STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215055	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Healthcare Center	512 Winifred Road Cumberland, MD 21502

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 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 review and interview, it was determined that facility staff failed to ensure that their resident's were treated with dignity and respect. This was evident for 1 (#2) of 4 residents reviewed for abuse. The findings include: A medical record review for Resident #2 on 5/26/26 at 1:54 PM revealed a discharge summary from the hospital dated 1/7/26 that documented the resident had a debridement of a right heel wound. The resident was ordered Percocet 5-325 mg noted the resident was ordered to take 1 tablet of oxycodone and Tylenol combination drug commonly referred to as Percocet 5-325 mg (5 mg of oxycodone and 325 mg of Tylenol) every 4 hours for pain as needed. A progress note dated 1/7/26 at 8:37 PM documented the resident had been readmitted to the facility. On 1/8/26 at 1:11 AM Licensed Practical Nurse (LPN) #11 wrote that the resident was upset because s/he had asked earlier for pain medication and was offered Tylenol for pain while awaiting the pharmacy to drop off Percocet. She further noted that when she took the Percocet to the resident, they became upset again because they thought it should be 2 tablets instead of 1. She wrote she attempted to explain it to the resident. On 5/26/26 at 1:35 PM a review of the facility's investigation file for facility reported incident 2711325 was conducted. A review of the final report revealed the resident accused Registered Nurse (RN) #8 of slamming discharge paperwork onto his/her chest. A review of RN #8's statement revealed that she wrote that when the resident accused her of abuse, I left the room, yelled down the hallway that resident stated I hit him and the police needed called. Review of Certified Nursing Assistant II (CNA II) #10's statement revealed she wrote that at 3:15 AM, I heard yelling. It was [RN #8] coming out of room [resident's room number] yelling call 911 [Resident #2] said I hit him. LPN #11 wrote in her statement that, I heard [RN #8] coming out of the resident's room yelling in the hall that the residents stating that she hit [him/her] & to call the cops. An interview with Resident #2 on 5/27/26 at 9:46 AM revealed that in response to a question as to whether staff treated him/her with dignity and respect, they stated that the night they were re-admitted staff had not. The resident reported that they felt RN #8 became very angry with him/her because the resident was trying to tell facility staff that the hospital was giving him/her 2 tablets of Percocet. The resident stated that all s/he wanted was to get the correct amount of pain medication because they were in a great deal of pain. The resident confirmed that RN #8 went out of the room yelling down the hallway, so staff and other residents could hear that s/he accused her [RN #8] of abuse and to call the police. During an interview with LPN #11 on 5/26/26 at 4:25 PM, via telephone, she confirmed that RN #8 came out of the room and was yelling down the hallway to the nurses' station what the resident said and that they needed to call the cops. She stated when RN #8 arrived at the nurses' station and started to call the cops, she stopped her and reminded her to call the DON first. An interview with RN #8 on 5/26/26 at 4:03 PM, via telephone, revealed she was not sure if she yelled down the hallway and what she said. Once her statement was read to her, she stated that the statement was true. On 5/27/26 at 11:49 AM the investigation was reviewed with the DON. She reported she did not think that RN #8 yelled down the hallway to intimidate the resident but that she takes abuse allegations seriously. She agreed that it was not appropriate for staff to yell what the resident said in the hallway so others could hear what was going on.

