

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
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	
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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interviews, record reviews and staff interviews, it was determined that the facility failed to provide pain management according to professional standards. This was evident for 3 (Residents #59, #3, and #8) of 6 residents reviewed for unnecessary medications and pain during the annual/complaint survey. This resulted in actual harm to Resident #59. The findings include: A pain scale is a 0-10 numerical tool for assessing pain severity, with zero representing no pain and 10 the worst pain imaginable. According to the Mayo Clinic, pain scores from 1-3 are mild, 4-6 are moderate, and 7-10 are severe. 1) On 05/11/2026 at 9:49AM, during an interview, Resident #59 reported pain from head to toe and expressed that two types of pain medication, including a nightly scheduled dose, had been unavailable for days. On 05/13/2026 at 11:40 AM, a review of Resident #59's Care Plan (revised 04/30/2026) noted chronic pain from arthritis and a spinal fracture. Interventions required following physician orders and administering prescribed medications. On 05/13/2026 at 10:56 AM, a review of Resident #59's medical record revealed physician orders for Buprenorphine sublingual film, one sublingual film daily (04/30/2026), and Oxycodone 5 mg every 6 hours as needed (04/29/2026). Further review of Resident #59's medication administration record (MAR) revealed buprenorphine was last given on 05/06/2026, with subsequent entries (May 7&ndash;10) coded as 9 (other&mdash;see nurses' notes). On 05/13/2026 at 11:11 AM, a review of Resident #59's progress notes from May 7&ndash;10, 2026, revealed that buprenorphine HCl-naloxone HCl (2-0.5 mg daily) was delayed by the pharmacy; there was no explanation for the missed dose on 05/09/2026. Continued review showed there was no evidence suggesting the facility used its emergency backup medication system or contacted the provider to obtain alternative pain medications. Additionally, a review of Resident #59's pain level summary from 05/07/2026 and 05/11/2026 shows Resident #59's pain scores ranged from 2 to 7, while the buprenorphine patch remained unavailable since its last administration on 05/06/2026. On 05/15/2025 at approximately 8:50 AM, a review of Resident #59's narcotic sign-out sheets for Oxycodone indicated that Oxycodone was administered twice a day from 05/01/2026 through 05/08/2026, with the exceptions of 05/02 (one dose) and 05/03 (no doses). The last dose available was recorded on 05/09/2026. Continued review of Resident #59's medication administration record (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 0697 Level of Harm - Actual harm Residents Affected - Few	(MAR) showed that 8 doses corresponded to pain levels between 5 and 7. Additionally, a review of Resident #59's pain level summary from 05/09/2026 and 05/11/2026 revealed pain scores ranging from 2 to 5, while the oxycodone as needed pain medication remained unavailable since its last administration on 05/09/2026. On 05/13/2026 at 11:16 AM, further review of Resident #59's progress note dated 05/08/2026 at 6:59 AM revealed overnight complaints of nausea, headache, and frequent stools. Ondansetron (a medication used for nausea and vomiting) was administered for nausea but was not effective. On 05/15/2026 at 8:37 AM, an interview with Staff #15 (LPN) Staff #15 reported a system glitch with a 05/08/2026 reorder of buprenorphine and oxycodone, noting that the pharmacy failed to deliver timely despite a follow-up call by her on 05/09/2026. However, there was no evidence of a pharmacy call until 05/10/2026, noted for the buprenorphine sublingual film pain medication as awaiting pharmacy to deliver; call put in by writer. The new scripts for both pain medications arrived on 05/12/2026 at 9:00 AM&mdash;72 hours after the last Oxycodone dose and six days after the last Buprenorphine dose. On 05/14/2026 at 5:08 PM, further review of Resident #59's medical record revealed that during a 05/11/2026 Nurse Practitioner (NP) encounter (signed 05/13/2026), Resident #59 was tearful during the NP visit, reported anxiety, and requested an increase in Oxycodone for widespread pain (extremities, shoulder, back, knees, and face). Despite documenting these symptoms, the nurse practitioner discontinued oxycodone and buprenorphine HCl-naloxone HCl, maintaining only Tylenol, lidocaine, and gabapentin. While stable pain control was the goal, the NP only provided a psychiatric referral without an alternative pain management plan. Consequently, the resident called 911 for uncontrolled pain and nausea on 5/12/26. On 05/13/2026 at 11:35 AM, a review of Resident #59's medical record revealed an E-Interact form dated 05/12/2026 at 12:30 AM documented a blood pressure reading of 174/94. The documentation noted that Resident #59 personally contacted emergency services (911) because of persistent pain and nausea. The resident described the pain as being all over from head to toe, rating it at a maximum intensity of 10/10. On 05/13/2026 at 2:47 PM, during an interview, the Director of Nursing (DON) outlined the protocol for unavailable pain medication. Nurses