STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215065	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Suites Rehabilitation and Wellness Center	13908 New Hampshire Avenue Silver Spring, MD 20904

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 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 record review and facility staff interviews, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's clinical status and physician-documented care for 2 of 3 sampled residents (Resident #9 and Resident #12). Facility failed to accurately code the presence of Intravenous (IV) access for Resident #9, and the administration of hypoglycemic medication, which was coded as administered when it had been placed on hold per physician orders for Resident #12. Findings included:Resident #9 was admitted to the facility on [DATE] with a diagnosis of high-grade papillary urothelial carcinoma status post chemoradiation, chronic kidney disease stage 4, and chronic obstructive pulmonary disease.Review done on 3/16/26 at 6:25 pm of admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #9 was moderately impaired with no intravenous (IV) access.Review done on 3/16/26 at 6:25 pm of the quarterly minimum data set (MDS) assessment dated [DATE] revealed that Resident #9 was moderately impaired with no IV access.Review done on 3/16/26 at 6:59 pm of hospital records (Discharge summary page 7/37 - lines/drains/airways) dated 11/20/25 at 8:25am, indicated that Resident #9 had an implanted port (adult) right chest.Review done on 3/16/26 at 6:51 pm of nurse progress notes dated 11/22/25 at 1:37 am written by Staff Nurse #23 indicated that Resident #9 had a Central IV line on the right chest, which was used for chemotherapy.Review done on 3/16/26 at 6:51 pm of history and physical dated 11/25/25 at 11:19 am, written by Medical Doctor (MD) 40, indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 6:51 pm of provider progress notes dated 11/27/25 at 12:59 am written by MD #34 indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 6:51 pm of provider progress notes dated 11/29/25 at 12:59 am, written by MD #34, indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 6:51 pm of provider progress notes dated 12/2/25 at 8:19 am, written by MD #34, indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 6:51 pm of provider progress dated 12/3/25 at 4:51 pm, written by Medical Doctor (MD) 40, indicated that Resident #9 had a Port-a-catheter on the right upper chest.During the interview on 3/17/26 at 10:56, GNA #5 indicated that she recalled Resident #9. GNA #5 indicated that Resident #9 had an IV line that was on the right chest. GNA #5 stated that Resident #9 was admitted with an IV line in place.During the interview on 3/19/26 at 9:50 am, Staff Nurse #7 indicated that they recalled Resident #9. Staff Nurse #7 stated that Resident #9 had access IV due to the presence of a port-a-catheter on his/her right chest.During the interview on 3/19/26 at 11:59 am, MDS Staff Nurse #35 indicated that she would verify why the IV access was not accurately coded on the MDS assessment. b. Resident #12 was admitted to the facility on [DATE] with a diagnosis of diabetes, chronic obstructive pulmonary disease, obstructive and reflux uropathy, chronic kidney disease, hypertension, and dementia.Review done on 3/16/26 at 8:53 pm of the significant change in status, minimum data set (MDS) assessment dated [DATE], indicated that Resident #12 was taking a hypoglycemic (including insulin) medication during the last 7 days or since admission/entry or reentry if less than 7days.Review done on 3/16/26 at 9:29 pm of physician orders dated 9/3/25 at 11:06 pm, written by MD #34, indicated that Glipizide ER (hypoglycemic) oral tablet (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extended release 24-hour 5mg, give 1 tab by mouth one time a day for diabetes, was placed on hold due to patient being lethargic.Review done on 3/16/26 at 9:29 pm of physician orders dated 9/19/25 at 11:34 pm, written by MD #34, indicated that Glipizide ER (hypoglycemic) oral tablet extended release 24-hour 5mg, give 1 tab by mouth one time a day for diabetes, was discontinued due to poor oral intake and risk of hypoglycemia.Review done on 3/16/26 at 9:29 pm of the Medication Administration Record (MAR) for September 2025 revealed that Glipizide ER (hypoglycemic) Oral tablet extended release 24-hour 5 mg was on hold from 9/4/25 to 9/19/25. MAR indicated that Resident #12 did not receive glipizide ER (Hypoglycemic) oral tablet from 9/4/25 to 9/19/25.Multiple attempts (3/18/26 at 10:34am, 3/18/26 at 3:36 pm, 3/19/26 at 1:13 pm) to interview MD #34 were unsuccessful.During the interview on 3/19/26 at 11:59am, MDS Nurse #35 indicated that the MDS assessment should be accurately coded to reflect the care plan.During the interview on 3/16/26 at 12:03 pm, the Administrator indicated that the MDS assessment should accurately reflect the medical record and resident plan of care.