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

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interview, it was determined that the facility failed to implement an effective discharge planning process. This was evident for 4 (#4, #8, #9, and #10) of 5 residents reviewed for discharges. On 5/21/26 at 2:05 PM, an immediate jeopardy (IJ) was declared for the facility's failure to ensure that post-discharge services were set up for Resident #4 prior to their discharge date . An IJ summary tool was provided to the facility. The facility submitted a plan for removal at 2:10 pm that was not accepted, the second draft submitted at 3:09 pm, the third submitted at 4:05 pm and fourth submitted at 4:44 pm were not accepted. On 5/21/26 at 5:55 PM, the facility staff submitted an IJ removal plan to the Office of Health Care Quality (OHCQ) which was accepted, The IJ was removed on 5/22/26 at 3:30 PM after confirmation that the accepted plan had been fully executed. After removal of the immediacy, the deficient practice remained at a scope and severity of E. The findings include: The discharge care plan is part of the comprehensive care plan and must:Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;Address the resident's goals for care and treatment preferences;Identify needs that must be addressed before the resident can be discharged , such as resident education, rehabilitation, and caregiver support and education;Be re-evaluated regularly and updated when the resident's needs or goals change;Document the resident's interest in, and any referrals made to the local contact agency; and Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance. 1. A medical record review for Resident #4 on 5/19/26 at 12:20 PM for Resident #4 revealed an admission MDS (minimum data set) with the assessment reference date of 3/10/26 that documented the resident had moderately impaired cognition. On 3/13/26 a discharge care plan was initiated for the resident's decision to return to the community. The goal was the resident would understand and verbalize the discharge plan. There was no evidence that the discharge care plan was developed by the Interdisciplinary team. The resident's goals for care and treatment preferences were not included. The interventions failed to include resident-specific interventions. The resident care plan failed to identify the discharge location or post-discharge care needs: such as medical equipment or home health services. In addition, there was no evidence that the team re-evaluated the care plan regularly and updated with resident's care needs and goals. On 3/26/26 the Social Worker (SW) #5 documented that the resident had decided to appeal the insurance's decision to end coverage. On 3/31/26 Nurse Practitioner (NP) #6 completed the home health certification and certification statement that documented the resident needed the following post discharge services: skilled nursing wound management, physical therapy, occupational therapy, and a home health aide. SW #5 wrote on 4/3/26 that the resident had lost her appeal to the insurance company and wanted to move forward with the second appeal and she wanted to learn more about LTC (long term care) medicaid. On 4/16/26, 3 days after the resident discharged , SW #5 wrote a note that was a late entry for 4/9/26 that stated the resident decided not to appeal the second time and that SW #5 asked the resident if s/he wanted to be discharged home since s/he was not appealing. She noted the resident had not taken care of his/her wounds in the past and agreed to discharge home with home health services. On 4/16/26 SW #5 wrote a second note as a late entry for 4/13/26 that stated the resident was discharged home and she was sending a referral for home health services. However, this information had not been added to the discharge care plan. Facility staff failed to develop and implement a post discharge care plan with the resident and their representatives input. There was no documentation of the resident's interest in community resources instead it was noted that community resource phone numbers were provided. Furthermore, on 4/13/26 the resident was discharged home without skilled nursing wound management, physical therapy, occupational therapy, and home health aide services in place that the NP documented the resident needed post discharge. On 5/19/26 at 11:45 AM a review of complaint (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3010520 revealed the complainant reported Resident #4 was unsafely discharged home. They reported the resident was unable to safely stand, ambulate, and attend to their ADLs (activities of daily living such as bathing, preparing and eating food, toileting, etc.) at the time of discharge. Reportedly the resident fell on the day s/he returned home and was not found for 3 days. A review of the emergency department (ED) and hospital course medical records on 6/11/26 at 8:00 AM, for Resident #4, revealed s/he was brought to the ED on 4/16/26 by EMS (emergency medical services) staff and they reported the resident was found on the floor of his/her apartment with large amounts of vomit and urine. They documented the family member who found the resident on 4/16/26 reported to them that no one had heard from or seen the resident since they were discharged from the