STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that facility staff failed to ensure a resident received mail. This was evident for 1 (#5) of 8 residents reviewed during a complaint survey. The findings include: During an observation of the facility activity area on the first floor on 03/04/26 at 2 pm, an unopened letter addressed to Resident #5 was observed in the activity area. The letter to Resident #5 was from the local county DHS program and was stamped 10/24/25. A review of Resident #5's closed record revealed that Resident #5 was admitted to the facility on [DATE] and was discharged home on [DATE]. In an interview with the facility director of nurses (DON) on 03/04/26 at 3:32 pm, the facility DON was handed Resident #5's letter and stated that Resident #5 was recently discharged from the facility and could not give any details why the resident did not receive the letter in October 2025.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of medical records and all pertinent documents, and staff interview, it was determined that the facility failed to immediately notify a resident's physician with the results of a swallowing evaluation. This was evident for 1 (Resident #1) of 8 residents reviewed during a complaint survey. The findings include: On 02/26/26 the Office of Health Care Quality received a complaint #2789783, concerning the facility staff notifying Resident #1's physician regarding the results of a swallowing test. Review of Resident #1's closed clinical record on 03/03/26 revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that included but not limited to severe calorie malnutrition, pharyngeal dysphagia, dementia, and malignant neoplasm of the prostate. At the time of admission to the facility Resident #1 was noted to have cognitive issues. On 12/30/25, the facility staff conducted a BIMS assessment. A Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive status. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. On 12/30/25 Resident #1 was determined to have a BIMS score of 3/15 which indicates severe impairment. A Fiberoptic Endoscopic Evaluation of Swallowing (FEES procedure) is a 20-minute, in-office procedure used to assess swallowing safety and efficiency. A speech-language pathologist (SLP) passes a thin, flexible camera through the nose to view the throat directly on a screen while the patient eats and drinks, helping to detect aspiration or food residue. During the admission process, Resident #1 was evaluated by the facility Speech and Language Pathologist (SLP) on 12/30/25. A 12/30/25progress note indicated the facility SLP spoke to Resident #1's responsible party via the telephone regarding Resident #1's current diet and prognosis for an upgraded diet. The facility SLP indicated that Resident #1's responsible party indicated Resident #1 failed a swallowing test at hospital, but they would like Resident #1 to have another swallowing test, in hopes of upgrading the diet. The facility SLP obtained physician orders and scheduled a FEES exam for Resident #1 to be done at the facility on 01/09/26. On 01/09/26, the FEES procedure results for Resident #1 were available to the staff on the same day. Resident #1 FEES results indicated the following recommendations: Resident #1 should have a soft and bite sized/mechanical soft chopped diet with thin liquids. Compensatory strategies included sitting upright, no straws, single sips, small bites, with a slow rate of intake. The staff may consider obtaining a PROVALE drinking cup if patients do not complete single sips independently. A Provale Cup delivers small sips of thin liquids with every normal drinking motion. This may promote safer swallowing. In an interview with the facility director of nurses (DON) on 03/05/26 at 10:15 am, the DON stated that there were no nursing progress notes in Resident #1's chart indicating Resident #1's physician was made aware of the FEES procedure results on 01/09/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on reviews of facility reported incident and staff interview, it was determined the facility staff failed to immediately report an allegation of suspected resident abuse to the local police. This was evident for 1 (Resident #4) of 8 residents reviewed during a complaint survey. The findings include: On 02/03/26 the Office of Health Care Quality received a facility reported incident concerning allegations that Resident #4 was identified with a fractured left humerus. The incident was reported as an injury of unknown source on 02/03/2026. The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse are to be reported to the Office of Healthcare Quality and the local police in a timely manner. A review of the facility investigation into the injury of unknown source on 03/03/26 revealed a 5-day follow-up investigation report that an x-rayed identified Resident #4's fractured left humerus. At the time, Resident #4 was unable to tell the staff how the injury may have occurred. The