must check the NexyS system; if the specific dosage is unavailable, they must obtain a one-time order, contact the physician for an alternative, and follow up with the pharmacy for an expected arrival time. All interventions must be documented in nursing notes. The DON emphasized that the physician should be notified immediately if a resident requires pain medications that are unavailable. The Director of Nursing was notified of the concern at this time. On 05/14/2026 at 4:59 PM, during a phone interview, the Nurse Practitioner (NP) stated there was currently no plan for Resident #59's pain management following the discontinuation of pain medications on 05/11/2026. The NP noted that Resident #59 complained that the current pain regimen was ineffective, surgery was declined, and opioids or NSAIDs were not safe due to respiratory and cardiac risks. Although she was planning to recommend outpatient non-opioid management, the (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	resident was hospitalized , and she acknowledged the resident had been without prescribed medications for several days. On 05/15/2026 at 3:57 PM, the Director of Nursing (DON) reported that Staff #15 (LPN) confirmed the resident requested pain medication, and that is what prompted a call to the pharmacy. No further actions/interventions were documented or completed. The DON acknowledged the ongoing pain management concerns. 2) Non-pharmacological interventions are identified as the alternative methods of treatment for a medical concern without the use of medication. This could include physical, psychological, and lifestyle interventions designed to reduce pain and improve quality of life. The CDC's 2022 Clinical Practice Guideline for Prescribing Opioids emphasizes non-pharmacological, non-opioid therapies as the first line of treatment for subacute and chronic pain. On 5/13/2026 at 09:18 AM a review of Resident #3's care plan created on 04/8/2026, revealed that the resident had complaints of chronic pain and was at Risk for Pain Disease processes, Impaired mobility. Care plan intervention indicated: administer non-pharmacological interventions and evaluate the effectiveness of interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery). Further record review on 05/13/2026 at 11:45 AM, a review of Resident #3's Medication Administration Record (MAR) revealed: oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain Hold for signs of overdose, sedation and or RR less than 12 -Start Date 05/05/2026. Oxycodone 5mg orally was administered on 05/13/2026 at 09:25 AM. On 05/14/2026 at 08:15 AM, in an interview with the Director of Nursing (DON), the DON agreed that the residents should have non-pharmacological measures documented as required per the care plan. She explained that an audit of the charts for residents who were prescribed as needed pain medications were completed and the non-pharmacological interventions were added to their records. She also explained that staff will be educated on pain management and documentation. On 05/14/2026 at 09:51 AM, in a DON interview, the DON was made aware that Resident #3 has an order for as needed pain medication and care plan documentation indicate non-pharmacological intervention; however, there was no documentation to suggest that the facility implemented alternative treatment methods for pain as suggested on the care plan. 3) On 05/13/2026 at 3:46 PM, during record review for unnecessary medication, it was noted that resident # 8 was ordered the following medications for pain: -Acetaminophen Oral Tablet 325 MG, Give 2 tablets by mouth every 4 hours as needed for Pain, Active since 12/10/2025. -oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl). Give 1 tablet by mouth every 24 hours as needed for pain, scale 5-10. Active since 2/5/2026. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Care Plan reviewed on 5/13/2026 at 3:52 PM, noted that Resident # 8 has chronic pain related to diagnosis of paraplegia, chronic pain syndrome. Date Initiated: 12/19/2023 Revision on: 04/16/2026; in addition, administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery). Date Initiated: 04/13/2025 Revision on: 04/04/2026. On 5/14/2026 at 11:32 AM, during the review of the Medication Administration Record (MAR), Treatment Administration Record (TAR) and the Behavior Monitoring Record, there were no nonpharmacological interventions listed to be used when an as needed pain medication was administered. During an interview with the DON on 5/15/2026 at 1:30 PM concerning the documentation of pain assessment and the use of nonpharmacological interventions, she stated that there was none for this resident, and that the staff will implement them as soon as possible. The DON was made aware that this was a concern related to pain management documentation. On 5/15/2026 at 2:44 PM, a review of the orders noted that Resident #8 had an order for PRN (as Needed) pain medication Non-Pharmacological Intervention Documentation: 1=Repositioning, 2=Heat application, 3=Cold application, 4=Massage of painful area, 5=Dim lights/Quiet environment, 6=Distraction/Music/TV/Books, 7=Offer Rest Period, 8=Food/Drink, 9=Did Not administer PRN this shift, for every shift written after the surveyor's intervention of concern for pain management.