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	10/09/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews it was determined that the facility failed to ensure a sanitary and homelike environment. This was found to be evident on two out of two nursing units in the facility.The findings include: 1) On 10/1/25 at 12:58 PM surveyor observed the sink in the bathroom shared between rooms [ROOM NUMBERS]. Multiple cracks were observed around the drain and in the basin of the sink. On 10/09/25 at 10:53 AM surveyor and the Director of Nursing observed the cracks in the bathroom sink located between rooms [ROOM NUMBERS]. On 10/09/25 at 12:33 PM during an interview, the Maintenance Supervisor (Staff #14) reported that he was aware that some of the sinks were in rough shape and that they had replaced some of them. He also reported that he has submitted reports to Quality Assurance for rooms that need updating. On 10/9/25 at 12:45 PM surveyor and the Maintenance Supervisor observed sinks in two randomly selected rooms on the 200 unit, with concerns identified in one out of these two rooms. The sink shared between room [ROOM NUMBER]-206 revealed more than 30 small cracks around the drain. Additionally, multiple cracks of varying length were noted in the basin of the sink. The Maintenance Supervisor confirmed the presence of the cracks. The surveyor informed the Maintenance Supervisor of the previous observation of the sink shared by rooms 203-204. Maintenance Supervisor reported if money had been approved for renovation for these rooms it would of already had been completed. On 10/09/25 at 1:00 PM the surveyor reviewed the concern regarding the cracked sinks with the Nursing Home Administrator. 2) On 9/30/2025 at approximately 9:30 AM, Resident #114 complained their bathroom smelled of urine—surveyor observation on 09/30/2025 at 9:58 revealed a strong odor of urine in Resident #114's bathroom. Review of complaint #317846 referenced a complaint of strong odor in the facility. On 10/09/2025 at 1:33 PM, an environmental observation and walk-through was conducted with the facility Maintenance Supervisor. The Maintenance Supervisor confirmed that the facility regularly assesses the airflow and ventilation, and the facility's general ventilation was observed and questioned. This was initiated in room [ROOM NUMBER] on the first floor, followed by rooms [ROOM NUMBERS] on the same floor. Each resident bathroom was observed and tissue tested for air ventilation, in which the surveyor uses a single sheet of one-ply tissue paper against an air intake (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	register. Two of the three resident bathroom areas observed were not able to pull up and hold a single sheet of one-ply toilet tissue against the air intake register. On 10/09/2025 at 1:47 PM, the resident room observed on the second floor, room [ROOM NUMBER], had a ceiling height of more than 10ft and was not assessed. The Maintenance Supervisor provided a record from January 2025 to September 2025 of maintenance for the second-floor exhaust fans, indicating whether they were working or not working and stating they are accessed from the outside. Provided a description that the exhaust fans in the resident rooms on the second floor engage when the light switch is turned on, and operate at a lower intake airflow horsepower, and do not provide continuous air intake. No evidence was provided that air movement is adequate for comfort or odor control, and the Maintenance Supervisor confirmed this. On the second floor, the Maintenance Supervisor was present for the observation of the air intake in the hallway outside resident room [ROOM NUMBER] and explained that air is only drawn in when the air conditioning is enabled and the facility is cooling to the set ambient temperature. Otherwise, there is no continuous air movement or air cycling. On 10/9/2025 at 2:45 PM, the findings and deficiency was reviewed with the Nursing Home Administrator and Director of Nursing.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview and pertinent document review it was determined that the facility failed to have a process in place to ensure that residents received the items listed on the meal ticket or specific items that were requested by the residents. This was found to be evident for 2 residents (Resident #70 and #15) during random dining observations and one (Resident #2) during an interview with the resident council.The findings include:1.On 10/02/2025 at 1:09 PM Resident # 70, a long-term resident of the facility and without cognitive decline was interviewed. Resident #70 reported that a week before s/he was not served a BBQ sandwich that was on the facility menu and her/his meal ticket. Resident #70 reported that s/he was looking forward to the BBQ sandwich all day. S/he reported that the facility staff told her/him that they ran out of the BBQ sandwiches. On 10/6/2025 at 3:15 PM the facility Certified Dietary Manager (Staff #23) provided the meal ticket for the resident's dinner for 9/25/25. Review of the meal ticket for Resident # 70 revealed that a BBQ sandwich was listed as the primary meal. 2.On 10/02/2025 at 8:22 AM Resident #15 was observed sitting up in bed with her/his breakfast tray on the bedside table. Further observation revealed that Resident had not eaten her/his eggs. On 10/2/2025 at 8:23 AM during a brief interview with Resident #15 s/he reported s/he did not like her/his breakfast. S/he stated s/he would request oatmeal for breakfast instead. On 10/2/25 at 8:23 AM Resident #15 was observed calling the kitchen and requested oatmeal for breakfast. In addition, the surveyor heard Resident #15 request an alternative lunch items from the always available menu. The items were a grilled cheese sandwich and tomato soup. On 10/2/25 at 12:29 PM an observation was made of Resident #15's lunch. The observation revealed a grilled cheese sandwich and chicken soup. Resident #15 reported that s/he was told that they were out of tomato soup. On 10/2/25 at 12:30 PM the surveyor observed, on the wall near the second-floor dining area, the Always available items from the kitchen, which included tomato soup. On 10/7/25 at 12:40 PM during an interview with the Certified Dietary Manager (Staff # 23), confirmed that the tomato soup is on the always available menu and comes in cans. He confirmed that the tomato soup was not available for Resident #15 on 10/2/25. 3. On 10/3/25 at 1:47 PM during a small Resident council meeting, Resident #2 reported that s/he was supposed to receive a breaded chicken sandwich for lunch on 10/3/25 but just received a plain piece of chicken. S/he reported s/he was allergic to fish and was supposed to receive the breaded chicken as her meal. On 10/3/25 at 1:52 PM the Regional Certified Dietary Manger (Staff #25) reported to the resident council meeting that there was an error in the kitchen and that regular chicken was served in place of the breaded chicken. On 10/7/25 at 12:40 PM the Certified Dietary Manager (Staff #23) reported that the facility ran out of breaded chicken because there was an unusually high request for the breaded chicken that was listed (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as the alternative meal. On 10/7/25 the Certified Dietary Manger (Staff #23) provided Resident #2's meal ticket for lunch on 10/3/25. Review of Resident #2's meal ticket listed that Resident #2 was allergic to fish, and that Breaded Chicken was listed as her/his primary meal and not as an alternative meal item. On 10/7/25 at 11:40 AM the above concerns were discussed with the Director of Nursing and the Administrator. They reported that they would work with the kitchen management to address the issue. No further information