facility reported there were no witnesses to the incident. The facility concluded that the conclusion was inconclusive and abuse had been ruled out. In the investigation, the facility measured Resident #4's BIMS and determined the score to be 13/15 though that Resident #4's BIMS score does fluctuate. A review of the facility Abuse policy on 03/05/26 revealed that the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with State law. Further review of the 5 day facility follow-up investigation indicated that the facility did not report this allegation of abuse to law enforcement. In an interview with the facility administrator and director of nurses (DON) on 03/11/26 at 3:45 pm during the exit conference, the facility administrator confirmed that law enforcement was not notified of the allegation of abuse of Resident #4 on 02/03/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of all pertinent documents and a closed medical record and facility staff interview, it was determined that the facility failed to revise care plans to meet a resident's needs. This was evident for 1 (Resident #1) of 8 residents reviewed during a complaint survey. The findings include: On 02/26/26 the Office of Health Care Quality received a complaint #2789783, concerning the facility staff notifying Resident #1's physician regarding the results of a swallowing test. Review of Resident #1's closed clinical record on 03/03/26 revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that included but not limited to severe calorie malnutrition, pharyngeal dysphagia, dementia, and malignant neoplasm of the prostate. At the time of admission to the facility Resident #1 was noted to have cognitive issues. On 12/30/25, the facility staff conducted a BIMS assessment. A Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive status. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. On 12/30/25 Resident #1 was determined to have a BIMS score of 3/15 which indicates severe impairment. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Review of Resident #1's care plans on 03/05/26 revealed the facility dietician identified and developed a nutritional risk care plan for Resident #1, dated 12/29/25, related to diagnoses that included: dementia, congestive heart failure, limited mobility, and possible food and medication interactions. Nutritional care plan goals included Resident #1 will tolerate a modified diet texture/consistency without difficulty and will maintain adequate nutritional status as evidenced by no significant weight change, no signs or symptoms of malnutrition, and will consume 50% of daily meals. Interventions to Resident #1's nutritional care plan included 1) administering medications as ordered and monitor and document any side effects and effectiveness. 2) Monitor, document, and report any signs and symptoms of dysphagia, pocketing food, choking, coughing, drooling, holding food in the mouth, several attempts at swallowing, refusing to eat, or appear concerned during a meal. 3) provide 1:1 assistance with meals as needed. 4) provide supplements as ordered. 5) Provide, serve diet as ordered and monitor intake and record every meal. 6) The dietician is to evaluate and make diet change recommendations as needed. During the admission process, Resident #1 was evaluated by the facility Speech and Language Pathologist (SLP) on 12/30/25. A 12/30/25progress note indicated the facility SLP spoke to Resident #1's responsible party via the telephone regarding Resident #1's current diet and prognosis for an upgraded diet. The facility SLP indicated that Resident #1's responsible party indicated Resident #1 failed a swallowing test at hospital, but they would like Resident #1 to have another swallowing test, in hopes of upgrading the diet. The facility SLP obtained physician orders and scheduled a FEES exam for Resident #1 to be done at the facility on 01/09/26. A Fiberoptic Endoscopic Evaluation of Swallowing (FEES procedure) is a 20-minute, in-office procedure used to assess swallowing safety and efficiency. A speech-language pathologist (SLP) passes a thin, flexible camera through the nose to view the throat directly on a screen while the patient eats and drinks, helping to detect aspiration or food residue. On 01/09/26, the FEES procedure results for Resident #1 were available to the staff on the same day. Resident #1 FEES results indicated the following recommendations: Resident #1 should have a soft and bite sized/mechanical soft chopped diet with thin liquids. Compensatory strategies included sitting upright, no straws, single sips, small bites, with a slow rate of intake. The staff may consider obtaining a PROVALE drinking cup if patients do not complete single sips independently. A Provale Cup delivers small sips of thin liquids with every normal drinking motion. This may promote safer swallowing. In an interview with RN#1 on 03/05/26 at 10:50 am, RN#1 stated that Resident #1's Nutritional Risk care plan was not updated with