STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Autumn Lake Healthcare at Homewood	6000 Bellona Avenue Baltimore, MD 21212

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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 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. Based on medical record review and interview, it was determined the facility staff failed to notify a resident's representative (Resident #13 and #110) and a resident's physician (Resident #13) for a change in condition. This was evident for 2 of 64 residents reviewed during a recertification/complaint survey. The findings include:1.The facility staff failed to notify Resident #13's representative and physician on 6/10/25 when the Resident's BiPAP machine stopped working. BiPAP, or bilevel positive airway pressure, is a type of non-invasive ventilation used to assist breathing, particularly for individuals with sleep apnea or other respiratory conditions. A review of a complaint was conducted on 7/17/25 regarding the Resident's representative (RP) was not notified when the Resident's BiPAP stopped working on 6/10/25. Review of Resident #13's medical record on 7/17/25 revealed the Resident was admitted to the facility with diagnosis to include chronic respiratory failure and obstructive sleep apnea. Obstructive sleep apnea (OSA) is a common sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage of the airway. Further review of Resident #13's medical record revealed a nurse's note on 6/10/25 at 9:20 PM that states Patient's BiPAP was not administered, device dysfunctioning, shows error code, writer called supplier, order placed awaiting technician. There is no documentation the RP was notified. There is no documentation the physician was notified in case the physician wanted to change the Resident's orders while the BiPAP machine was not working. Review of facility documentation provided by the Administrator revealed the BiPAP machine was replaced on 6/11/25. Interview with the Director of Nursing on 7/23/25 at 2:20 PM confirmed the facility staff failed to notify Resident #13's RP and physician when the Resident BiPAP machine was not working on 6/10/25. 2.The facility staff failed to notify Resident #110's representative timely when the Resident was transferred to the hospital. A review of a complaint was conducted on 7/16/25 regarding the Resident's representative (RP) was not notified about the Resident's transfer to the hospital until after the hospital had notified the RP first. Review of Resident #110's medical record on 7/16/25 revealed the Resident was admitted to the facility in May 2023 with a diagnosis to include Dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident #110's medical record revealed the Resident was assessed by the doctor (Staff #59) on 9/24/23 at 10:58 AM and ordered to be sent to the Emergency Room. Review of the emergency room Clinical Summary revealed the Resident arrived at the emergency room on 9/24/23 at 12:57 PM. Further review of Resident #110's medical record revealed a Change in Condition that stated the Resident's RP was notified on 9/24/23 at 2:00 PM. Review of a nurse's note documented on 9/24/23 at 2:11 PM stated RP was notified that patient was sent out via 911 per On-call Doctor's order after he/she was found unarousable. Interview with the Director of Nursing on 7/16/25 at 11:45 AM confirmed the facility staff did not notify Resident #110's RP timely for a change of condition and transfer to the emergency room on 9/23/23.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was evident on 2 of 3 nursing units observed during the recertification/complaint survey. The findings include:The following environmental concerns were observed during the initial entrance rounds in the facility on 7/15/25 at 7:45 AM and throughout the survey until 7/25/24.room [ROOM NUMBER] - in the bathroom there were 4 ceiling tiles with brown stains/water marks.room [ROOM NUMBER] - there was no toilet paperroom [ROOM NUMBER]A - the laminate was peeling on the headboard and footboard of the bed. There was peeling paint on the entire front edge of the window sill down to the bare wood. There was no string for the over-the-bed light.room [ROOM NUMBER] - The frame on the over the toilet riser was rusted in the front and on the legs room [ROOM NUMBER] - There was approximately 3 feet of molding by the window that was separated from the wall approximately 3 to 4 inches.There were several rooms that had spackled walls that were not painted. There were wheelchairs that had torn vinyl on the armrests:Observation was made of Resident #58 sitting in a wheelchair. The vinyl on the right front armrest was missing and the vinyl on the left armrest was cracked throughout.Observation was made of Resident #53 sitting in a wheelchair. The vinyl on the right wheelchair armrest was cracked throughout.Observation was made of Resident #6 sitting in a wheelchair. There was an approximate 2- inch tear in the vinyl on the right wheelchair armrest with the underneath foam padding exposed.On 7/15/25 at 8:47 AM an interview was conducted with the Maintenance Director who stated that he had just started the end of July 2024 and August/September 2024 is when they switched to TELS so staff could put any concerns about repairs in the system. The Maintenance Director stated he was the only staff member in the maintenance department and sometimes one of the housekeeping staff will help him.On 7/22/25 at 9:13 AM went over the environmental concerns with the Director of Nursing.