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview, review of intake #2671457, and record review, it was determined the facility failed to provide a resident with a written notice and reason for the room change before the resident was moved. This was evident for 1 (Residents #54) of 1 who had expressed a concern regarding room changes during the recertification survey. The findings include: On 05/11/2026 at 11:50 AM, during an interview, Resident #54 expressed a concern that the facility moved him/her from one room to another with no advance notice. He/she did not want to change rooms. On 05/12/2026 at approximately 12:10 PM, review of intake #2671457 revealed Resident #54 was moved from one room to another at the facility without notice. Neither the resident nor their power of attorney (POA) received prior notification; the POA only learned of the relocation when the facility demanded advance payment for Resident #54's continued care after the room change was completed. On 05/12/2026 at 12:15 PM, a review of Resident #54's progress notes dated 10/31/2025 at 1:04 PM revealed that a room change had occurred. During this transition, all personal belongings were moved, and administrative staff addressed the concerns raised by the resident and their family members. Subsequent documentation on 10/31/2025 at 1:11 PM confirmed the completion of the room transfer. With the resident present, the social worker contacted the power of attorney (POA) by telephone; the POA agreed to visit the facility to support the resident through the transition. On 05/12/2026 at 11:58 AM, during an interview, the Administrator stated that room changes occur with the agreement of the resident or their responsible party. The roommate is notified before the change is made. This process is documented in PCC and Social Services progress notes, and written notification of the room change is provided to the resident and maintained in their paper chart. On 05/12/2026 at 12:30 PM, a review of Resident #54's paper chart was conducted in the presence of Staff #6 (Registered Nurse Unit Manager); it was determined that the record contained no evidence of a written room change notice being provided to Resident #54. The unit manager verified this finding. On 5/12/2026 at approximately 3:00 PM, the Administrator was made aware of the concern.		

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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. Based on interviews, review of Intake #2801915, and facility document review, it was determined that the facility failed to provide grievance procedure information to residents or maintain an effective grievance process. This was evident during a resident council meeting and review of 2 months of grievances during the recertification survey. The findings include: On 05/14/2026 at 1:23 PM the surveyor attended a resident council meeting with six residents. During the meeting, the residents stated that they did not know how to file a grievance/concern. On 05/11/2026 at 11:05 AM, during an interview, Resident #64 reported that GNAs frequently deactivate this/her call lights and verbalize they will return-claiming administrative monitoring-but then staff fail to provide assistance for several hours afterward. Resident #64 noted he/she has reported this issue to multiple staff members. On 05/12/2026 at approximately 2:30 PM, review of Intake #2801915 identified concerns regarding significant delays in the delivery of care, as well as disrespectful, intimidating, and occasionally coercive behavior by staff members. On 05/13/2026 at 2:30 PM, a review of a grievance form dated 07/14/2025 revealed a resident called staff after having an accident. Staff came and said they would come back but did not return until 3 hours later. The form lacked investigation details, conclusions, resolution dates, corrective measures, and evidence of communication. Two grievances from 09/16/2025 detailed staff disrespect and ignored needs. In one, a resident threatened to leave the facility due to a Geriatric Nursing Assistant's disrespectful behavior; although marked resolved, the facility provided no proof of actual resolution, only noting a nurse would administer medications. In the second, a resident reported rude treatment, but the facility lacked documentation for the staff meeting allegedly held to address the concern. On 05/13/2026 at approximately 3:15 PM, during an interview, the Director of Nursing (DON) reviewed the grievance forms dated 07/14/2025 and two forms from 09/16/2025 and acknowledged that the identified concerns had not been addressed. During the discussion, the DON noted that while customer service training had been in the facility's planning stages, it had not yet been implemented. The concern was shared with the DON at this time. On 05/14/2026 at 3:42 PM, during an interview between Staff #3 Social Worker (SW) and the Administrator, the SW identified herself as the grievance officer. SW explained that residents submit grievance forms, which various departments resolve, followed by verbal notification of outcomes to residents or responsible parties. SW claimed, while residents are informed of the grievance process during care plan meetings, no formal documentation confirms this practice. The concern was shared with the Administrator/SW at this time.