any new nursing interventions after the 01/09/26 FEES procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0684 Level of Harm - 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 the complaint, medical record review, reviews of all pertinent records from a local hospital and emergency services provider, interviews with current staff, and an interview with the resident's attending physician, it was determined that the facility failed to 1) honor a resident's end of life wishes. This caused harm to Resident #2. The facility also failed to follow the physician's specific pulse and blood pressure parameters before administering a cardiac medications. This was evident for 2 (Resident #2, Resident #4) of 8 residents reviewed during a complaint survey.The findings include:The Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding CPR and other life-sustaining treatment options. It is valid in all healthcare facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Within the No CPR section, there are three options: A-1 Intubate; A-2 Do Not Intubate but comprehensive efforts may include limited ventilatory support by CPAP or BiPAP; and Option B No CPR, Palliative and Supportive Care, do not intubate or use CPAP or BiPAP.On [DATE], the Office of Health Care Quality received a complaint regarding issues with notification of a change in condition and concerns about the quality of care provided to Resident #2.On [DATE], a review of Resident #2's electronic medical record revealed that Resident #2 was admitted to the facility on [DATE] with a MOLST form dated [DATE] indicating the resident was a full code and wished to receive all life-sustaining treatments. Resident #2 was readmitted to the facility on [DATE] after a hospitalization for pneumonia and electrolyte abnormalities. The resident's diagnoses included, but were not limited to, cerebrovascular accident with residual left-sided weakness, atrial fibrillation, diabetes, chronic anemia, gastrostomy tube, and metastatic prostate cancer to bone. On [DATE], the attending physician documented an extensive discussion with Resident #2 and the resident's power of attorney regarding the care plan and code status. It was decided that Resident #2 was to be DNR/DNI with other measures permitted but allowing natural death. The attending physician also documented that Resident #2 did not have the capacity to make medical decisions. A new MOLST form dated [DATE] was completed, indicating No CPR, Option A-2 Do Not Intubate (DNI).A review of Resident #2's Medicare 5ˆday readmission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], documented a Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment.In an interview with LPN #1 on [DATE] at 3:01 p.m., LPN #1 confirmed that they were the nurse who sent Resident #2 to the hospital on the evening of [DATE]. LPN #1 stated that Resident #2 had a change in condition and was observed vomiting coffeeˆgroundˆlike material. LPN #1 stated the on-call physician was notified and ordered Resident #2 to be transferred to the hospital via 911 ambulance. LPN #1 reported making copies of Resident #2's medical record, including medication orders and the MOLST form, but could not recall the specific contents of the MOLST form and stated only that the resident was a hospital transfer.During an interview on [DATE] at 4:00 p.m., Resident #2's attending physician stated that they were not aware of which MOLST form was sent to the hospital on [DATE] with Resident #2. The attending physician confirmed that on readmission to the facility on [DATE] they spoke with the resident's spouse, who stated that Resident #2 was to be DNR. The attending physician reported completing a new MOLST form and placing it in the resident's medical record.A review of Resident #2's hospital record on [DATE] revealed a MOLST form dated [DATE] indicating that Resident #2 was a full code and desired all life-sustaining measures. A hospital label dated [DATE] with Resident #2's medical record information was attached to the [DATE] MOLST form which arrived with Resident #2 in the hospital emergency room. The [DATE] MOLST had not been voided by the facility staff on [DATE] when the new MOLST was created.The facility staff failed to ensure the updated written wishes of Resident #2's end of life care by voiding the [DATE] MOLST when a new MOLST form was created on [DATE]. Resident #2 had a change in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 0684 Level of Harm - Actual harm Residents Affected - Few	condition on [DATE] and was sent to the hospital. At that time, the facility staff failed to clearly communicate Resident #2's updated MOLST form dated [DATE] to the emergency services personnel (EMS staff) on [DATE]. This failure resulted in harm to Resident #2, who had a do not resuscitate (DNR) and do not intubate (DNI) order on the [DATE] MOLST form. Resident #2 received cardiopulmonary resuscitation (CPR) and intubation during the transport to the hospital from the