facility and that the resident was wearing the same clothing that s/he was wearing on 4/13/26 when s/he was discharged from the facility. The resident was found to be hypotensive (low blood pressure), hypothermic (low body temperature), and was diagnosed with traumatic rhabdomyolysis, acute kidney injury, and cellulitis in both lower legs. Rhabdomyolysis is a condition in which muscle tissue starts to break down and can be caused by injury, prolonged immobilization, and extreme exercise with no breaks. The condition can be fatal when not treated. Per ED report the resident stated that s/he was to have wound care for his/her lower legs, but had not had that done since discharge from the facility. A review of the hospital course records revealed the resident was admitted to the intensive care unit and then transferred to a regular floor and the resident spent a total of 15 days in the hospital before being transferred to another skilled nursing facility for rehabilitation. The complainant was interviewed on 5/19/26 at 11:56 AM. During the interview, the complainant reported that the home health agency tried to call Resident #4 on 4/15/26 to set up a visit but was unsuccessful. On 4/16/26 they tried to call again and with no response they decided to try to visit the resident at home. The home health nurse reportedly went to the resident's home address and was unable to gain access to the building to knock on the resident's door. The complainant said that the home health agency called her and she called someone to conduct a welfare check on the resident. At which time the resident was found lying on the floor inside the door of the apartment. The resident was transported to the hospital via 911. An interview with SW #5 on 5/19/26 at 3:20 PM revealed that the process for discharging a resident home and in need of durable medical equipment and/or home health services was to send the referrals the day of or day after discharge. SW #5 reported that the home health agency that they used told her not to send the information before that time. When asked how the facility ensures that the resident has the needs and services post-discharge she stated that she sent the referral and after that it was up to the home health agency. When asked about Resident #4 she reported that she sent the referral on 4/13/26, however she had no evidence that she sent it on that day. On 5/19/26 at 4:02 PM the clinical manager of the local home health agency was interviewed via a phone call. She explained that a resident needed an established primary care provider (PCP) in the community who had seen them recently to obtain an order for home health services. She explained it was acceptable to send referrals prior to the discharge date and they were placed in a pending file. She further explained that although they were in the pending file the home health agency staff worked on those referrals to ensure that when the discharge occurred they were ready to start the services. She stated that as long as the resident had a PCP, they needed 48 hours to confirm services would start at the time of discharge. When asked about Resident #4, she reported that they received the referral on 4/14/26. She stated that while it was not their normal process, they attempted to call this resident on 4/15/26 because they were familiar with the resident and knew they had trouble taking care of themselves at home. They were unable to reach the resident on 4/15/26 and 4/16/26 by phone, so they attempted a home visit and it was unsuccessful. Prior to leaving the residence they called the emergency number listed for the resident and made them aware. The emergency contact told the home health nurse that they had not spoken to the resident since 4/13/26 and was going to call someone to do a welfare check. The home health nurse left the residence; however, they were informed later that the resident was found lying on the floor inside the residence during the welfare (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	check. During an interview with the Rehab Director, who was an Occupational Therapist (OT), on 5/20/26 at 3:49 PM it was revealed that they had not made a home visit to Resident #4's home to ensure the resident could safely transition home. She stated that they provide rehab services that assist residents to meet their goals to become more independent while in the facility. They rely on the resident and/or resident families report of the home environment to work on some goals for discharge; however, a community rehab team needed to evaluate them in the home to ensure a safe discharge. The Nursing Home Administrator (NHA) was made aware of the concerns on 5/19/26 at 4:47 PM. She reported that she was unaware that home health and therapy services could be set up prior to discharge. She stated that it had taken weeks for some of their residents to be seen after discharge by home health. The facility's provisions of the plan to remove the immediacy included the following: The residents identified during the survey (Resident #4, #8, #9) no longer reside at the facility. Identified one resident who wished to sign out against medical advice (AMA). The resident was educated regarding the risks, benefits, and potential negative outcomes associated with leaving AMA including a possible decline in their