was provided prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to ensure proper hand hygiene; and maintain a sanitary environment in a manner that minimizes the potential development and transmission of communicable diseases and infections. This was found to be evident for three (Resident # 2, #17 and #115) out of 53 residents reviewed; and two of three medication storage rooms observed during the survey. The findings include: 1.On 9/30/25 at 10:44 AM, Resident #115, admitted to the facility for rehabilitation, reported poor hygiene practices by staff. The resident stated that staff emptied a urine bottle in the bathroom but did not rinse or wipe it before placing it back on the bedside table. On 10/2/25 at 1:12 PM, an observation was made in Resident #17's room. Resident #17 was admitted to the facility for rehabilitation and antibiotic therapy due to an infection. On 10/2/25 at 1:16 PM, continued observation revealed a plastic urinal on the resident's bedside table. The urinal fell off the table onto the floor. The Human Resource Director (Staff #24), retrieved gloves, picked up the urinal, and placed it on the resident's dresser. Further observation revealed that Nurse #15 was next to Resident #17 and providing care to Resident #17. Continued observation revealed Staff #24 placed Resident #17's lunch tray on the bedside table. Observation did not reveal that the bedside table was sanitized after the urinal was removed and before the lunch tray was placed. On 10/2/25 at 1:20 PM, during a brief interview, Nurse #15 (who is the Infection Preventionist nurse), confirmed that the bedside table was not sanitized after removing the urinal and before placing the lunch tray. Nurse #15 stated it was the facility's expectation that the table be sanitized after urinal removal and before food service. 2.On 10/6/25 at 6:00 AM, an observation was made of wound care provided to Resident #2 by Nurse #2. On 10/6/25 at 6:10 AM, Nurse #2 was observed cleaning a dirty wound, removing dirty gloves, and putting on clean gloves without sanitizing hands between tasks. On 10/6/25 at 6:20 AM, Nurse #2 confirmed during an interview that hand hygiene was not performed between removing dirty gloves and applying clean ones. On 10/6/25 at 12:07 PM, Infection Preventionist Nurse (Nurse #15) reported that it was the expectation that all nurses sanitize hands after removing dirty gloves and before putting on clean gloves. The Infection Preventionist (Nurse #15) stated that re-education of the nursing staff had begun. On 10/15/25 at 11:40 AM, these concerns were discussed with the Director of Nursing (DON) and the Administrator. The DON reported being aware of the issues and confirmed that the Infection Preventionist had initiated staff re-education to correct the deficient practices. 3. On 10/3/2025 at 8:40 AM, Nurse #3 provided a review of the medication storage room on the second floor that is at the front of the unit. The sink in the storage room had a dark, green-to-black substance around the drain, and a tabletop dehumidifying device was draining. There was an expired full canister of Sani-Cloth wipes, are designed to disinfect and kill a wide range of microorganisms, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including bacteria, viruses, and bloodborne pathogens, from 09/2023. On 10/3/2025 at 8:40 AM, Nurse #3 unlocked the refrigerator in the medication storage room, and it was revealed that resident specimens were also stored in the resident medication refrigerator. This was evident from clear sleeves containing what appeared to be red, body-fluid-like samples. Nurse #3 confirmed that resident specimens are kept in the resident medication refrigerator and stated they have observed stored specimens in other resident medication storage room refrigerators. On 10/3/2025 at 9:10 AM, the first-floor resident medication storage room was observed with Nurse #5. The sink in the resident medication storage room had a dark, green-to-black substance around the drain, and a tabletop dehumidifying device was draining. Nurse #5 unlocked the refrigerator in the resident medication storage room, and it was revealed that resident specimens were stored there. This was evident from clear sleeves containing what appeared to be red, body-fluid-like samples. Nurse #5 confirmed, all resident specimens are kept in the medication refrigerator as a standard practice. On 10/09/2025 at 2:45 PM, the Nursing Home Administrator and Director of Nursing were made aware of and acknowledged the deficiency. Refer also to F 761

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation and interview, it was determined that the facility failed to ensure that each resident had the right to a dignified existence and communication. This was found to be evident during one (Resident #7) out of two investigations regarding resident dignity conducted during the survey.The findings include: On 9/30/2025 at 9:40 AM, during the initial tour of the facility, Resident #75 shared with the surveyor concerns about interactions with a GNA on the first floor who works on the unit during the day. On 10/01/2025 at 10:35 AM, during an interview with Resident #7, the surveyor asked whether there were concerns regarding dignity, respect, staff rapport, etc. Resident #7 and their family member, who was present during the interview, referred to a GNA during the surveyor's interview. Concerns raised by both Resident #7 and #75 pertained to the GNA's approach, tone, and demeanor toward the residents. Resident #7 stated, She is rude with residents and appears aggravated with the job. Resident #75 and #7 had both described the GNA's demeanor as mean to the surveyor. On 10/1/2025 at 12:05 PM, the surveyor began observing a GNA moving throughout the unit with a meal tray cart and observing the GNA's interactions. The GNA responded to two resident call lights in rooms [ROOM NUMBERS]. Upon entry, the response to the residents was: What do you want? (in a sharp, gruff tone) and What do you need now? The staff member was identified as GNA #35, the person referenced in resident and family interviews earlier that day on 10/1/2025. On 10/01/2025 at 12:40 PM, GNA #7 was assigned to the first floor and was interviewed. The GNA was asked about general resident care, staffing, and task delegation. During the interview, GNA #7 was asked whether they had any concerns about staff interactions with residents. GNA #7 confirmed with the surveyor that she has concerns with GNA #35's interactions with residents. She states that she has not witnessed abuse; however, she stated she has observed GNA #35 speak to residents in a disrespectful tone and manner consistently. On 10/02/2025 at 1:49 PM, an observation on the first-floor nursing unit was made by the surveyor. Nurse #6 was one of the nurses on the unit for the afternoon. On 10/02/2025 at 1:59 PM, during an interview with Nurse #6, who is from the first floor. Nurse #6 denied any concerns related to abuse. When asked whether they have concerns about the dignity of residents on the unit and interactions between staff and residents, Nurse #6 stated that they have observed GNA interactions with residents on the unit that they believe 'could be handled better'. When asked if there are specific staff member(s) they have observed where staff-to-resident interactions are not dignified, Nurse #6 identified GNA #35. On 10/2/2025 at 2:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were interviewed. The DON was asked, What is your expectation when staff respond to a call light -- what kind of communication would you expect to see and hear? The DON stated, I would expect staff to be decent and respectable in approach when addressing the resident and identifying their needs. The DON was asked how staff are trained and monitored on resident rights, resident dignity, and respectful communication. The DON stated that staff are provided with computer-based training modules on topics such as abuse, neglect, and cognitive decline. Computer-based learning modules are provided to staff upon hire, annually, and as needed. The NHA confirmed that this is the in-service (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delivery model used for staff at the facility across multiple topics. The NHA and DON stated they were unaware of any complaints regarding GNA interactions with residents. During the interview, the surveyor shared observations of GNA #35's interactions when responding to resident call lights, along with staff interviews regarding these observations. On 10/2/2025 at 2:40 PM, the DON and NHA stated they had not been aware of this concern and confirmed the concern regarding resident dignity.