EMS crew. Resident #2 was resuscitated in the ambulance and remained in the hospital ICU for 20 days.2) Resident #4 was admitted to the facility on [DATE]. Resident #4's physician wrote an order, dated [DATE] at 9 am, instructing the nursing staff to administer the blood pressure medication Lisinopril, 10 mg, by mouth, one time a day, for hypertension, hold for a systolic pressure of less than 100 mm/Hg. A review of Resident #4's January and February 2026 medication administration records (MAR) revealed the nursing staff withheld administering a dose of Lisinopril 10 mg orally to Resident #4 on the following days: [DATE] - blood pressure documented 106/58XXX[DATE] - blood pressure documented 106/58XXX[DATE] - blood pressure documented 107/63XXX[DATE] - blood pressure documented 109/61XXX[DATE] - blood pressure documented 109/64XXX[DATE] - blood pressure documented 108/56XXX[DATE] - blood pressure documented 108/69. In an interview with LPN#3 on [DATE] at 12:13 pm, LPN#3 reviewed Resident #4's January and February 2026 MARs in relation to the documented blood pressure for each dose of Lisinopril. LPN#3 confirmed that they were the nurse who withheld a dose of Lisinopril to Resident #4 on the days in question. LPN#3 stated that they should have administered the dose of Lisinopril after re-reading the physician prescribed blood pressure parameters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 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 interviews it was determined that the facility failed to ensure medications were kept in locked compartments. This was evident in 1 (100 hall) of 4 nursing units observed. The findings include: On 03/10/26 at 10:58 am surveyor observed a medication cart unlocked an unattended in the hallway outside room [ROOM NUMBER]. No staff were observed around the medication cart at the time of the observation. This observation was immediately brought to the attention of LPN#2 who closed and locked the medication cart. This observation was brought to the attention of the director of nurses on 03/11/26 at 3:45 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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 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 reviews of a medical record and all pertinent administrative records, and staff interview, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 1 (Residents #4) of 8 residents reviewed during a complaint survey.The findings include:1) Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in conditions that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles. In an interview with the facility director of nurses (DON) on 03/04/26 at 4:33 pm, the DON stated that none of the facility policies and procedures have dates when they were implemented. Review of the facility policy Medication Administration on 03/09/26 instructs the nursing staff to: #20 - Sign the resident's Medication Administration Record (MAR) after the medication has been administered and #21 - If the medication is a controlled substance, sign the narcotic book. It was also noted that the Medication Administration policy did not reveal a date when the policy was implemented, revised, or what staff member reviewed and revised the policy. Resident #4 was admitted to the facility on [DATE]. During a review of Resident #4's medical record on 03/05/26, the nurse surveyor requested the Director of Nurses to please ask the medical records staff to bring all of Resident #4's thinned paper documents and access to Resident #4's electronic medical record. On 02/04/26 at 11:15 am, Resident #4's physician wrote an order instructing the nursing staff to administer the schedule II pain medication, Oxycodone, 5 mg, orally, every 6 hours as needed for left arm pain greater than 5/10 for 30 days. During the review of Resident #4's controlled medication utilization record medical records on 03/09/26, it was discovered that the nursing staff had administered 18 doses of the medication Oxycodone, 5 mg, orally between 02/05/26 and 03/09/26 to Resident #4. A review of Resident #4's February and March medication administration records (MAR) revealed the nursing staff had signed out and administered only 6 doses to Resident #4 between 02/05/26 and 03/09/26. 3 of the Oxycodone 5 mg doses documented as being signed out and administered to Resident #4 indicated Resident #4 complained of the following pain scale number:02/08/26, 6:08 pm, 3/10 pain.02/09/26, 6:50 pm, 0/10 pain.02/21/26, 7:05 pm, 3/10 pain. Further review of Resident #4's controlled medication utilization record and the February and March 2026 MAR's on 03/09/26, revealed that the nursing staff failed to perform a pain assessment and initial Resident #4's MAR as having administered a dose of 5 mg Oxycodone to Resident #4 on the following days:02/07/26 at 7 pm.02/13/26 at 6 pm.02/16/26 at 7 pm.02/17/26 at 6 pm.02/20/26 at 7 pm.02/27/26 at 7 pm.03/02/26 at 7 pm.03/04/26 at 8 pm.03/06/26 at 7 pm.03/08/26 at 7 pm.