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interviews, it was determined that the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of admission. This was evident for 1(Resident#104) of 2 Residents care plan reviewed for tracheostomy care during the recertification survey process. The Findings included:On 05/13/2026 at 10:32 AM, a review of Resident #104's care plan revealed that the facility created a tracheostomy care plan was initiated on Tuesday 05/12/2026; however, a review of Resident #104's care plan revealed that the resident was admitted over the weekend of May 8, 2026.On 05/13/2026 at 11:07 AM, in an interview with the Director of Nursing (DON) she was asked about the baseline care plan, and she was also asked if the facility was responsible for care plan development on the weekend shift as well. The DON explained that the baseline care plans were usually done within the first 24 hours period during the weekday and weekends. At that time the DON was made that the baseline care plan for a newly admitted resident with a tracheostomy was not completed until 5/12/2026 which was more than 48 hours from the date of admission. She reported that she will review the above concerns mentioned. No additional documentation was provided.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review and interviews, it was determined that the facility failed to ensure that they provided communication services consistent with the resident's needs. This was evident for 1 (Resident #5) of 4 Residents with communication or sensory difficulty during the recertification survey. The Findings Included: On 05/11/2026 at 10:09 AM, during the initial tour of the survey process, the surveyor attempted to communicate with Resident #5. However, Resident #5 indicated that he/she was non-English speaking. Upon further observation of the resident's room there was no observation of any communication tool for the resident's use at bedside. On 05/11/2026 at 10:10 AM, the surveyor spoke with License Practical Nurse (LPN#17) about how staff communicated with Resident #5 and she explained that the Resident does know how to affirm basic needs; however, when asked how the staff would communicate a more extensive conversation, she stated that they used a language line. When asked about how the language line was used by staff, she explained that she was not sure and will need to clarify with nurse manager. On 05/11/2026 at 12:43 PM, in an interview with Resident #5's representative, the resident's representative explained that he/she had concerns that the resident had communication challenges with the staff because the resident did not speak English. The representative also explained that the resident's facility issued phone in the resident's room was not working, therefore the resident was unable to communicate with family via telephone. On 05/12/2026 at 12:30 PM, in an interview with the Director of Nursing (DON), the DON reported communication was assessed upon admission and placed on the admission assessment tool form in the Electronic Health Record. If they were unable to speak, they are provided with communication boards. If someone was a non-English speaking resident and if they cannot communicate using simple phrases, they communicate using a language line. The communication language line information was posted for any caregiver to use and have access to. They do not use family members as interpreters, and they do not use any other method of communication. She reported that it is the expectation that if the residents were unable to communicate their needs even for personal care the staff should use the language line. On 05/13/2026 at 3:05 PM, a review of Resident #5 Nursing admission Evaluation completed on 04/27/2026 revealed that Resident #5 had a communication language barrier problem. Documented goals: Resident #5 will maintain /improve current level of communication function through the review date. Documented interventions indicated: Provide reading materials, movies, newspapers, and music in the resident's preferred language. Provide the following tools to aide in communication in primary language (interpreter, communication board, etc. Intervention: Utilize language line for interpreter needs. On 05/14/2026 at 08:52 AM, in an interview with Geriatric Nursing Assistant (GNA#22), she was asked how the staff communicate with residents who didn't speak English, and she explain that she used google translate on her personal cellphone or a facility issued tablet used for translation on the language line. We don't use the language line as much, because the google translate or tablet was quicker. On 05/14/2026 at 08:56 AM, in an interview with GNA #23, she was asked how she communicated with residents who did not speak English, and she explained that she would try to find out what language they speak because she was bi-lingual and spoke French. If She was unable to communicate verbally, she would also use physical cues to ask what residents' needs were. When asked about a language line she reported that she was not aware of a language line. On 05/14/2026 at 09:21 AM, a review of Resident #5's admission notes indicated that resident was alert, oriented X3 and Spanish-speaking. On 05/14/2026 at 09:22 AM, a review