medical condition and interruption of treatment. Resident/Resident Representative verbalized understanding of the information/education provided and elected to proceed with signing out AMA. Community referrals were sent today, 5/21/26, by the Nursing Home Administrator for any upcoming resident discharges, as well as discharges in the past 30 days to ensure all community referrals are in place prior to discharge. All discharges will be reviewed upon admission and weekly with updates documented on the plan of care by the interdisciplinary team to identify required post-discharge services to include: home health, durable medical equipment, outpatient therapy, dialysis, physician follow-up appointments, community resources, medication management and support, and hospice or palliative services, when applicable. The NHA will confirm that the discharge audit tool is completed at least 24 hours prior to discharge to ensure the services are in place prior to discharge. If the resident refuses to stay until the recommended services are put in place and despite identified risks, the resident/resident representative will sign out AMA on appropriate form with the required documentation. Social Services staff and interdisciplinary team received immediate reeducation by the NHA regarding the transfer and discharge regulations. The NHA will conduct an immediate audit of all current pending transfers/discharges to ensure compliance with safe discharge planning and ensure appropriate documentation is in place weekly times 4 weeks and then monthly for 3 months or until substantial compliance is met with results reported to Quality Assurance and Performance Improvement (QAPI). Compliance date of 5/21/26. On 5/22/26 at 9:15 AM, an onsite visit was conducted. After validation of the implementation of the facility's plan of removal, which included staff interviews and record reviews, it was determined the facility met the minimum standards of compliance to remove the findings of an Immediate Jeopardy on 5/22/26 at 3:30 PM. 2. On 5/20/26 at 12:18 PM a medical record review for Resident #8 revealed a progress note that the resident was admitted to the facility for management of chronic medical conditions and wound management and the resident had left side hemiparesis following a previous stroke. On 2/17/26 a discharge care plan was initiated for the resident's decision to return to the community/other location. The goal was the resident would be discharged to an appropriate location for physical and cognitive status. An intervention was entered on 2/17/26 that facility staff will determine the equipment needed and facilitate obtaining the equipment. This was not resident specific and was not updated with what the resident actually needed post-discharge. On 3/4/26 a care planning meeting note entered by SW #5 revealed the resident's wishes were to go home, however, the interdisciplinary team failed to update the care plan to reflect this and formulate a care plan to help the resident achieve this goal if possible. There were no other discharge planning progress notes entered until 4/9/26 when SW #5 wrote that she asked the resident about their discharge plans when the resident's skilled nursing coverage ends. On 3/31/26 NP #6 completed a home health certification and certification statement that documented the resident needed the following services post-discharge: skilled nursing for medication teaching, (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physical, speech, and occupational therapy, and a home health aide to provide personal care. Sw #5 wrote a note on 4/13/26 that documented it was the resident who requested a high back wheelchair, mechanical lift, and a hospital bed. There was no evidence that the IDT determined the post discharge equipment that the resident needed. On 4/15/26 SW #5 documented that the resident wanted to discharge home when appropriate and when s/he [the resident] had a community care plan in place. In this note the SW noted that the resident and family member were concerned that the family member had health issues of their own and may not be able to provide care for the resident even with a second family member willing to help out. However, there was no evidence this concern was addressed in the discharge care planning. The SW provided a copy of the Notice of Noncoverage issued to the resident that stated the last day of coverage was 4/17/26, however the signature page was not included and it was unclear which date it was issued. There were no progress notes written as to when the notice was given and that the appeal process was discussed with the resident. Per SW #5's progress notes the resident was back and forth about hospice at home and long-term care options. On 4/23/26 an intervention was added to discharge the resident home on 4/24/26, but there was no evidence that a post discharge care plan was developed and implemented before the resident was discharged home. A review of the resident's referral packet on 05/20/2026 2:51 PM revealed a fax cover sheet that had no date on it. There was a fax transmittal sheet that indicated the fax was sent on 4/24/26 the day the resident discharged home. A telephone interview on 5/22/26 at 2:51 PM with the home health clinical manager revealed they had not received the referral prior to 