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure residents' personal possessions were treated with respect and safeguarded from interference by other residents. This was evident for one (Resident #37) of two residents reviewed for wandering behavior during the annual recertification survey.The findings include: On 9/30/2025 at 11:22 AM, during the initial facility tour and interview with Residents #62 and #72 on the first floor, they voiced concerns over Resident #37 coming in/out of rooms and taking personal belongings. Residents #62 and #72 stated that Resident #37 has entered their rooms at different times, most often overnight, and has taken items. On 10/1/2025 at 10:10 AM, during observation of the resident on the unit, it was observed that Resident #37 was wandering in the doorway of other resident rooms (rooms [ROOM NUMBERS]) and was redirected by irritated residents twice within ten minutes. Three other staff were present during the surveyor's observation without intervening or redirecting. On 10/06/2025 at 1:29 PM, a review of Resident #37's care plan initiated 09/20/2025 identified wandering behavior and potential for elopement, with interventions to assess for hunger, toileting, and to provide supervision and redirection when entering others' rooms. However, there was no documentation demonstrating that these interventions were consistently implemented. On 10/02/2025 at 2:25 PM, an interview was conducted with Nurse #5 regarding the resident's wandering and their reported stealing of items. Nurse #5 stated, Oh, that's just Resident #37, they are well known to wander and steal, but most often items are food-related, and it's not a big deal. Nurse #5 stated the resident is easily redirectable and is not observed to be aggressive with staff or other residents when exhibiting wandering behavior. Nurse #5 further stated that the resident does not exhibit signs of eloping during wandering and is safe on the unit, most often roaming for a snack. Nurse #5 stated that there have been no permanently missing items involving this resident that could not be recovered. Nurse #5 stated that if items go missing and cannot be found by staff, they would be reported to the Nursing Home Administrator (NHA) and the Director of Nursing (DON). On 10/9/2025 at 2:45 PM, the findings were reviewed with the DON and NHA, and the deficiency was confirmed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, observation and record review, it was determined that the facility failed to make grievance information and the process of how to file a grievance readily available to staff and residents. This was evident for 1 (Resident #77) out of 1 resident reviewed for personal property during the survey. The findings include: On 10/2/25 at 1:49 PM Resident #77 reported to surveyor that 6 underpants were missing and stated, I've told everyone who comes in here. On 10/2/25 at 1:57 PM Social Service Assistant (Staff #10) provided the requested Grievance Policy. It stated the Grievance Official defaults to the Director of Social Services. And, in part, the facility will prominently post and make information available to all residents and others involved in resident care. And, in part, the location of grievance forms.will be posted near or on the grievance box. On 10/2/25 at 2:00 PM a record review of the 2025 Grievance Log lacked documentation that a grievance was filed on behalf of Resident #77 related to missing underpants. On 10/3/25 at 7:43 AM Surveyor observed that both Nursing Stations and units, level 1 and level 2 lacked grievance forms. A broken and unsecured Grievance Box was observed near the level 2 elevator. On 10/3/25 at 9:20 AM in an interview, Resident #77 and Geriatric Nurse Assistant (GNA #9), denied knowing how to file a grievance. GNA #9 stated, I don't know how it [the grievance process] goes and honestly a lot of people don't know how. Resident #77 stated, I go directly to [NAME], (referring to the Nursing Home Administrator (NHA)). On 10/7/25 at 8:13 AM in an interview, Registered Nurse (RN #11) on level 2, reported, If there's a complaint, I would go to the Unit Manager on that floor. RN #11 could not locate nor produce a grievance form per surveyor request. On 10/7/25 at 8:45 AM in an interview, Licensed Practical Nurse (LPN #12), reported, If there's a complaint, I would go to Christa (referring to the Director of Nursing (DON)). On 10/7/25 at 1:59 PM in an interview, the NHA reported that nurses can get a grievance form at the nursing station or from the computer, however, they are not openly available. On 10/7/25 at 2:17 PM in an interview, the Director of Social Service (Staff #13), identified as the facility Grievance Officer, reported that staff, residents, or family can file a grievance either in writing or verbally. She stated, grievance forms are readily available at the nursing station. On 10/9/25 at 1:30 PM the NHA and DON were made aware of the concern.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment. This was evident for one (Resident #22) of two residents reviewed for positioning and mobility during the survey.The findings include: On 10/2/25 at 10:28 AM, Resident #22, a long-term resident of the facility, was observed lying in bed and reported doing well. On 10/2/25 at 1:53 PM, a review of occupational therapy notes provided by the Director of Therapy (Staff #19), for the certification period 7/9/24–8/7/24, did not indicate that Resident #22 had an upper extremity contracture. On 10/2/25 at 1:54 PM, a brief interview with the Director of Therapy (Staff #19), confirmed that Resident #22 did not have an upper extremity contracture. On 10/2/25 at 2:10 PM, a review of the annual MDS Section GG assessment, with a reference date of 8/15/25, revealed that the resident was coded as having a functional limitation in one upper extremity. The MDS is part of the Resident Assessment Instrument, federally mandated by legislation passed in 1986. It is a standardized, comprehensive assessment process used to identify each resident's individual needs, develop a care plan based on those needs, and ensure the care provided meets those needs. On 10/2/25 at 3:06 PM, the Director of Nursing (DON) reported that the Director of MDS had made an error on the MDS and that Resident #22 did not have range-of-motion issues in either upper extremity. On 10/6/25 at 8:23 AM, a review of the MDS revealed that a correction had been made. A modification dated Thu [DATE], at 03:26:25 PM, indicated that Resident #22 did not have impairments in the upper extremities. On 10/6/25 at 8:34 AM, during an interview, the MDS Coordinator Nurse (Staff #18), reported that documenting a impairment to the upper extremity for Resident #22 was an error and that a correction was completed following surveyor intervention.