of Resident #5's progress notes written on 04/27/2026 at 10:56 PM revealed (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident is Spanish speaking. Upon arrival to unit, Resident was offered language interpreter services but daughter refused, she said that language interpretation service is not helpful for [the resident]. On 05/14/2026 at 9:44 AM, in an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), they were made aware that there were concerns that the resident could not communicate with the staff. They were also notified that (LPN) #17 was not aware of the communication resources that would be available to the resident. They were also made aware of the representative's concern about the resident's inability to communicate his needs and their concern about the resident's phone line not working. On 05/14/2026 at 11:05 AM, the surveyor conducted an observation of Resident #5's room and the surveyor noted that the telephone was not working (no dial tone). Staff #24 (maintenance) was present during this observation, and he stated that he will need to follow up with the telephone company to address the issue. There was no evidence that the resident had a working phone line to facilitate the interpretative care and communication needs of the resident who was non-English speaking. There was also no evidence that there was a universal understanding among staff about how to communicate with residents who are non-English speaking.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record reviews and interviews, it was determined that the facility failed to ensure that respiratory care needs, including tracheostomy care was provided in a manner that was consistent with professional standards of practice. This was evident for 1 (Resident #104) of 2 Residents records reviewed for respiratory and tracheostomy care during the recertification survey process. The Findings Included:Tracheostomy is a surgical hole or stoma which consists of making an incision on the front of the neck to open a direct airway to the trachea. A tracheostomy allows air to pass into the windpipe to help with breathing.On 05/11/2026 at 12:15 PM, during the initial screening phase of the survey, the surveyor observed that Resident #104 was on 2 Liters of oxygen via tracheostomy.On 05/11/2026 at 2:37 PM, a review of Resident #104's orders revealed: 05/10/2026 Trach care every shift and as needed; have same size trach and one size smaller at bedside at all times; and Oxygen at 3 liters via Nasal cannula continuous every shift start on 5/10/2026.On 05/13/2026 at 10:04 AM, the surveyor conducted another observation of Resident #104's room and respiratory care needs with Registered Nurse (RN#14). The surveyor observed that the resident was on 4 liters of oxygen. RN #14 was asked how much liters of oxygen the resident was ordered to have and she reported 4 liters. At that time the surveyor informed RN#14 that resident's current oxygen order was for 3 liters. RN #14 checked Resident #104's order and confirmed that the order was for 3 liters of oxygen, not 4 liters. She then stated will adjust the resident's oxygen as ordered.The surveyor also observed that Resident #104 had a size 7 trach tube in-use and there were several unused size 7 trach tubes at the bedside; however, there was no evidence to support that there was a smaller trach size at bedside as ordered, in case of dislodgement.On 05/13/2026 at 1:44 PM, in an interview with the Director of Nursing, she was notified of the above findings. She explained that they had a smaller size trach available in the facility but acknowledge that the smaller trach size was not present at bedside as ordered and that a smaller trach size was later placed at bedside. Oxygen audit was done throughout the building, and an in-service will be completed for facility staff.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance reviews at least every 12 months on 3 out of 5 personnel files reviewed during the recertification survey. The findings included: On 5/15/2026 at 08:45 AM, during the sufficient and competent and nurse staffing task review, the personnel file of Geriatric Nursing Assistant (GNA) #19, #20, and #21 were reviewed. There were no up to date yearly evaluations found in their personnel files. GNA#19 is missing an annual evaluation for 2025; GNA #20 is missing an annual evaluation for 2024 and 2025; and GNA #21 is missing an annual evaluation year 2025. On 5/15/2026, at 11:00 AM, when asked about the yearly performance reviews for GNAs the Nursing Home Administrator (NHA) stated that the documents are in a system called workday and she will be able to retrieve them if given time. The facility has gone through new ownership, and the new company must allow permission to retrieve the information. At the time of Exit from the survey on 5/15/2026 at 5:30 PM, the NHA didn't have the required documents and stated that they were being retrieved. The surveyor requested for the documents be sent to the office once they were retrieved or this would result in a concern for GNAs not having their yearly evaluations. On business day 2 following the survey, the requested documents were not sent to the surveyor; thus, the facility failed to provide documentation that the GNAs had completed their yearly evaluations.		