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on medical record review, review of facility documentation and interview, it was determined the facility staff failed to protect a resident from verbal abuse from facility staff (Resident #104). This was evident for 1 of 64 residents reviewed during a recertification/complaint survey.The findings include: On 7/16/25 a review of facility reported incident 326163 was conducted. The facility reported on 10/3/24 at approximately 6:46 PM, Staff #55 and #56 were providing care to Resident #104. Resident #104 was screaming in pain and stated I am dying, I have cancer. Staff #55 reportedly told Resident #104 well go ahead and die then so you can stop all this screaming. Review of Resident #104's medical record on 7/16/25 revealed the Resident was admitted to the facility in February 2024 with a diagnosis to include malignant neoplasm of the bone (bone cancer). Review of the facility's investigation revealed a statement from the Resident's family member to the Administrator stating at the time of the incident he/she was on the phone with the Resident and heard Staff #55 say to the Resident: go ahead and die then so you can stop all this screaming. The family stated he/she came to the facility later that evening on 10/3/24 and spoke with Staff #56 who confirmed what Staff #55 stated to Resident #104. Further review of the facility's investigation revealed a statement from Staff #56 confirming Staff #55 told Resident #104 to go ahead and die. Review of the completed investigation submitted on 10/10/24 to OHCQ (Office of Health Care Quality) stated the allegation of abuse was verified in that the Resident's family member was on the phone and Staff #56 stated Staff #55 told Resident #104 to go ahead and die then after Resident #104 stated he/she felt like he/she was dying. After the incident the facility terminated Staff #55 and reported Staff #55 to the board of nursing. Review of the facility's Abuse, Neglect and Exploitation policy provided by the Administrator revealed the facility's definition of verbal abuse is the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Interview with the Administrator on 7/16/25 at 9:00 AM confirmed the verbal abuse of Resident #104 by Staff #55 on 10/3/24.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility reported incident, medical records, controlled drug sheets, and interviews it was determined that the facility failed to ensure residents were free from misappropriation of narcotics. This was evident for 1 (#81) of 22 residents reviewed for facility reported incidents during the recertification/complaint survey. The findings include: On 7/18/25 at 6:49 AM a review of facility reported incident 326170 was conducted and it was alleged that narcotic medication was missing from Resident #81 on 5/13/25 at the end of the 3:00 PM to 11:00 PM shift. A review of Resident #81's medical record revealed the resident was admitted to the facility in January 2025 with diagnoses that included, but were not limited to, unilateral primary osteoarthritis of the left knee, pain in the left ankle and joints of the left ankle, low back pain, other polyneuropathies, chronic pain syndrome, and spinal stenosis of the cervical and lumbar region. The resident had an order for the (Opioid) Oxycodone 5 mg to be administered every 8 hours as needed for pain. This order has been in effect since 2/18/25. The Controlled Drug Administration Record includes information as to when the supply of the narcotic was received, and the total number of doses received. There are spaces for nursing staff to document the date and time a dose was removed, the number of doses removed, the number of remaining doses and if any were wasted. There is also an area for the nurse who removed the narcotic to sign their name. Review of the facility's investigation revealed that on 5/13/25 at the end of the 3:00 PM to 11:00 PM shift the sheet of medication (oxycodone) was missing. The facility interviewed the 7:00 AM to 3:00 PM nurse, Staff #8 who stated she turned the medication cart over to the agency nurse, Staff #46, and the count was 24 at the start of the shift. Staff #8 stated that Resident #81 did not receive any Oxycodone on her shift. When the 11:00 PM to 7:00 AM nurse came on duty, Staff #21, the count was 23, but the discrepancy wasn't noticed until 5/14/25 at 7:00 AM when the 7:00 AM to 3:00 PM nurse, Staff #8, came on duty. A written statement from Staff #21 on 5/16/25 documented, I relieved the nurse working on [NAME] hallway 5/13/25 (3p-11p) at or around 11 PM. I counted with the nurse and the count was 23 narcotic cards and 23 sheets. The count was not altered by me from the morning 7-3 shift which indicated that there were 24 narcotic cards and 24 sheets. I did not know that the count had been altered until it was brought to my attention by the nurse who relieved me and worked 7-3 the next day. The 7-3 nurse did not bring it to my attention until I came back into work 3-11 later on 5/14/25. A written statement from