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement a comprehensive, person-centered care plan to address a resident's central venous access device for 1 of 3 sampled residents (Resident #9). Findings include:Resident #9 was admitted to facility on 11/21/25 with diagnosis of high-grade papillary urothelial carcinoma status post chemoradiation, Infrarenal abdominal aortic aneurysm without rapture, atherosclerotic heart disease of native coronary artery without angina pectoris, peripheral vascular disease, chronic kidney disease stage 4, syncope and collapse, gastrointestinal hemorrhage, duodenal ulcer, dysphagia, obsessive compulsive disorder, major depression, chronic obstructive pulmonary disease, respiratory failure with hypoxia, presence of cardiac pacemaker, and duodenal ulcer. Review done on 3/16/26 at 6:25 pm of the admission minimum data set (MDS) assessment dated [DATE] revealed that Resident #9 was moderately impaired. Review done on 3/16/25 at 6:31 pm of the care plan initiated on 12/2/25 indicated that Resident #9 had impaired cognitive function. Care plan initiated on 12/2/25 revealed that Resident #9 was at risk for abnormal bleeding or hemorrhage due to anticoagulant/antiplatelet use. Review of care plan initiated 11/22/25 did not reveal evidence addressing the presence of a port-a-catheter, including no interventions for site care or dressing changes, no interventions for flushing or maintenance of the line, no monitoring for complications such as infections, occlusion or dislodgement, no staff guidance regarding management of the central intravenous (IV) access lines (Central line, or any other type of IV line access). Review done on 3/16/26 at 6:59 pm of hospital records (Discharge summary page 7/37 - lines/drains/airways) dated 11/20/25 at 8:25am, indicated that Resident #9 had an implanted port (adult) right chest. Review done on 3/16/26 at 6:51 pm of nurse progress notes dated 11/22/25 at 1:37 am written by Staff Nurse #23 indicated that Resident #9 had a Central IV line on the right chest, which was used for chemotherapy. Review done on 3/16/26 at 6:51 pm of history and physical data dated 11/25/25 at 11:19 am, written by Medical Doctor (MD) 40, indicated that Resident #9 had a Port-a-catheter on the right upper chest. Review done on 3/16/26 at 6:51 pm of provider progress notes dated 11/27/25 at 12:59 am written by MD #34 indicated that Resident #9 had a Port-a-catheter on the right upper chest. Review done on 3/16/26 at 6:51 pm of provider progress notes dated 11/29/25 at 12:59 am, written by MD #34, indicated that Resident #9 had a Port-a-catheter on the right upper chest. Review done on 3/16/26 at 6:51 pm of provider progress notes dated 12/2/25 at 8:19 am, written by MD #34, indicated that Resident #9 had a Port-a-catheter on the right upper chest. Review done on 3/16/26 at 6:51 pm of provider progress dated 12/3/25 at 4:51 pm, written by Medical Doctor (MD) 40, indicated that Resident #9 had a Port-a-catheter on the right upper chest. During the interview on 3/17/26 at 10:56, GNA #5 indicated that she recalled Resident #9. GNA #5 noted that Resident #9 had an IV line in the right chest upon admission and stated they did not know what type of line it was or how it was managed. During the interview on 3/19/26 at 9:50 am, Staff Nurse #7 indicated that they recalled Resident #9. Staff Nurse #7 confirmed that Resident #9 had IV access via a port-a-catheter and that care related to the IV access, including dressing management, was unclear due to the absence of a care plan. During the interview on 3/19/26 at 11:59 am, MDS Staff Nurse #35 stated that Resident #9 had a significant clinical condition and treatment that should have been reflected in the care plan. During the interview on 3/19/26 at 12:03 pm, the Administrator stated that the care plan should address the residents' clinical needs and guide staff in delivering care.