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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 record review and interview, it was determined the facility failed to ensure accurate accountability of controlled medications. This was evident for 1 (Resident #59) of 4 residents reviewed for pain during the recertification/complaint survey. The findings include:According to the Mayo Clinic, oxycodone is a potent prescription opioid analgesic (pain medication) used to treat moderate to severe pain. It works by acting on the central nervous system to change how your body perceives and responds to pain. On 05/13/2026 at 10:56 AM, a review of Resident #59's medical record revealed physician orders for Oxycodone 5 mg every 6 hours as needed for pain (04/29/2026). On 05/15/2026 at 2:32 PM, Resident #59's medication administration record (MAR) for May 2026 was reviewed and compared to the narcotic count sheets for Oxycodone. 12 doses of oxycodone 5 mg were signed out on the controlled medication utilization record (count sheet) from 05/01/2026 through 05/09/2026. Only 8 of the 12 doses were documented on the MAR as administered to Resident #59.On 05/15/2026 at 3:17 PM, during an interview with the Director of Nursing (DON), expectations for the administration of narcotic medications were discussed. The DON stated that entries on the narcotic count sheet should consistently be reflected in the medication administration record (MAR). Furthermore, the DON recognized that any inconsistencies between these two sets of documentation could be an indicator of potential drug diversion. The concern was shared with the DON at this time.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview it was determined that the facility staff failed to ensure a resident was administered medications according to a physician's order. This evident for 1 (Resident #201) out of 3 residents reviewed for medication administration. The findings include: A review of Resident #201's clinical record on 7/29/26 revealed that the resident's primary physician wrote an order on 7/1/26 for Percocet 7.5-325 mg give every 4 hours as needed for pain at a level of 6-10 on a 0-10 scale. On 7/2/26 at 1:00 PM the resident rated their pain as 5 and was administered the medication. On 7/3/26 at 6:45 PM the resident rated their pain as 0 but was administered the medication. On 7/8/26 at 10:00 AM and at 2:54 PM the resident rated their pain as 0 on both occasions but were administered the medication. On 7/9/26 at 1:06 AM the resident rated their pain as 5 but staff administered the medication. On 7/11/26 at 7:38 PM the resident rated their pain as a 5 but staff administered the medication. The resident on 7/14/26 at 5:12 AM and at 1:46 PM rated their pain as 0 but staff administered the medication. On 7/15/26 at 12:08 PM the resident rated their pain as 5 but staff administered the medication. On 7/16/26 at 04:30 AM, at 12:37 PM and at 8:00 PM the resident rated their pain as 5 but staff administered the medication. On 7/19/26 at 4:30 AM the resident rated their pain as 3 but staff administered the medication. On 7/20/26 at 6:44 PM the resident rated their pain as a 4 but staff administered the medication. On 7/24/26 at 7:00 PM the resident rated their pain as a 5 but staff administered the medication. The resident on 7/25/26 at 3:42 AM rated their pain as a 1 and at 7:20 PM rated their pain as a 5 but staff administered the medication. The resident on 7/26/26 at 8:03 PM rated their pain as a 5 but staff administered the medication. This surveyor interviewed the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Regional Director of Clinical Services on 7/29/26 at 3:15 PM. This surveyor asked, What does it mean when an order says give one tablet when pain is 6-10? They responded that you give the medication if the resident said the pain is 6 or higher. This surveyor then asked what if the resident said their pain was a 5, do they get the medication? They responded with you don't give it. Lastly, this surveyor asked if the resident said their pain was 0 should the medication be given? They responded with you don't give it because there is no pain.		