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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 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 interview, it was determined that the facility failed to provide quality of care for their residents. This was evident for one (Resident #125) of three residents reviewed for nutrition and one (Resident #3) out of five residents reviewed for unnecessary medication.The findings include: 1.A complaint was received by the State Agency (SA) on 8/25/25, alleging the facility was not allowing Resident #125 to have water by mouth. The complainant explained that due to the extensive facial surgery (due to a diagnosis of buccal cavity (mouth) cancer) the resident had, s/he often experienced dry mouth and had been drinking water in the hospital. The complainant reported that the facility was giving the resident 1 can (237 milliliters mL) of Glucerna when s/he had been getting 2 cans (480 mL) in the hospital. The complainant reported this was due to the extra calories and protein needed to allow the resident to heal. Furthermore, the complainant reported that family had attempted to explain this to the facility on multiple occasions, but nothing was changed. On 10/8/25 at 1:33 PM a medical record for Resident #125 revealed 2 documents from the acute care hospital that was uploaded in the miscellaneous section of the electronic medical record. A Discharge summary dated [DATE], that revealed the resident had been living at home and came to the hospital for treatment of a urinary tract infection that was causing weakness and to resume the at home diet. A History and Physical from the acute care hospital dated 8/3/25 revealed in the Assessment/Plan section that the resident had buccal cavity cancer with surgical intervention, the resident tolerated oral fluids but had aspiration precautions. Furthermore, it read to continue the tube feedings via a gastric tube (g-tube is a tube that is directly inserted into the stomach) of 480 mL of Glucerna 1.5 at 9 am, 2 pm, and 7 pm. (Each can of Glucerna is 237 mL, so the resident was getting 2 cans). A review of the resident's orders revealed the resident was ordered on 8/7/25 not to have anything by mouth (NPO) except for swabs dipped in water. The tube feeding order for 8/7/25 read to give Glucerna 1.5 give 1 can (237 mL) three times a day entered by Licensed Practical Nurse (LPN) #12. There were no orders for flushing the gastric tube (g-tube) or giving the resident hydration via the gastric tube. These orders were signed off by Nurse Practitioner (NP) #33 as approved. According to nutritional facts on a can of Glucerna 1.5, one can of Glucerna 1.5 has 356 calories thus 3 cans total 1068 calories daily. According to the National Institute of Health adults should receive between 1600 – 2400 calories daily. A review of the NP #33 visit notes for 8/8/25 revealed the resident had been at the hospital for treatment of a urinary tract infection and was admitted to the facility for short term rehabilitation so s/he could return home. There was no mention of the resident's diet orders or lack of hydration fluids via g-tube. NP #33 visited the resident on 8/11/25 and noted she spoke to the resident's family member who had a concern with the amount of tube feeding the resident was receiving and scheduled the resident to see their oncologist on 8/12/25. She also noted that the resident was requesting to have water to drink because of dry mouth, but because of the receiving orders (orders from the hospital) indicated the resident was to remain NPO. However, the orders received from the hospital noted the resident was tolerating fluids orally. The NP noted that she had consulted the dietitian. The orders for 1 can of Glucerna 3 times a day remained the same. No orders were added for hydration through the G-tube and the resident remained nothing by mouth. A review of Registered Dietitian (RD) #34's nutritional assessment dated [DATE] at 1:21 PM, revealed in F. Comparative Standards, Estimated Energy, Protein, Fluid needs: the resident needed to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have between 1680 – 1960 calories a day. The resident needed 1600 mL of fluids each day. The dietitian noted that with the resident's current tube feeding orders s/he was getting 33% of his/her daily fluid needs. The dietitian recommended that the resident receive Glucerna 1.5, 1 can 5 times a day with 30 mLs of water before and after each tube feeding and 120 mL of water 6 times a day to meet the resident nutritional needs. This recommendation was 1 can less than the oncologist had recommended daily. However, even though the resident as getting 712 less calories and 67 % less water than these recommendations, the dietitian failed to enter the new orders until the following day on 8/12/25, allowing the resident to go 5 days without proper nutrition and hydration. On 10/8/25 at 2:53 PM an interview with LPN #12 revealed she used the discharge summary and other information from the hospital to enter orders for new admissions. She stated that she probably got the tube feeding orders from the History and Physical dated 8/3/25. However, when shown that the order was 480 mL of Glucerna 1.5 3 times a day and she had entered 237 mL Glucerna 3 times a day, she stated that she must have gotten that order from report from the nurse at the hospital or other paperwork. Reviewed the progress note that indicated another nurse had taken report from the hospital for the resident. Requested that she review the record and bring the documentation she used to get that order. A subsequent interview with LPN #12 on 10/8/25 at 3:51 PM revealed she was unable to find any documentation to support the order she entered for the tube feedings. On 10/8/25 at 5:19 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of the concerns. The DON was asked if she expected her staff to realize that 1 can of Glucerna 3 times a day did not equal the minimum number of calories a person needs each day, she stated she would not expect them to know this information and clarify the order. An interview with the Medical Director on 10/14/25 at 5:10 PM revealed that it was expected that the Nurse Practitioner reviews the resident's hospital records and follows the recommended diet orders. He stated that it was concerning that NP #33 failed to ensure that the resident had the correct diet orders and that hydration fluids were included for the resident. Cross Reference F711 2.Review of Resident #3's medical record revealed the resident had an order for Rivaroxaban 20 mg tablet every morning for the prevention of deep vein thrombosis (blood clot) in place from 8/13/25 to 9/28/25. Rivaroxaban is the generic name for Xarelto, an anticoagulant (blood thinning) medication. Deep vein thrombosis can lead to a pulmonary embolism (blood clot in the lung) and death. On 10/6/25 review of the Medication Administration Record (MAR) revealed documentation that the resident did not receive the Rivaroxaban on September 14, 15, 16, 19 or 20, 2025. Nursing staff documented a 9 on the MAR which indicated the medication was not administered and to see nursing notes for the reason why it was not administered. Review of the corresponding nursing notes revealed that on 9/14/25 the medication was not given due to Waiting for pharmacy to deliver. On 9/15/25 the nurse documented on order from pharmacy. Med unavailable at this time. On 9/16/25 the nurse documented: on order. Review of the corresponding nursing notes for 9/19/25 and 9/20/25 failed to include documentation by the nurse to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicate why the medication was not administered on those two dates. Review of a pharmacy delivery manifests revealed 14 tablets of Xarelto 20 mg were delivered on 9/9/25. This manifest was signed by Nurse #4 on 9/9/25 at 8:04 AM. On 10/07/25 at 10:40 AM the Director of Nursing (DON) reported that sometimes the manifest is wrong. On 10/07/25 at 5:14 PM surveyor reviewed with the DON the concern that for some of the 9s that were documented on the MAR for the rivaroxaban, the nurses failed to document why it was not given. On 10/09/25 at 4:19 PM surveyor reviewed the concern with the DON that, based on review of the pharmacy manifest reports, there was an adequate supply of the rivaroxaban on the dates when nursing staff had documented that it was not available due to waiting on delivery from pharmacy. DON acknowledged the concern. As of time of survey exit on 10/9/25 at 5:00 PM no additional documentation was provided regarding this concern.