4/24/26 because the resident was not in their pending list and that services were ready to start as of 4/27/26, 3 days after the resident was discharged . On 5/20/26 at 3:49 PM an interview with the Rehab Director revealed that during the Utilization Review meeting they discussed the resident and his/her needs prior to discharge. She reported that the resident had a family member who was actively involved with the resident's care and training was provided for him during therapy. The resident used a slide board for transfers. However, this resident needed home health services, including therapy, and best practice was to have this available upon discharge. She reported a delay of 3 days may have caused the resident to decline functionally. An interview on 5/21/26 at 10:03 AM with the Nursing Home Administrator (NHA), SW #5, and the Director of Nursing was conducted. The NHA stated that she had been reading the [previous discharge regulations] and could not find the information presented by the surveyor as discharge requirements. She was unaware of the current Federal Regulations for appropriate discharge planning. SW #5 confirmed she sent the home health referral on 4/24/26 and reported that she was not sure how she was supposed to secure the post-discharge needs for their residents prior to discharge. The DON reported that the resident's family member was quite involved with the resident's care, often providing care while the resident was at the facility and was able to provide the care at home. However, this was contrary to the information provided by therapy staff who had been involved with training the family member. 3. On 5/20/26 at 11:10 AM a medical record review for Resident #9 revealed that on 3/19/26 a care plan was initiated that the resident wished to return home when safe and appropriate. The goal was that the resident would be discharged to the appropriate location based on physical and cognitive status which was not a resident centered goal. The interventions were not resident specific and generalized. On 4/16/26 SW #5 wrote a note effective for 4/6/26 which documented the resident lost an appeal regarding insurance noncoverage and was going to talk to the business office to apply for Medicaid to stay long term. However, she failed to document when the Notice of Noncoverage had been given to the resident or if the resident chose to file the second appeal. On 5/4/26 the resident's attending physician completed a home health certification and certification statement that documented the resident needed skilled nursing for medication teaching and wound management, in addition s/he needed physical and occupational therapy services and a home health aid for personal care needs. There was no evidence that staff developed and implemented a post discharge care plan for the resident. There was no evidence that the resident's interest in community resources was identified (continued on next page)

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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 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, record review and interview, it was determined that staff failed to provide nursing services for residents that met the standards of professional practice. This was evident during 1 random observation of nursing unit 1. The findings include: 1) On 05/19/26 at 11:04 AM Certified Nursing Assistant (Aid) #9 was observed asking Resident #14 if the resident had brought back his/her medication yet. The resident responded no and Aid #2 reassured the resident that the nurse was aware and would be back shortly. The resident was observed to be sitting up in bed, pursed lip breathing with use of accessory muscles and appeared restless. The resident was asked what s/he needed and s/he reported s/he had requested his/her inhaler because s/he was having trouble breathing. The resident reported they were unsure of the time it was requested. An interview with Aid #9 at 11:11 AM revealed about 5 minutes ago she had reported to Certified Medicine Aid #13 that the resident was asking for their inhaler because they were having trouble breathing. On 5/19/26 at 11:16 AM the surveyor stopped by and asked Resident #14 if the nurse had come in yet and the resident reported no. CMA #13 was observed in the hallway stocking the medication cart. On 5/19/26 at 11:17 AM during an interview with CMA #13 she reported that when a resident requested a PRN (as needed medication) she was able to administer some without the nurse assessing the resident first. She stated that this was the case with a rescue inhaler. When asked if she was aware that Resident #14 had requested their rescue inhaler, she stated she was aware and had not been back to check the resident. She stated she was stocking her medication cart while waiting for the time the resident's inhaler was due because it had not been quite 3 hours. She stated Resident #14 would become anxious when it was close to the time for the inhaler and start asking for it early. When asked if she had reported this to the nurse she stated she had not. A medical record review for Resident #14 on 5/19/26 at 11:44 AM revealed the resident medication administration report. The documentation revealed the resident was ordered a rescue inhaler to be given every 3 hours for shortness of