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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. Based on observation and interview, it was determined that the facility failed to ensure safe and secure storage of medications by allowing unauthorized personnel access to the medication room and medication room keys. This was evident for 1 of 2 medication rooms reviewed during the recertification survey. The findings include: On 5/14/2026 at 9:31 AM, during a medication administration observation, Staff #11 requested the medication room keys from Licensed Practical Nurse (LPN) #13. The keys provided access to both the medication room and the medication cart. Staff #11, who was carrying a box measuring approximately 12x 12 inches, entered the medication room independently and placed the box inside the medication refrigerator. On 5/14/2026 at 9:33 AM, Staff #11 returned the keys to LPN #13. On 5/14/2026 at 9:46 AM, the surveyor inspected the first-floor medication room with LPN #13 and observed the box previously placed in the medication refrigerator by Staff #11. The medication refrigerator contained unopened insulin pens and a clear locked drawer storing Ativan vials, a Schedule IV controlled substance. During an interview, LPN #13 stated, I've watched other nurses giving the keys to other staff personnel too. On 5/14/2026 at 9:59 AM, LPN #12 stated that the medication room keys were kept by the nurses and acknowledged that staff members occasionally borrowed the keys. LPN #12 further stated that staff should be accompanied while inside the medication room. On 5/14/2026 at 10:23 AM, the surveyor inspected the second-floor medication room with LPN #17. He/she confirmed that only licensed nursing staff were authorized to enter the medication room. The refrigerator's locked medication box was observed empty at that time. On 5/14/26 at 11:04 AM, during an interview, Staff #11 confirmed bringing a box containing wound care medications to the medication room and placing it inside the refrigerator. Staff #11 stated that he/she would normally deliver the box directly to the floor nurse; however, because the nurse was unavailable, he/she requested the medication room key and independently entered the medication room to store the medications. On 5/14/26 at 11:27 AM, the Director of Nursing (DON) confirmed that only nursing staff were authorized to access the medication carts and the medication rooms. In the presence of the DON, Staff #13 demonstrated and confirmed that the set of keys provided to Staff #11 also included the key used to open the locked drawer inside the refrigerator containing controlled substances. The DON was notified of the concern and stated that staff education had been initiated.		

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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. Based on record review and interviews, it was determined that the facility failed to ensure that staff accurately document medication administration for each resident in accordance with accepted professional standards and practices. This was evident for 3 (Resident #16, #3, and #97) of 4 residents reviewed for medication administration during the recertification survey. The findings include: 1) During the screening process of the survey on 5/12/26 at 09:41AM, Resident #16 stated that sometimes he/she gets his/her medications and sometimes he/she does not get them, because the nurse would say they are not available. The medical records review on 5/12/2026 at 1:05 PM noted that resident has a Brief Interview of mental status (BIMS) score of 15 (indicating intact cognition) with diagnoses not limited to hypertension, chronic kidney disease, end stage renal disease with dependence on renal dialysis. Further medical record review on 5/12/2026 at 1:19 PM, found that the resident goes to dialysis on Mondays, Wednesdays, and Fridays. Further review of the residents' Medication Administration Record (MAR) revealed that there was no documentation of medications given on the following shifts that were not dialysis days for the resident: -On 4/6/2026: 6 medications were not documented for the Evening and Night shifts as administered, no vital signs were documented, and no Finger sticks with results were documented. -On 4/9/2026 and 4/23/2026: 4 medications were not documented as administered on the AM shift and 1 on evening shift. No documented Finger sticks was resulted on the before lunch shift (11 AM), no monitoring for hypo or hyperglycemia was documented, and no pain level was assessed for both AM shifts. On 5/12/2026 at 2:43 PM Staff #8 was asked what the staff would do if medications were not available. Staff #8 stated that he/she would call the pharmacy to send medications stat or check the Omnicell for some of the medications not available in the medication carts; and write a progress note to explain the situation. On 5/13/2026 at 02:50 PM, a follow up interview was done with the DON who stated that it was not a matter of missing medications, but an Agency nurse was working on those days and that Agency nurse was made a Do not Return (DNR) to the facility because she failed to complete her documentation. The DON was made aware that this was a concern because no documentation is proof that the resident did not get his medications as he/she voiced. The DON agreed. 