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NAME OF PROVIDER OR SUPPLIER: Harmony Suites Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 13908 New Hampshire Avenue Silver Spring, MD 20904	

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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 staff interviews, the facility failed to ensure a resident received necessary care and services to maintain the highest practicable physical well-being by failing to assess, monitor and obtain appropriate treatment orders for an accessed implanted port for 1 of 3 sampled residents (Resident #9). The facility failed to initiated care from admission on [DATE] until 12/15/25, when physician orders were finally obtained, placing the resident at risk for complications including infection and loss of device patency. Findings include: Resident #9 was admitted to facility on 11/21/25 with diagnosis of high-grade papillary urothelial carcinoma status post chemoradiation, Infrarenal abdominal aortic aneurysm without rapture, atherosclerotic heart disease of native coronary artery without angina pectoris, peripheral vascular disease, chronic kidney disease stage 4, syncope and collapse, gastrointestinal hemorrhage, duodenal ulcer, dysphagia, obsessive compulsive disorder, major depression, chronic obstructive pulmonary disease, respiratory failure with hypoxia, presence of cardiac pacemaker, and duodenal ulcer. Review done on 3/16/26 at 6:25 pm of the admission Minimum Data set (MDS) assessment dated [DATE] revealed that Resident #9 was moderately impaired. Review done on 3/16/26 at 6:51 pm of nurse admission progress notes dated 11/22/25 at 1:37 am, written by Staff Nurse #23, indicated that Resident #9 had a Central intravenous (IV) line on the right chest, which was used for chemotherapy. Review done on 3/16/26 at 6:51 pm of the medical record revealed that no physician orders were obtained for dressing changes, flushing protocols, or site maintenance from admission on [DATE] through 12/15/25. Review of medical records revealed there was no evidence of ongoing assessment or monitoring of the device. Review done on 3/16/26 at 6:51 pm of physician orders revealed an entry created by Staff Nurse #38 on 12/15/25 at 11:24am, signed by Nurse Practitioner (NP) #8, which indicated that IV: implanted port (venous) lumens not in use flush port lumen with 20cc of saline followed by 5cc of heparin (100u/ml) every month. one time a day. During the interview on 3/19/26 at 9:50 am, Staff Nurse #7 stated that the dressing on Resident #9's IV access was not changed, and the port-a-catheter was not flushed because no physician orders had been initiated. During the interview on 3/19/26 at 1:04 pm, NP #8 confirmed that they were notified weeks after admission that Resident #9 had no orders obtained for management of the port-a-catheter. During the interview on 3/19/26 at 2.19 pm, Staff Nurse #38 stated that, upon assessment on 12/15/25, Resident #9 had a port-a-catheter with a Huber needle in place and no prior orders for care. During the interview on 3/19/26 at 11:36 am, the Director of Nursing (DON) confirmed that the facility did not maintain IV access or perform dressing changes and acknowledged that the resident did not have physician-ordered interventions initiated on admission. During the interview on 3/19/26 at 11:49 am, the Administrator stated that the oncology provider reported that the port-a-catheter on Resident #9 was not maintained appropriately and that the lumen remained in place.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, records review and facility investigative material the facility failed to ensure adequate supervision and failed to implement appropriate interventions to prevent one Resident (R), R16, with a history of exit seeking behaviors from elopement, when R16 exited the facility without the facility knowledge for approximately eight hours. Out of 1 of 3 sampled Residents. The census was 90. Findings Include:A review on 3/17/26 at 9:15 am of the undated facility policy Elopement Prevention and Management Overview found that elopement occurs when a resident leaves the facility or a safe area without permission or supervision, putting them at risk. If a resident who can make decisions leaves on purpose, it is not usually considered elopement