the spread of germs (viruses/bacteria) transmitted through short-range, large-particle respiratory droplets (coughing, sneezing, talking). They require the following PPE: a surgical or procedure mask, eye protection, gown, and gloves. Enhanced Barrier Precautions (EBP) involve the use of gowns and gloves during high contact care activities. This practice is specifically aimed at residents with wounds or indwelling medical devices. 1) On 2/9/26 at 8:19 AM the surveyor observed a Droplet Precautions sign outside of Resident #51's room. Review of the sign revealed, STOP Droplet Precautions STOP. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit. On 2/9/26 at 10:13 AM review of Resident #51's medical record revealed an order for Droplet Isolation Precautions. Every shift for RSV (Respiratory syncytial virus) for 10 Days. Order date: 2/5/26. On 2/10/26 at 8:55 AM the surveyor observed Geriatric Nursing Assistant (GNA #5) entering Resident #51's room to pick up and remove a meal tray wearing only a mask. On 2/10/26 at 8:59 AM in an interview with GNA #5, when asked if she just came out of Resident #51's room and if she knew he/she was on Droplet Precautions, she stated, Yes. I didn't know I was supposed to put on a gown. I thought that was only if I was going to like wash him/her up. The surveyor shared this was a concern. GNA #5 acknowledged understanding of the concern. When asked how long she worked at the facility, she stated, A few months. When asked if there was a designated Infection Preventionist, she stated, I'm not sure. 2) On 02/09/2026 at 11:12 AM, the surveyor noted an Enhanced Barrier Precautions (EBP) signage on Resident # 89's door indicating that staff need to wear personal protective equipment (PPE) such as gloves and gowns during high-contact resident care activities. On 2/10/2026 at 1:12 PM, the surveyor observed Staff #26 with treatment cart outside of Resident #89's room and gathering supplies for a dressing change. Staff #26 placed 2 pairs of gloves on his/her hands and entered room where resident was turned on the side for a wound dressing change. Staff #26 removed the old dressing and cleansed the wound and then removed the top pair of gloves and proceeded with placing the new dressing on the wound. Resident #89's record review on 2/10/2026 at 2:18 PM indicated an order for Enhanced Barrier Precautions for wound every shift. Cleanse Coccyx cluster with soap and water, pat dry, apply santyl and Calcium Alginate. Apply barrier cream to periwound and cover with bordered foam Q daily and PRN written on 1/14/2026. (continued on next page)

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	215054	A. Building B. Wing	02/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2026 at 12:30 PM with unit manager, Staff #22, stated that staff must wash hands and put on proper PPE when performing wound care for a resident. Staff #22 also stated that during the wound care, after the old dressing is removed, staff must remove gloves and wash hands or use hand sanitizer and place a new pair of gloves before placing the clean dressing onto the wound. In addition, Staff #22 stated that there is ongoing training for use of PPE and proper wound care treatment. On 02/13/2026 at 1:48 PM, during an interview with the DON, she stated that the proper procedure steps for wound care are to gather supplies, put on PPE, when in the room, set up supplies for the wound care. when the old dressing is removed, staff must remove gloves, wash hands or use hand sanitizer and put on a new set of gloves and proceed with the wound care. On 02/13/2026 at 1:52 PM, the surveyor shared the concern with the DON that a staff member was observed not wearing PPE and double gloving during wound care. The DON stated that the facility is going to have Healing Partners, the facility wound care partner, conduct wound care treatment to all staff.