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on medical record review, observation and interview it was determined that the facility failed to ensure that prior to installation of bed rails appropriate alternatives were attempted, that residents were assessed for the risk of entrapment, and that informed consent was obtained, and failed to ensure re-evaluation for the continued use of the bed rails. This was found to be evident for two (Resident #41 and #88) out of two residents reviewed for bed rail usage. The findings include:1) Resident #41 has resided at the facility for more than a year and has a diagnosis of dementia. On 10/01/25 at 12:46 PM resident was observed in bed asleep with quarter bed rails in the up position.On 10/07/25 at approximately 11:00 AM resident was observed in bed asleep with quarter bed rails in the up position.On 10/7/25 at approximately 12 noon review of the medical record revealed the resident was dependent on staff for bed mobility. Review of the current care plan addressing activities of daily living, revealed an intervention of Bilateral bedrails to promote independence and assist with turning and repositioning. This intervention was initiated 4/12/25. Review of the physician orders revealed an 8/28/25 order to: Maintain bilateral bedrails to promote independence with turning and repositioning.Further review of the medical record failed to reveal documentation to indicate alternatives to bed rails were attempted or that a risk of entrapment was completed prior to the addition of bed rails in April 2025.Review of the facility's Safe Use of Bed Rails policy, that was provided for review during the survey, revealed in the Procedure section: 1.Assessment of residents with bed rails include: a. Level of independence with bed mobility; b. Review of prior interventions and outcomes prior to the initiation of bed rails; c. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms should be evaluated prior to initiation.On 10/07/25 at 12:38 PM the Therapy Director (Staff #19) was interviewed in regard to the use of bed rails. The Therapy Director reported that nursing does research first to see if there is anything else they can initiate prior to bed rails, and then nursing would refer to therapy for a screening. The director confirmed there is a paper that they utilize if they recommend bed rails and that they provide that document to nursing. When asked if that document goes into the medical record the director referred the surveyor to the Director of Nursing. In regard to Resident #41, the Therapy Director reported that the resident has been dependent for everything for some time and that she would have to re-evaluate the resident to see if bed rails were currently appropriate.On 10/7/25 the Therapy Director provided the discharge summary for the resident's most recent treatment by physical therapy. Review of this document revealed that the resident received services from 4/8/25 - 4/18/25. Although the skilled interventions included therapeutic activities for bed mobility training the pt demonstrating poor carryover secondary to impaired cognition with limited new learning capacity. No mention of the use of bed rails was found in this discharge summary.On 10/07/25 at 5:22 PM the Assistant Director of Nursing (ADON Staff #17) was interviewed in regard to the bed rail process. The ADON reported that the nurses are required to complete a bed evaluation and repeat this evaluation quarterly. If bed rails are required then therapy is involved. In regard to Resident #41, the ADON reported she had completed rounds with the therapy director today, the resident was unable to follow commands and that the bed rails had just been removed within the past hour. She also reported the order has been discontinued and bed rails have been removed from the care plan. Surveyor reviewed the concern that no documentation was found to indicate an initial evaluation was completed prior to the initiation of the bed rails.Further review of the Safe Use of Bed Rails policy revealed in the Procedure section: 3. Monitoring: a. Bed Safety Evaluation is completed upon admission, quarterly, and as needed such as a significant change in condition.Review of the Bed Safety Evaluation assessment form revealed it includes, but is not limited to, information about the resident's ability to make decisions, use a call light, mobility, and medications that would require increased safety precautions.On 10/8/25 further review of the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record failed to reveal documentation to indicate a Bed Safety Evaluation was completed in 2024 or 2025. An evaluation was found for 2023, but it indicated the resident did not have bed rails at that time.On 10/08/25 at 4:40 PM surveyor reviewed the concern with Nursing Home Administrator (NHA) and the Director of Nursing (DON) that no documentation was found to indicate there was an evaluation prior to the initiation of the Bedrails. The most recent evaluation found in the electronic health record was for 2023 and indicated the resident did not have rails. Surveyor also reviewed that the bed rails were added to the care plan in April 2025, but no order was found until August 2025. As of time of survey exit on 10/9/25 at 5:00 PM no documentation was provided to indicate an evaluation was completed prior to the initiation of the bed rails in April or that a Bed Safety Evaluation was completed by the nurses since 2023.2. On 10/09/25 at 9:20 AM Resident #88 was observed in bed with bed rails in the up position. Review of the medical record revealed a current order to Maintain bilateral bedrails to promote independence with turning and repositioning. Further review of the medical record revealed a Care Plan Note, dated 5/19/25 related to the resident's care plan for falls. This note included the following: Recommendation of IDT [interdisciplinary team] was to apply perimeter mattress to make [Resident #41] more aware of mattress edges; however, [Resident] does not wish to have the perimeter overlay applied. [S/he] requested to have bilateral bedrails applied in order to promote independence with turning and repositioning. No documentation was found in the medical record to indicate therapy completed an evaluation prior to the initiation of the bed rails; and no documentation was found to indicate the resident was educated on the risks of side rails.During an interview on 10/9/25 at 9:45 AM the Director of Nursing (DON) was asked how bed rails get on a resident's bed. The DON reported we generally take a request for side rails to the clinical meeting, discuss with the team then therapy usually does an evaluation, if resident is capable and no risk factors then sometimes nursing will contact the doctor to get the order and obtain the consent and then maintenance is notified.On 10/9/25 at 10:07 AM surveyor, DON and Medical Records (Staff #26) reviewed the resident's thinned record but were unable to identify documentation to indicate an evaluation was completed or an informed consent was obtained prior to the initiation of the bedrails. The DON reported that the document that therapy uses to evaluate is an internal work document that they would share in a meeting and stated: I would throw them away. Further review of the Safe Use of Bed Rails policy revealed in the Procedure section: 2. Consent: a. Disclosure of the needs, risks and benefits of use; b. Education provided to the resident or resident representative; c. Signed by the resident or, if applicable, the resident representative.; and 6. Documentation: a. Physician order is required; b. Completion of Bed Safety Evaluation; c. Consent obtained for bed rail use; and d. Education provided to the resident or, if applicable, resident representative.On 10/9/25 at approximately 4:45 PM surveyor reviewed with the DON and the NHA the concern regarding the failure to assess and failure to obtain consent for the use of bed rails.