Staff #8 documented, On 5/14 I noticed [resident #81] did not have any Oxycodone 5 mg on the med cart. I checked the order to see if it was d/c (discontinued). It was not. I checked with oncoming nurse; it was not discharged . So, I reordered it. On 5/16/25, which was a Friday, the unit one unit manager informed the Assistant Director of Nursing (ADON), who was the current DON, by phone at 7:23 AM of the missing narcotics. The unit one unit manager was notified by Staff #8 that the narcotic and the narcotic sheet were missing. Upon discovery of the discrepancy the staffing manager was notified by Staff #21 on Wednesday, 5/14/25. A search was done by the Director of Nursing (DON) and the Assistant DON. The staffing manager at the agency was notified and stated that they talked to the nurse, Staff # 46, and she said she did not have the medication and that she did not wish to speak with anyone at the facility. Review of Resident #81's May 2025 Medication Administration Record (MAR) documented the resident only received the medication one time in May, on 5/20/25 at 9:15 AM. Review of the Controlled Substance Administration and Accountability Policy with a revision date of 4/8/24 revealed the following under Procedures: #8: Inventory Verification, b. for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. Discrepancy Resolution, a. any discrepancy in the count of controlled substances or disposition of the narcotic keys is resolved by the end of the shift during which it is discovered. D. any discrepancies which cannot be resolved must be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy. On 7/18/25 at 7:50 AM an interview was conducted with the DON, who was the ADON at the time of the incident. The investigation was reviewed with the DON and the DON was asked if she expected the RN Supervisor, Staff #21, who was the weekend supervisor and also worked on the floor, to have reported the incident sooner. The DON stated, Yes. I have concerns with the process as it is broken. The DON confirmed that it was misappropriation of resident property. On 7/22/25 at 7:23 AM an interview was conducted with Staff #21. Staff #21 stated that he came in at 11:00 PM to take over. During the count at the end of the shift I did not see it because she counted the numbers. When I came back in 3 to 11 the next day, [Staff #8] said, you know when I left [Resident #81] had about 20 oxy and now

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility reported incidents, record review, and interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation and misappropriation of property within 24 hours to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 8 (#120, #107, #117, #67, #81, #103, #104, #122) residents reviewed for 21 facility reported incidents during the recertification/complaint survey. The findings include: 1) On 7/16/25 at 8:23 AM a review of facility reported incident 326126 was conducted and revealed Resident #120 alleged that on 3/21/23 at 12:30 PM the phlebotomist came to draw the resident’s blood while the resident was in the middle of prayer. The resident alleged the phlebotomist punched him/her in the chest and wrestled his/her arms and said, “listen to me. Review of the facility’s investigation failed to produce an email confirmation as to when the initial report was submitted to OHCQ. Review of the Comprehensive and Extended Care Facilities Self-Report Form documented the form was submitted on 3/22/23 at 12:00 PM. Review of Resident #120’s medical record revealed a 3/21/23 at 12:30 PM nurses note that documented the attempted blood draw. On 7/16/25 at 9:05 AM an interview was conducted with the NHA. The NHA stated that this incident happened prior to her working at the facility. The NHA agreed that residents should have been interviewed. The NHA confirmed finding of timely reporting. 2) On 7/17/25 at 8:45 AM a review of facility reported incident 326115 was conducted and revealed Resident #109 alleged that he/she saw a GNA (geriatric nursing assistant) #38 hit Resident #107 in the chest on 10/31/22 at 3:45 PM. Review of the facility’s investigation revealed an email confirmation that the initial report was not submitted to OHCQ until 11/1/22 at 12:09 PM. The initial report was not submitted within 2 hours of alleged abuse. On 7/17/25 at 10:56 AM an interview was conducted with the NHA. The NHA stated she was not employed at the facility during the time period. The investigation was reviewed with the NHA, and she confirmed the findings. 3) On 7/16/25 at 12:35 PM a review of facility reported incident 326120 was conducted and revealed Resident #117 alleged that he/she was hit by GNA #39 and GNA #40 and that GNA #40 picked up a wheelchair and threatened to hit the resident with it on 1/20/23 at 11:00 PM. Review of the facility’s investigation revealed the initial self-report was emailed to OHCQ on 1/21/23 at 2:27 PM, which was not within 2 hours of the alleged abuse. On 7/23/25 at 9:21 AM an interview was conducted with the Director of Nursing (DON). The DON stated she was not employed at the facility during that time period. The DON confirmed the findings. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 7/16/25 at 1:16 PM a review of facility reported incident 326129 was conducted and revealed Resident #117 alleged Licensed Practical Nurse (LPN) #45 hit the resident on the arm on 3/16/23. The resident alleged that he/she was asking questions about the prescriptions being delivered to the nurse in the hallway and that the nurse hit him/her on the hand and that the nurse was lying. Review of the OHCQ’s intake form documented the initial report was received on 3/29/23. There was no investigation provided to the surveyor from the facility. On 7/16/25 at 2:48 PM the NHA was interviewed. The NHA stated they have looked around and cannot find the investigation or report, therefore could not validate when the initial and 5-day report were submitted to OHCQ. The NHA stated she was not employed at the facility at the time. 5) On 7/16/25 at 1:23 PM a review of complaint 326172 alleged that sometime in April 2025 Resident #67 sustained swelling in the wrist with an unknown cause. Review of Resident #67’s medical record revealed the resident was admitted to the facility in January 2025 with diagnoses that included but were not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Type 2 Diabetes Mellitus, and Alzheimer’s disease. Review of a 4/14/25 change in condition note documented, “pt. reported swelling in the left wrist. Denies recent trauma or fall. Denies pain or discomfort. Visible swelling noted to the left wrist.” An x-ray was ordered to rule out dislocation or cyst. On 7/24/25 at 7:51 AM an interview was conducted with the DON and NHA. The 4/15/25 incident with the swelling was reviewed. The DON and NHA were asked if the incident was reported to OHCQ. The DON stated that the physician determined the swelling was from the stroke. The DON was asked if they knew why there was swelling when they first saw Resident #67’s wrist, knowing that the resident had cognitive impairment and memory problems. The DON and NHA were asked if someone had grabbed or twisted the resident’s wrist. The DON and NHA agreed that the incident should have been reported. 6) On 7/18/25 at 6:49 AM a review of facility reported incident 326170 was conducted and it was alleged that narcotic medication was missing from Resident #81 on 5/13/25 at the end of the 3:00 PM to 11:00 PM shift. Review of the facility’s investigation revealed that the initial report was not submitted to OHCQ until 5/16/25 at 2:30 PM. On 7/18/25 at 7:50 AM an interview was conducted with the DON, who was the Assistant Director of Nursing at the time of the incident. The timeline was reviewed with the DON, and she confirmed that the staff did not report it timely to nursing administration, therefore it was not reported to OHCQ within 24 hours. 7) On 7/18/25 a review of facility reported incident 326161 was conducted. The facility reported on 9/27/24 Resident #103 alleged some of his/her personal items and money were missing after his/her return from the hospital. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #103’s medical revealed on 7/18/25 the Resident was admitted to the facility on [DATE] and transferred to the hospital on 9/24/24 returning the same day at approximately 9:30 PM. Review of the facility’s investigation revealed a statement from Staff #54 that stated: On 9/25/24 Resident #103 advised Staff #54 that someone went into his/her room and took his/her candy and cigars. Staff #54 stated she told the Resident to report to his/her nurse. Review of the facility's investigation revealed although the Resident reported the incident on 9/25/24 to Staff #54 the facility administration did not become aware of the incident until the next day 9/26/24. The facility administration began their investigation on 9/26/24. The incident was not reported to the Office of Health Care Quality (OHCQ) until 9/27/24, 2 days after the Resident first reported the incident to staff. 8) On 7/16/25 a review of facility reported incident 326163 was conducted. The facility reported on 10/3/24 at approximately 6:46 PM, Staff 55 and #56 were providing care to Resident #104. Resident #104 was screaming in pain and stated I am dying, I have cancer. Staff #55 reportedly told Resident #104 “well go ahead and die then so you can stop all this screaming”. Review of Resident #104’s medical record on 7/16/25 revealed the Resident was admitted to the facility in February 2024 with a diagnosis to include malignant neoplasm of the bone (bone cancer). Review of the facility’s investigation revealed a statement from the Resident’s family member to the Administrator stating at the time of the incident he/she was on the phone with the Resident and heard Staff #55 say to the Resident: “go ahead and die then so you can stop all this screaming”. The family stated he/she came to the facility later that evening on 10/3/24 and spoke with Staff #56 who confirmed what Staff #55 stated to Resident #104. Further review of the facility’s investigation revealed a statement from Staff #56 confirming Staff #55 told Resident #104 to “go ahead and die”. Review of the facility reported incident revealed although the incident occurred on 10/3/24 at approximately 6:46 PM, it was not reported to OHCQ (Office of Health Care Quality) until 10/4/24 5:01 PM. Interview with the Administrator on 7/16/25 at 9:00 AM confirmed the facility did not report an allegation of abuse for Resident #104 on 10/3/24 within 2 hours as required to OHCQ. 9) On 7/18/25 a review of facility reported incident 326131 was conducted. The facility reported Residents #122 and #123 were having a verbal altercation on 4/23/23 when Resident #123 started hitting Resident #122. Review of Resident #123’s medical record on 7/18/25 revealed the Resident had just been admitted to the facility 4 days prior. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility’s investigation revealed although the police were called on 4/23/23 at 10:00 PM, the facility staff did not notify the Office of Health Care Quality (OHCQ) until 4/24/23 at 9:00 AM. Interview with the Administrator on 7/18/25 at 12:35 PM confirmed the facility did not report an allegation of abuse for Resident #122 on 4/23/23 within 2 hours as required to OHCQ.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility reported incidents, medical records, and staff interview, it was determined the facility failed to provide documentation that allegations of abuse and misappropriation of property were thoroughly investigated. This was evident for 7 (#120, #127, #117, #101, #81, #103, #126) of 21 residents reviewed for facility reported incidents during the recertification/complaint survey. The findings include: 1) On 7/16/25 at 8:23 AM a review of facility reported incident 326126 was conducted and revealed Resident #120 alleged that on 3/21/23 at 12:30 PM the phlebotomist came to draw the resident’s blood while the resident was in the middle of prayer. The resident alleged the phlebotomist punched him/her in the chest and wrestled his/her arms and said, “listen to me.” Review of Resident #120’s medical record revealed a 3/24/23 change in condition note that documented the resident filed a grievance related to the incident. Review of the facility’s investigation revealed (13) staff interviews and an interview with the resident and the phlebotomist. The facility failed to interview other residents on the unit to determine if any of the other residents had concerns about the phlebotomist. On 7/16/25 at 9:05 AM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated that the incident happened prior to her working at the facility. The NHA confirmed the finding and agreed that residents should have been interviewed. 2) On 7/16/25 at 9:33 AM a review of facility reported incident 326154 was conducted and revealed Resident #127 alleged that there was a specific amount of money that was in an envelope that was in the resident’s purse. The resident alleged that money was missing on 9/22/24 at 11:00 AM. Review of the facility’s investigation documented that the police were notified, and the roommate was interviewed. The report stated that all alert and oriented residents were given an education and reminder to keep their valuables locked up at all times when not in use. There were 2 unsigned statements from staff and 4 residents were interviewed. There were no other staff interviews from previous shifts of staff that worked on the weekend and with the resident. The investigation was incomplete. On 7/16/25 at 9:45 AM an interview was conducted with the NHA, and the facility’s investigation was reviewed. The NHA confirmed that the investigation was incomplete. 3) On 7/16/25 at 1:16 PM a review of facility reported incident 326129 was conducted and revealed Resident #117 alleged that Licensed Practical Nurse (LPN) #45 hit the resident on the arm on 3/16/23. The resident alleged that he/she was asking questions about the prescriptions being delivered to the nurse in the hallway and that the nurse hit him/her on the hand and that the nurse was lying. Review of OHCQ’s intake form documented the initial report was received on 3/29/23. There was no investigation provided to the surveyor from the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/25 at 2:48 AM the NHA was interviewed. The NHA stated they have looked around and cannot find the investigation or report, therefore could not validate that a complete investigation was done. The NHA stated she was not employed at the facility at the time. 4) On 7/17/25 at 7:50 AM a review of facility reported incident 326138 was conducted and revealed another resident in the facility alleged that she witnessed Resident #101, “being treated in a “not normal way” and it was observed from the courtyard” on 8/20/23 in the morning. Review of the facility’s investigation revealed Resident #101 was assessed and noted to have a bruise on the right interior forearm. Resident #101 reported that the right anterior forearm bruise was caused during ADL (activities of daily living) care. The staff member that was assigned to the resident was an agency GNA (geriatric nursing assistant) and had been made to be a do not return pending finalization of the investigation. Review of Resident #101’s medical record revealed an 8/23/23 psychiatric evaluation that documented, “this patient was seen per facility request for psychiatric evaluation due to a recent incident that occurred. The patient states, “she was rough, and she grabbed my hand, and it hurt. ” The facility’s investigation failed to produce staff interviews and there were no other resident interviews. The investigation was incomplete. On 7/17/25 at 10:55 AM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated she was not employed at the facility at the time of the incident. The NHA stated she found the investigative file in the drawer, and she said it was kind of thrown together. The NHA confirmed the incomplete investigation. 