breath and wheezing and the last time the resident was given the inhaler was at 6:38 AM approximately 4 hours and 20 minutes prior to asking for the medication around 11:00 AM (the exact time was unknown). At 11:22 AM CMA #13 had documented a late entry administration of the rescue inhaler for 11:05 AM, which was not accurate as this was when the observation was made and before the interview with the CMA in which she reported she had not administered the medication. Further review of the progress notes revealed that a nurse had not assessed the resident prior to administering the medication. An interview with the Director of Nursing (DON) on 5/19/26 at 1:26 PM revealed that PRN medication were allowed to be administered by the CMA after a nurse assessed the resident and gave their approval. She was made aware that this had not been done for Resident #14 and made aware of the delay in treatment. She reported that it was not acceptable practice because the nurse should have assessed the resident's lung sounds prior to the administration. When asked if the facility had a standard of professional practice manual that staff could refer to she reported they had not established one. She was made aware of the late entry administration by CMA #13 indicating that she gave the resident the medication earlier than she had. The DON responded that she would find out what happened and report back to the surveyor. The DON reported back on 5/20/26 at 2:44 PM that CMA #13 had opened the PRN order when the aid told her that Resident #14 was requesting the medication. Then when she signed it off it came back as a late entry for 11:05 AM when she had initially opened the order. The DON reported that she educated the CMA that orders were not to be opened until she was ready to administer the medication to avoid this from reoccurring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215055	A. Building B. Wing	05/28/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that facility staff failed to provide appropriate pain management for their residents. This was evident for 1 (#2) of 1 resident reviewed for pain management. The finding include: A medical record review on 5/26/26 at 1:54 PM for Resident #2 revealed a Discharge summary dated [DATE], from the hospital, that documented the resident was taking Percocet 5-325 mg 1 tab every 4 hours as needed after a heel wound debridement procedure. According to a progress note written on 1/7/26 at 8:37 PM the resident was re-admitted to the facility. On 1/8/26 at 2:00 AM Licensed Practical Nurse (LPN) #11 wrote a progress note that documented Resident #2 was upset and mad at the nurse because she had offered him/her Tylenol while waiting for the physician to sign off the order for Percocet. She documented that the resident refused all pain medications offered. She wrote the resident asked again for the Percocet at 1:00 AM and at this time it was signed off, and she was able to give it to the resident. When she took in 1 tablet the resident became further upset and told her that they were receiving 2 tablets in the hospital. She failed to document when the resident first asked for the pain medication, an assessment of the pain, and what nonpharmacological interventions were offered. She failed to document that the resident informed her that s/he was told to avoid taking additional Tylenol while on Percocet (because it has Tylenol in it) and that she educated him/her. The telehealth provider documented a visit on 1/8/26 (she failed to include the time of the visit) that the resident was reporting a pain level of 10/10. The telehealth provider documented the resident appeared to be lethargic and she did not want to increase his/her dose of Percocet at this time, but that it should be considered due to uncontrolled pain. A review of the physician's orders revealed the resident was ordered Percocet 5-325 mg 1 tablet for pain 6-10. The Tylenol order stated it was to be given for a fever and for a pain level of 1-5. On 1/8/26 at 4:3 AM Physician #12 wrote a note that the resident was admitted and having pain since admission. She reported that the resident was on Percocet 5/325 mg 2 tablets every 4 hours as needed. but it was discontinued at the time of discharge, and a new order was written for continuing the Percocet 5/325 but 1 tablet every 4 hours as needed. Physician #12 gave an order for a one-time dose of Percocet 5/325 mg, 2 tablets for pain management now. LPN #11 documented on 1/8/26 at 6:20 AM that the resident had been given the 2 tablets of Percocet for a pain level of 9/10 and had no further complaints of pain. On 5/27/26 at 9:46 AM Resident #2 was interviewed and it was determined the resident was alert and oriented to person, place, and time and was able to answer questions appropriately. The resident reported, when s/he was re-admitted to the hospital following the procedure on his/her heel s/he awoke and was in a great deal of pain. The resident reported that staff were only offering Tylenol for the pain, and s/he had been told by the doctor at the hospital to avoid taking Tylenol while on Percocet. When asked if s/he told the nurse this was the reason for refusing the Tylenol, the resident report s/he had told the nurse. The resident reported that when they finally gave him/her the Percocet it was 1 tablet