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the physician failed to review the hospital records for a resident who was newly admitted to the facility to ensure continuity of care. This was evident for 1 (Resident #125) of 3 residents reviewed for nutrition. The findings include:On 10/8/25 at 1:33 PM a medical record for Resident #125 revealed a History and Physical dated 8/3/25 from the acute care hospital that was uploaded in the miscellaneous section of the electronic medical record. A review of the History and Physical (H&P) revealed in the Assessment/Plan section under the treatment for buccal cavity (mouth) cancer it was documented the resident had surgical intervention, the resident tolerated oral fluids but had aspiration precautions. Furthermore, it read to continue the tube feedings and medications via a gastric tube (g-tube is a tube that is directly inserted into the stomach). The resident was ordered 480 milliliters (mL) of Glucerna 1.5 at 9 am, 2 pm, and 7 pm. A review of the resident's orders revealed an order dated 8/7/25 that the resident was to be NPO (nothing by mouth) except for swabs dipped in water. The tube feeding order dated 8/7/25 read to give Glucerna 1.5 give 1 can (237 mL) three times a day. These orders were entered by Licensed Practical Nurse (LPN) #12 and approved by Nurse Practitioner (NP) #33 on 8/8/25. According to nutritional facts listed on a can of Glucerna 1.5, there are 356 calories per can, thus 3 cans would total 1068 calories daily, which was less than the National Institute of Health recommendation that adults should receive between 1600 – 2400 calories daily. NP #33 failed to review the order for accuracy prior to signing as approved. In addition, she failed to review the orders to realize the resident had not been ordered water via the g-tube for hydrational needs. A review of the NP #33 visit notes for 8/8/25 revealed there was no mention of the resident's diet orders or lack of hydration fluids via g-tube. NP #33 visited the resident on 8/11/25 and noted she spoke to the resident's family member who had a concern with the amount of tube feeding the resident was receiving and scheduled the resident to see their oncologist on 8/12/25 because of this concern. She also noted that the resident was requesting to have water to drink because of dry mouth, but because of the receiving orders (orders from the hospital) indicated the resident was to remain NPO. This was inaccurate as the H&P from the hospital dated 8/3/25 noted the resident was tolerating fluids orally. The NP noted that she had consulted the dietitian. The NP failed to review the hospital records and current plan of care after the concerns were brought to her attention by the resident and family members. NP #33 failed to catch that the resident had no orders for hydration through the g-tube after these two visits. The NP was not working at the facility at the time of the survey. A review of Registered Dietitian (RD) #34's nutritional assessment dated [DATE] at 1:21 PM, confirmed that the resident should have received between 1680 – 1960 calories daily and 1600 mL of fluids each day for hydration. An interview with the Medical Director on 10/14/25 at 5:10 PM revealed that it was expected that the Nurse Practitioner reviews the resident's hospital records and follows the recommended diet orders. He stated that it was concerning that NP #33 failed to ensure that the resident had the correct diet orders and that hydration fluids were included for the resident. On 10/8/25 at 5:19 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of the concerns. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross Reference F684

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review and interview it was determined that the facility failed to ensure regularly scheduled medication was re-ordered and delivered in a timely manner; and failed to ensure staff accessed interim supply of medication when needed. This was found to be evident for one (Resident #3) out of five residents reviewed for unnecessary medications.The findings include: On 10/6/25 review of Resident #3's medical record revealed the resident had an order for Atorvastatin 20 mg at bedtime for hyperlipidemia (high cholesterol). This order had been in place since 8/12/25. Review of a pharmacy delivery manifest, signed by nurse #16, revealed 30 tablets of Atorvastatin 20 mg were delivered to the facility for Resident #3 on 8/12/25. On 10/6/25 review of the Medication Administration Record (MAR) revealed documentation that the resident received the Atorvastatin when due 8/12 through 9/15/25. This is 35 dosses that were documented by staff.On 10/6/25 review of the Medication Administration Record (MAR) and the progress notes revealed the Atorvastatin was not administered on 9/16/25 because the medication was on order. The medication was documented administered as ordered for the next 12 days on 9/17 - 9/28/25. On 9/29 staff documented that the Atorvastatin was not administered due to Waiting for pharmacy to deliver. The medication was documented administered as ordered for the next 5 days on 9/30 - 10/4/25. On 10/5/25 staff documented that the Atorvastatin was not administered due to Awaiting delivery from pharmacy.During the medication storage review, on 10/3/25, surveyor observed that the facility has an Omnicell pharmacy device. The Omnicell is a device used for medication storage that staff can access as needed if a medication is required prior to delivery from the pharmacy. This supply is sometimes referred to as an interim supply. On 10/6/25 at 3:36 PM review of the Omnicell inventory sheet (which was Current as of 1/15/25) revealed Atorvastatin 10 mg tablets are kept available at the facility. On 10/06/25 at 3:41 PM Nurse #8, who was assigned to care for Resident #3, was unable to find Atorvastatin in the medication cart, either in the main supply area or in the overflow. Nurse #8 confirmed she did not see the medication in the cart. Nurse #8 then checked the computer stating, I can see if it's been re-ordered. After checking the computer, Nurse #8 reported it did not look like the medication had been re-ordered. Nurse #8 stated they usually send a 30-day supply. When asked what she would do if the medication was not available when due, Nurse #8 reported she would check the list of interim meds and could call the pharmacy. On 10/6/25 at 3:45 PM Surveyor reviewed the concern with the Director of Nursing (DON) that according to the medical record the Atorvastatin was not administered on 9/29 or 10/5 due to not being available; and there is no current supply and the nurse on the unit indicated it had not been re-ordered. The DON reported they can pull the medication from the Omnicell if available. During the 10/6/25 interview the DON went on to report a new process with the pharmacy if the resident is Long Term Care. They can sign them up to sustain refills, and if enrolled then the regularly scheduled