unless the facility did not know the resident left or where they were.The policy documents that the interdisciplinary team plans the least restrictive interventions to promote mobility and safety, and to meet the individualized needs and goals of the Resident/patient. Components of the Elopement Prevention and Management Program include Elopement drills, environmental modifications to promote safe mobility with monitoring effectiveness, and a protected list of names and photographs of at-risk Residents/Patients. Regular rounds and structured group activities are also components.Record review on 3/16/26 at 2:30 pm of Resident #16's Face sheet showed Resident #16 was admitted on [DATE]. Diagnoses included Dementia without Behavioral Disturbance, Psychotic Disturbance, Communication deficit, and Muscle weakness with difficulty walking.Record review done on 3/16/26 at 2:31 pm of Resident #16's Nursing admission Evaluation on 8/19/2025 at 8:45 PM, documented by Staff Nurse #24, showed Resident #16 exhibited exit-seeking behaviors. Record review conducted on 3/16/26 at 2:35 pm of Resident #16's Care Plan, initiated on 8/20/2025, documented risks including unsteady gait, impaired communication, skin integrity concerns, and impaired cognitive and visual function. Notably, wandering behaviors were not addressed in the care plan until 10/25/2025, over two months after admission, when interventions for wandering were finally included.Record review on 3/16/26 at 3:30 pm of Resident #16's quarterly Minimum Data Set (MDS) assessment dated [DATE], recorded Resident #16's Brief Interview of Mental Status (BIMS) score was 5. This indicated that Resident #16 had memory problems. with memory. Section GG noted Resident #16 used a wheelchair for locomotion and was dependent on staff for most activities of daily living (ADLs).Record review done on 3/16/26 at 3:35 pm of Resident #16's progress notes dated 10/25/2025 at 9:13 PM, documented by Staff Nurse #3, showed Resident #16 wandered and eloped from the facility. Resident #16 was found and brought back to the facility. Upon assessment, no visible injury or signs of distress were noted; Resident #16 denied pain.Record review done on 3/16/26 at 3:35 pm of Resident #16's progress notes dated 10/27/2025, the facility Nurse practitioner (NP)8 documented he/she interviewed Resident #16 and Resident #16 described the event calmly and stated he/she waited at the back door until an opportunity arose and left when the person nearby stepped away. NP #8 documented Resident #16 reported he/she experienced a fall during the episode of elopement, stated he/she lost balance and fell while leaving the building. Resident #16 denied pain at the time.During an interview on 3/16/2026 at 10:30 AM, Staff Nurse #7 stated that Resident #16 was well-spoken. Resident #16 used a wheelchair and self-propelled without assistance. On 10/25/2025 at approximately 12:30 PM, Environmental Service Aide (ESA) 10 opened the door for Resident #16, who left the facility. Resident #16 could not remember his/her way back and ended up at the local police department. In an interview on 3/16/2026 at 11:15 AM, the Administrator said ESA 10 opened the door for Resident #16, who left while ESA 10 was cleaning the floors. Resident #16 was last seen around 12:30 PM on 10/25/2025. A citizen found Resident #16, who may have fallen by a busy street, and took them to the police. The police called emergency services, and Resident #16 went to the hospital. The Administrator was informed by the police that Resident #16 had been sent to the hospital. The Administrator said staff (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were retrained and actions were taken about residents leaving; these were ongoing. During an interview on 3/17/2026 at 9:58 AM, the Director of Nursing (DON) stated Resident #16 was unable to walk long distances without a wheelchair. According to the DON, the last note in Resident #16's progress notes, dated 10/25/2025, showed that Resident #16 had lunch, and staff documented that Resident #16 ate independently. According to the DON, there was no documentation showing that Resident #16 was not accounted for approximately eight hours from 1:00 PM through 9:00 PM, until the facility received notification that Resident #16 was at the local emergency department.During