instead of the 2 that s/he received while in the hospital. The resident reported s/he told the nurse and the supervisor, however, all they seemed to want to do was argue with him/her. The resident stated s/he did not understand this because s/he was in a lot of pain and just wanted to be medicated to relieve the pain. During an interview with LPN #11 on 5/26/26 at 4:25 PM the timeline of when the resident started asking for the pain medication and when it had been administered was established. She reported the resident was re-admitted from the hospital 1/7/26 at 8:30 PM. The resident started complaining about pain at 10:00 PM. That was when the LPN realized the resident's admission orders had not been signed off by the physician. She sent a message to the facility providers through a system called eMedicall, however she was unsure of the time she sent the message. She reported the resident was complaining of a pain level of 10 out of 10 on the pain scale, so she took 2 Tylenol back to the resident. She stated that the resident became upset and refused the Tylenol. When asked if she had (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered the resident any nonpharmacological pain management, she stated that they [the facility] doesn't offer ice and heat for pain management. She reported that when she had not heard back from their providers, she called telehealth. She stated the first provider to call back they were unable to sign off on a narcotic in Maryland. She stated she had to call telehealth again and this time she was able to get the orders signed off. She was unable to recall the timing of these events and failed to document them in the resident's medical record. She stated that when she took the Percocet back to the resident, around 1:00 AM, the resident was upset that it was only 1 tablet and not 2 tablets. She reported she attempted to explain this to the resident but then the resident stated s/he was going to file a grievance against her so she called her supervisor. She reported the supervisor took the discharge paperwork back to the resident to show the resident what had been ordered. She reported she had not called the hospital to confirm that the resident should get 1 or 2 tablets. An interview with the supervisor, Registered Nurse (RN) #8 on 5/26/26 at 4:03 PM revealed she went to the resident to listen to their concerns and then attempted to show the resident the orders on the discharge instructions. She reported she had not called the hospital to confirm the orders, offer any nonpharmacological interventions, or educate the resident that it was ok to take the Tylenol until the Percocet was signed off and available to give them. The concerns were reviewed with the Director of Nursing (DON) on 5/27/26 at 11:49 AM. She reported that if the resident was admitted at 8:30 PM then the assigned nurse was probably passing medications to their assigned residents at that time, and this would cause a delay with admission orders. She agreed that the nurses should have clarified the Percocet order for the resident versus trying to convince the resident what the discharge orders were. She stated that they should have offered the nonpharmacological interventions even though she felt that the resident would not have accepted them. The DON reported they had not addressed the concerns with the orders not being signed off by the physician at the time of admission and 1 1/2 hours later the nurse was unable to administer the medications as ordered although she reported it was a known issue with their providers failing to respond to the messages timely. The concerns were reviewed with the Nursing Home Administrator on 5/28/26 at 8:47 AM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that facility staff failed to implement an effective infection control policy and procedures. This was evident during 1 of 1 random observation during the complaint survey. The findings include: A treatment cart is a cart that has supplies to provide treatments for resident and will have resident specific medicated treatments. The standard of nursing practice is to use this cart in the hallway to assemble treatment supplies for a resident, but does not go into the resident rooms for infection control purposes, just as medication carts and linen carts. On 5/19/26 at 9:59 AM a resident fell in their room on the second-floor nursing unit. In response Licensed Practical Nurse (LPN) #14 took the treatment cart with supplies laying on the top, into the resident's room between the bed and the wall and shut the door. When the nurse returned to the nurses' station on 5/19/26 at 10:07 AM, with the treatment cart she was interviewed. She reported that they do not normally take a treatment cart into the resident's rooms for infection control reasons. She stated she took the cart in because she was concerned about the resident's blood sugar because the resident was diaphoretic when she was found on the floor. She stated that because of this, she [the nurse] became anxious and inadvertently taken the cart in the room. An interview with the Infection Preventionist on 5/27/26 at 11:15 AM revealed it was not the practice of the facility to take treatment carts into the residents' rooms. She stated that this was unacceptable and the nurse was educated after surveyor intervention.