medication auto refills and should not need to be re-ordered. Review of the computer screen with the DON revealed the resident was opted in to Sustain refill on 10/3/25. The surveyor then requested the current list of Omnicell meds; if any Atorvastatin was recently pulled from Omnicell supply; and documentation regarding the delivery of Atorvastatin from the pharmacy. On 10/07/25 at 8:45 AM the DON provided the manifest from the pharmacy for a delivery on 8/12/25 that included 30 tablets of Atorvastatin 20 mg. The only report from Omnicell provided was for a different resident and a different medication. The surveyor then reviewed the concern that staff documented on 9/29/25 that they were waiting for the medication from pharmacy; the facility is not able to provide documentation that it was delivered or that it was removed from the interim supply, but staff documented the administration of the medication for several days after 9/29/25. DON states: I can't speak to that.On 10/7/25 at 10:40 AM the DON reported that sometimes the pharmacy manifest is wrong.Further review of the medical record on 10/7/25 revealed that the Atorvastatin was not given when due on 10/6/25 due to Waiting for pharmacy to deliver. No (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation was found to indicate staff attempted to access the interim supply from the Omnicell on 10/6/25.On 10/07/25 at 11:00 AM surveyor observed resident's current supply of medication with nurse #4. The current supply included 30 tablets of Atorvastatin 20 mg. Nurse #4 reported this supply just came in that day.On 10/07/25 at 5:14 PM surveyor reviewed with Nursing Home Administrator and DON that the Atorvastatin was not given again last night. The Assistant DON, who was also present, confirmed the 10 mg is in the Omnicell. The DON reported she has started education, and indicated the nurses are going to start getting the meds out of the Omnicell.As of time of survey exit on 10/9/25 at 5:00 PM no documentation was provided to indicate a refill of the Atorvastatin was delivered after the initial delivery of 30 tablets on 8/12/25 and prior to 10/7/25.

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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 observation and interview, it was determined that the facility failed to ensure resident treatment carts were locked when unattended; ensure insulin pens were dated upon opening and discarded according to manufacturer guidelines; and ensure that insulin pens were stored in a manner that prevented potential cross-contamination. This was evident during two random observation of treatment carts; 1 of 3 medication carts and 2 out of 3 medication storage rooms observed during the annual recertification survey. The findings include: 1.On [DATE] at 6:20 AM, an observation was made on the first floor. A treatment cart was noted near the nursing station but not within direct view of staff. The cart was unlocked, and the surveyor was able to open one drawer without staff noticing. The surveyor alerted Nurse (Staff #20) to the unlocked cart. Nurse (Staff #20) stated the cart should have been locked. On [DATE] at 6:21 AM, a review of the cart contents with Nurse (Staff #20) revealed, but was not limited to, the following medications: prescription medications Nystatin Powder and Tazarotene 1% Cream. In addition, a bottle of Hydrogen Peroxide 3% Solution. On [DATE] at 6:24 AM, Nurse (Staff #20) was observed locking the treatment cart. On [DATE] at 6:32 AM, a second observation was made on the second floor near, but not in direct view of, the nursing station. The surveyor was again able to open a treatment cart drawer without staff noticing. The surveyor alerted Nurse (Staff #21) to the unlocked cart. A review of the cart contents with Nurse (Staff #21) revealed, but was not limited to, Mupirocin (prescription topical antibiotic) and Hydrogen Peroxide 3% Solution. On [DATE] at 6:35 AM, Nurse (Staff #21) locked the treatment cart. On [DATE] at 6:45 AM, the Administrator was notified of the unlocked treatment carts. On [DATE] at 4:38 PM, the Administrator provided a facility policy titled Storage of Medications, effective 9/2018. On [DATE] at 4:39 PM, review of this policy revealed that only licensed nurses, pharmacy personnel, and other individuals lawfully authorized to administer medications (such as medication aides) may access medications. The policy further states that medication rooms, carts, and supplies must be locked when not attended by authorized personnel. On [DATE] at 11:38 AM, the above concerns were discussed with the Director of Nursing (DON) and the Administrator. The DON reported that re-education of nursing staff on ensuring treatment carts remain locked had already begun. 2) On [DATE] at 8:40 AM, Nurse #3 provided a review of the medication storage room on the second floor that is at the front of the unit. Stored in the front medication storage room cabinets on the second floor were expired [NAME]-brand electrode packages from 04/2025 for what appeared to be an adult-size Automatic External Defibrillator, though Nurse #3 cannot verify that. (continued on next page)

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	215055	A. Building B. Wing	10/09/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:40 AM, Nurse #3 unlocked the refrigerator in the medication storage room, and it was revealed that resident specimens were also stored in the resident medication refrigerator. This was evident from clear sleeves containing what appeared to be red, body-fluid-like samples. Nurse #3 confirmed that resident specimens are kept in the resident medication refrigerator and stated they have observed stored specimens in other resident medication storage room refrigerators. On [DATE] at 9:10 AM, the first-floor resident medication storage room was observed with Nurse #5. The sink in the resident medication storage room had a dark, green-to-black substance around the drain, and a tabletop dehumidifying device was draining. Nurse #5 unlocked the refrigerator in the resident medication storage room, and it was revealed that resident specimens were stored there. This was evident from clear sleeves containing what appeared to be red, body-fluid-like samples. Nurse #5 confirmed, all resident specimens are kept in the medication refrigerator as a standard practice. On [DATE] at 09:50 AM, Nurse # 4 provided access to the resident medication storage room at the rear of the second-floor nursing unit. During the observation of the resident medication cart at the rear nursing station, it was revealed that the top drawer contained loose, unlabeled insulin pens: Resident #70: had three open insulin pens in one resident-specific zip sleeve. There is no date indicating when they were first initiated for use. Resident #126: No resident-specific label, in a clear zip sleeve with a Sharpie-marked last name on the insulin pen. No open date. Resident #117: No resident-specific label, in a clear zip sleeve with a Sharpie-marked last name on the zip sleeve. No open date. On [DATE] at 10:02 AM, Nurse #4 was present during the observation of the resident's medication cart. During the observation, Nurse #4 approached the cart where the surveyor was documenting and declaring the findings. Nurse #4 implemented corrective action during the observation and began to remove all of the unlabeled insulin pens, returned to the resident medication storage room, and obtained all new insulin pens with resident-specific labels to return to the cart. Nurse #4 acknowledged this was usual storage practice, The pharmacy has us store it like this. On [DATE] at 10:37 AM, during a review of the facility's policies on the topics below, it was found that the facility does not follow its policies for medication labeling and storage. Storage of Medications (effective 