an interview on 3/17/2026 at 12:09 PM, the Maintenance Director said Resident #16 often tried to leave and expressed a desire to go home to see grandchildren.During an interview on 3/18/2026 at 10:20 AM, ESA 10 said Resident #16 often moved up and down the hall in a wheelchair. On 10/25/2025 at about 12:30 PM, Resident #16 asked ESA 10 to go outside. ESA 10 opened the door, and Resident #16 went outside. ESA 10 worked for less than 2 weeks at the facility and was not trained in elopement prevention. ESA 10 said he/she realized the mistake after being let go on 10/31/2025. During an interview on 03/18/2026 at 10:06 AM, the Regional Director of Clinical Services revealed that Resident #16's elopement on 10/25/2025 was preventable and concluded on 10/31/2025. All residents identified as wanderers were placed under wander guards.During an interview on 3/20/2026 at 8:30 AM, the Administrator stated that staff will be continuously educated on elopement prevention. Residents will request a pink slip before they can exit the building. Staff were unaware that Resident #16 had eloped and left the facility for several hours.On 3/18/2026, a past compliance Immediate Jeopardy was signed by the administrator.The facility implemented measures effective for supervision and elopement prevention for all residents with cognitive impairment and /or exit-seeking behaviors.Review on 3/18/25 at 7:30 am of the corrective action to address noncompliance indicated that on 10/25/2025 at approximately 4:45pm, law enforcement contacted the Administrator to notify them Resident #16 was observed on New Hampshire Avenue by a citizen who brought him/her to the police station. Law Enforcement stated they sent Resident #16 to a local hospital. The weekend supervisor, Registered Nurse (RN) 13, called the Administrator to report that Resident #16 had left the building and had been transferred to the local hospital. Maintenance Director and GNA #14 picked up Resident #16 from the hospital at approximately 8:17pm.On 10/25/25, the facility immediately implemented a 100% headcount. Resident #16 was immediately assessed following the elopement incident upon return from the hospital. Resident #16 was then placed on 1:1 care for 24 hours. Resident #16 had labs ordered, and a full body skin assessment was completed. Wander guard was placed on Resident #16's right wrist; the order was updated to reflect wander guard, the care plan was updated, and the elopement binder was updated. Resident #16's elopement risk assessment was reviewed and revised to ensure accuracy and appropriateness of interventions. On 10/25/25, an elopement drill was completed on each shift. Staff were educated regarding elopement, and statements were received.On 10/27/25, all residents in the facility were reviewed for elopement risk. Elopement assessments were completed and/or updated for current residents. Residents identified as at risk received a wander guard order, a wander guard placement, a care plan update, and behavior monitoring. The facility's elopement binder was audited and updated to ensure all at-risk residents are accurately identified and tracked.On 10/31/25, the facility initiated Systemic Changes to Prevent Recurrence. The facility implemented the following system-wide interventions: Wander guards were applied to identified at-risk residents; a Leave of Absence (LOA) pink form process was implemented, requiring the front desk to be notified before leaving the building. Staff were re-educated on elopement prevention protocols for the use of the LOA form; Elopement policies and procedures were reviewed and reinforced with all staff. The facilities Ongoing Monitoring and Quality Assurance. The facility conducted ongoing audits to ensure compliance: the elopement binder was audited continuously to ensure accuracy; LOA documentation was reviewed continuously for compliance; and a random sample of residents was audited to ensure elopement risk assessments and interventions were in place. The results of these audits were reviewed in the Quality Assurance and Performance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Improvement (QAPI) program. Any identified issues were addressed promptly with corrective action by the facility.On 3/17/2026 at 1:30pm, four staff members were interviewed (Geriatric Nursing Assistant #11, Geriatric Nursing Assistant #12, Maintenance Director #9, and Environmental Aide #10). All four staff stated that the facility used a pink slip system for all residents to present to staff upon exiting.Based on the above actions taken by the facility and verified by the on-site surveyor, it was determined that the facility's deficient practice was past noncompliance, with a compliance date of 10/31/2025.