2) On 05/13/2026 at 11:45 AM, a review of Resident #3's Medication Administration Record (MAR) and orders revealed that resident had an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 150 = 0 units Blood sugar (BS) less than 70mg/dl follow hypoglycemia protocol; 151 - 200 = 2units; 201 - 250 = 3 units; 251 - 300 = 4units; 301 - 350 = (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5units; 351 - 400 = 6 units Blood sugar greater than 400, give 7 units, repeat BS, and call provider, subcutaneously before meals and at bedtime for DM -Start Date04/07/2026 2100. A review of Resident #3's MAR revealed that on 05/12/2026 at 11 am was BS 154 but MAR documented comment #9 (other/see nurses notes). Resident ordered to receive 2 units of insulin. On 05/09/2026 the resident's BS was 155 at 9 PM but MAR documented #9 (other/see nurses notes). On 05/08/2026 there was no documented evidence that the resident's BS was obtained on 4:30 PM and 9 PM, the MAR was blank. A review of the resident progress notes revealed that there was no documentation to explain why the resident did not receive the medication as ordered. On 05/14/2026 at 9:51 AM, in an interview with the Director of Nursing (DON), the DON explained that she spoke with nurses and they reported that Resident #3 refused to take the insulin if the blood sugar was less 200mg/dl but the DON stated that the nurses did not document the refusal. The DON stated that the Nurse Practitioner was notified and the insulin orders were updated to meet the resident's needs. 3) On 05/12/2026 at 08:43 AM, in an interview with Resident #97, the resident reported I take thyroid medication in the morning, and I missed two different doses because the doctor changed the medication and the medication time and it was not communicated to me. It was changed between May 7th-9th. On 05/13/2026 at 3:40 PM, a review of Resident #97's orders and Medication Administration record revealed: Synthroid Oral Tablet 125 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism -Start Date05/06/2026 0700 -D/C Date05/08/2026'; on 5/7/2026 MAR documentation revealed: comment #9, which indicated (other/see nurses notes). Synthroid Oral Tablet 175 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism -Start Date04/16/2026 0700 -D/C Date04/17/2026; on 04/16/2026 documentation revealed: comment #9 (other/see nurses notes). A review of the resident progress notes revealed that there was no documentation to explain why the resident did not receive the medication as ordered. On 05/13/2026 3:48 PM, in an interview with the DON, the DON was informed that the MAR indicated that the resident did not receive his/her medication on 5/7/2026 and 4/16/2026. She stated she will look into it further. On 05/14/2026 at 9:52 AM, the DON acknowledged that the missing medication documentation for Resident #97 was a communication issue. She explained that after following up with the nurse responsible for medication administration they explained that the Resident refused the medication because of the medication changes. The DON acknowledged that the information should have been documented in the resident's record and was not.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to maintain an effective infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections. This was evident for 2 medication administration observations during the recertification survey. The findings include: On 5/14/2026 at 8:56 AM, during a medication administration observation, Licensed Practical Nurse (LPN) #13 obtained Resident #20's blood pressure using a portable blood pressure machine with a reusable blood pressure cuff. At approximately 9:05 AM, LPN #13 used the same portable blood pressure machine and reusable blood pressure cuff to obtain Resident #63's blood pressure. However, LPN #13 failed to disinfect the blood pressure machine and the cuff between resident use. In addition, no disinfectant wipes or sanitizing products were observed on or near the equipment to indicate supplies were readily available for cleaning between resident use. On 5/14/26 at 9:17 AM, the surveyor observed LPN #13 failed to disinfect the rubber septum or tip of Resident #94's insulin pen prior to attaching the needle for medication administration. On 5/14/26 at 9:40 AM, LPN #13 stated nurses were expected to disinfect shared equipment between resident use with disinfectant wipes and acknowledged forgetting to sanitize the rubber tip of the insulin pen prior to needle attachment. On 5/14/26 at 11:27 AM, the Director of Nursing (DON) was notified of the concerns and stated staff education had been initiated.		