09/2018, revised 08/2024): procedure 1. The provider pharmacy dispenses medication in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. , 3. All medications dispensed by the pharmacy are stored separately from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately per facility policy. and 9. Medication storage areas are kept clean, well-lit, and free of clutter, extreme temperatures, and humidity. Medication Labels (effective 09/2018, revised 08/2020): procedures1. Labels are permanently affixed to the outside of the prescription container. No medication is accepted with the label inserted into a vial. If a label does not fit directly onto the product, the label may be affixed to an outside container or (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carton, but the resident's name must be maintained directly on the actual product container 2. Each prescription label includes:a. Resident's name b. When required by state regulations, specific directions for use, including route of administrationc. Medication name. Non-innovator multiple-source (generic) drug products dispensed in place of innovator brand (brand name) products are labeled with the generic name and the manufacturer's name or an acceptable abbreviationd. Strength of medication. Injectables and liquids are labeled with the strength per mL (milliliter) and the amount to be given in mL equivalents on the label. (Example: When furosemide 40mg injectable is ordered ad the pharmacy supplies it in a vial containing 40mg/mL, the directions read Inject 1mL (40 mg) e. Prescriber's namef. Date dispensed g. Quantity of medication h. beyond use or expiration date of medication i. Name, address, telephone number of the dispensing pharmacyj. DEA number of the dispensing pharmacy, if requiredk. Prescription numberl Auxiliary labels indicate storage requirements and special procedures, such as shake well, or refrigeratem. Container number and total of containers (i.e., 1 of 3, 2 of 3, 3 of 3) when multiple containers are dispensed for one prescription/order n. Initials of the dispensing pharmacist o. Lot number of the medication dispensed4. Improperly or inaccurately labeled medications should be rejected and returned to the dispensing pharmacy, and 6. Medication labels are not altered, modified, or marked in any way by nursing personnel. Contents are not transferred from one container to another. Under no circumstances are unattached labels requested from or accepted from the pharmacy. Only the pharmacy/registered pharmacist may place a label on the medication container On [DATE] at 2:45 PM, the Nursing Home Administrator and Director of Nursing were made aware of and acknowledged the deficiency. Refer also to F 880.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to have a system in place to ensure only one active version of a resident's orders for life-sustaining treatment was located in the medical record. This was found to be evident for one (Resident #3) out of four residents reviewed for advance directives.The findings include: Review of Resident #3's electronic medical record revealed, in the miscellaneous section, an upload of a current Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form that included orders to Attempt CPR. This order, also known as a full code, means if cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR); this includes any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function. This MOLST was dated [DATE].MOLST forms include orders for Emergency Medical Services (EMS) and other medical personnel regarding CPR. It is valid in all health care facilities and programs throughout the state. If a resident is transferred out of the facility it is expected that a copy of the MOLST will be sent with the resident. A MOLST that has not been voided (by having a line drawn across it and the word VOID) is considered to be a current active order.Further review of the electronic medical record's miscellaneous section revealed an upload titled VOID MOLST, however when surveyor opened this document an unvoided MOLST was found. Review of this MOLST, dated [DATE], revealed orders for No CPR. This order, also known as a Do Not Resuscitate (DNR) means if cardiac and or pulmonary arrest occurs, do not attempt resuscitation, allow death to occur naturally.On [DATE] at 11:57 AM interview with the Director of Clinical Operations (Staff #27) revealed that when a new MOLST is established the old MOLST is Voided and given to the social worker. The surveyor reviewed the concern that the old MOLST was not voided and that staff could have access to two different MOLST with conflicting orders.On [DATE] at 12:20 PM the Nursing Home Administrator (NHA) reported that the old MOLST was voided and showed surveyor that a voided version of the [DATE] MOLST was included with the [DATE] MOLST upload. The surveyor reviewed the concern with the NHA that staff could still access the old unvoided MOLST that had conflicting orders. The NHA reported: we train them to go with the most recent.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, it was determined that the facility failed to document that the resident either received the pneumococcal and influenza vaccine(s) or did not receive the vaccine(s) due to medical contraindications, previous vaccination, or refusal. This was evident for 1 (Resident #117) out 5 residents reviewed for immunizations during the survey.The findings include: On 10/6/25 at 12:20 PM a record review in the electronic health record (EHR) regarding Resident #117 vaccination records revealed that the resident was admitted on [DATE]. It lacked documentation of immunization of whether the resident did or did not receive the vaccines, contraindications, vaccine history or refusal. On 10/6/25 at 12:45 PM in an interview with the Nursing Home Administrator (NHA) and the Infection Preventionist (Nurse #15), indicated that the process for immunizing or verifying a new resident's vaccine status was usually done in 5 days. They were unable to produce documentation that Resident #117's vaccine status had been assessed, whether a vaccine was offered or refused. Nurse #15 stated, s/he must have slipped through the cracks. I'll follow up today. On 10/6/25 at 1:00 PM in an interview Resident #117 indicated that s/he did not think they [the facility] even offered it. On 10/9/25 the NHA, Infection Preventionist (Nurse #15) and DON were made aware of the concern.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, it was determined that the facility failed to document that the resident either received the Covid vaccine or did not receive the vaccine due to medical contraindications, previous vaccination, or refusal. This was evident for 1 (Resident #117) out 5 residents reviewed for immunizations during the recertification survey.The findings include:On 10/6/25 at 12:20 PM a record review in the electronic health record (EHR) regarding Resident #117 vaccination records revealed that the resident was admitted on [DATE]. It lacked documentation of Covid immunization, of whether the resident did or did not receive the vaccine, contraindications, vaccine history or refusal. On 10/6/25 at 12:45 PM in an interview, the Nursing Home Administrator (NHA) and the Infection Preventionist (Nurse #15), indicated that the process for immunizing or verifying a new resident's vaccine status was usually done in 5 days. They were unable to produce documentation that Resident #117's vaccine status had been assessed, whether the Covid vaccine was offered or refused. Nurse #15 stated, s/he must have slipped through the cracks. I'll follow up today. On 10/6/25 at 1:00 PM in an interview Resident #117 indicated that s/he did not think they [the facility] even offered it. On 10/9/25 the NHA, Infection Preventionist (Nurse #15) and DON were made aware of the concern.