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and staff interviews, the facility failed to implement and maintain an effective infection prevention and control program by failing to follow established standards of practice for care and maintenance of an accessed central venous device (Port-a-catheter) for 1 of 3 sampled residents (Resident #9). These failures included not performing dressing changes, not maintaining aseptic technique, and leaving an accessed device (Huber needle- special type of needle used to access implanted ports)) in place without proper care, placing the resident at increased risk for infection.Findings include:Resident #9 was admitted to the facility on [DATE] with a diagnosis of high-grade papillary urothelial carcinoma status post chemoradiation, chronic kidney disease stage 4, and chronic obstructive pulmonary disease.Review done on 3/18/26 at 3:00 pm of facility's policy and procedures for Central Venous Catheter, Section 5.1, effective date 2/7/20, required changes on admission, weekly, and as needed; assessment of insertion site for erythema, drainage, and edema; use of aseptic techniques during dressing changes; routine flushing protocols for accessed and non-accessed ports; regular needless connector changes.Review done on 3/16/26 at 6:25 pm of admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #9 was moderately impaired.Review done on 3/16/26 at 6:31 pm of the care plan initiated on 12/2/25 indicated that Resident #9 had impaired cognitive function. Care plan initiated on 12/2/25 revealed that Resident #9 was at risk for abnormal bleeding or hemorrhage due to anticoagulant/antiplatelet use.Review done on 3/16/26 at 6:51 pm of nurse admission progress notes dated 11/22/25 at 1:37 am, written by Staff Nurse #23, indicated that Resident #9 had a Central intravenous (IV) (catheter inserted into a vein) line on the right chest, which was used for chemotherapy.Review done on 3/16/26 at 6:51 pm of history and physical data dated 11/25/25 at 11:19 am, written by Medical Doctor (MD) 40, indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 6:51 pm of provider progress notes dated 11/27/25 at 12:59 am written by MD #34 indicated that Resident #9 had a Port-a-catheter on the right upper chest.Review done on 3/16/26 at 7:01 pm of the medical record revealed that Resident #9 did not have any physician orders for Central intravenous (IV) access (port-a-catheter) dressing changes, flush protocols, and site maintenance on admission.During the interview on 3/17/26 at 10:56, Geriatric Nurse Aide (GNA) 5 indicated that Resident #9 had a dressing with an IV line to the right chest upon admission. GNA #5 indicated that they had provided showers to Resident #9 and observed that the dressing remained unchanged. GNA #5 stated that they were not provided with any instructions regarding the IV site or precautions during bathing or showering. During the interview on 3/19/26 at 2.19 pm, Staff Nurse #38 indicated that they recalled Resident #9. Staff Nurse #38 stated that on 12/15/25, they observed Resident #9 with a Port-a-catheter and a Huber needle (special type of needle used to access implanted ports) in place, with the dressing not changed.During the interview on 3/19/26 at 1:04 pm, Nurse Practitioner (NP) 8 stated they were notified weeks after admission that Resident #9 had a port-a-catheter with a lumen (inside space of a tube where fluid flows) still accessed and no dressing changes performed.During the interview on 3/19/26 at 11:36 am, the Director of Nursing (DON) confirmed that the facility did not maintain IV access or perform dressing changes and acknowledged that the resident was at high risk for infection.During the interview on 3/19/26 at 11:49 am, the Administrator stated that the oncology provider reported that the port-a-catheter on Resident #9 was not maintained appropriately and that the lumen remained in place.