5) On 7/18/25 at 6:49 AM a review of facility reported incident 326170 was conducted and it was alleged that narcotic medication was missing from Resident #81 on 5/13/25 at the end of the 3:00 PM to 11:00 PM shift. Review of the facility’s investigation revealed that on 5/13/25 at the end of the 3:00 PM to 11:00 PM shift the sheet of medication was missing. The facility interviewed the 7:00 AM to 3:00 PM nurse who stated she turned the medication cart over to the agency nurse, Staff #46 and the count was 24 at the start of the shift. When the 11:00 PM to 7:00 AM nurse came on duty the count was 23, but the discrepancy wasn’t noticed until 5/14/25 at 7:00 AM when the 7:00 AM to 3:00 PM nurse came on duty. However, at that time nothing was done until it was brought to the unit manager’s attention on 5/16/25 at 7:23 AM. There were other staff that worked that were not interviewed. On 7/18/25 at 7:50 AM an interview was conducted with the DON, who was the Assistant Director of Nursing at the time of the incident. The investigation was reviewed with the DON and the DON was asked if she expected the RN Supervisor, Staff #21, who was the weekend supervisor and also worked on the floor, to have reported the incident sooner. The DON stated, “Yes. I have concerns with the process as it is broken.” The DON confirmed that the other nurse documented that she noticed the medication was missing, so she reordered the medication. The DON also confirmed that the investigation was incomplete because there was no other nurse interviews for the 3-day lapse prior to reporting to nursing administration. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 7/18/25 a review of facility reported incident 326161 was conducted. The facility reported Resident #103 alleged some of his/her personal items and money were missing on 9/27/24 after his/her return from the hospital. Review of Resident #103’s medical revealed on 7/18/25 the Resident was admitted to the facility on [DATE] and transferred to the hospital on 9/24/24 returning the same day at approximately 9:30 PM. Review of the facility investigation revealed no statement from the Resident to include when he/she noticed the items missing and who he/she told. Further review of the facility investigation revealed that although the facility identified an alleged perpetrator, there is no dated statement from that resident. The investigation also does not include a statement from a staff member or resident that notified the facility administration of the incident and when. Interview with the Administrator on 7/18/25 at 12:20 PM confirmed the facility staff failed to complete a thorough investigation of Resident #103’s alleged incident of misappropriation of the Resident’s property. 7) On 7/17/25 a review of facility reported incident 326139 was conducted. The facility reported on 8/26/23 Staff #57 gave Resident #126 the middle finger and said, “If you ever put your middle finger up at me again I will F*** you up”. Review of the facility investigation revealed although 2 witnesses were named there is no statement from either witness to confirm or deny the allegation. Interview with the Administrator on 7/17/25 at 2:25 PM confirmed the facility staff failed to complete a thorough investigation of alleged abuse for Resident #126.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 3 (#127, #111, #108) of 64 residents reviewed during the recertification/complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/16/25 at 9:33 AM a review of Resident #127's medical record was conducted. Resident #127 was admitted to the facility in September 2024 with diagnoses that included polyneuropathy, chronic pain, generalized osteoarthritis and gout.Review of Resident #127's September 2024 Medication Administration Record (MAR) documented that the resident received Diclofenac external gel 1% for right knee pain 4 times per day. Review of Resident #127's MDS assessment with an assessment reference date (ARD) of 9/5/24, Section J0100A Pain, coded that the resident did not receive regular pain medication. That was an error as the resident received the Diclofenac gel 4 times per day.Review of Resident #127's October 2024 MAR documented Resident #127 received Gabapentin 2 times a day for nerve pain. Gabapentin is in a drug class called anticonvulsants.Review of Resident #127's MDS assessment with an ARD of 10/11/24, Section N0415 High-Risk Drug Class medications, K. anticonvulsant, was not coded as being received. This was an error as the resident received Gabapentin.On 7/21/25 at 9:49 AM an interview was conducted with the MDS Coordinator. Both MDS assessments were reviewed and the MDS Coordinator confirmed the findings.2) On 7/21/25 at 2:00 PM a review of Resident #111's medical record was conducted. Review of the 1/25/24 admission MDS, Section E0800, rejection of care was marked 0. Review of the 1/23/24 at 17:01 behavior note documented, refusal of medication and weight. Resident refused to be weighed and take AM meds despite education and encouragement.On 7/22/25 at 1:45 PM an interview was conducted with the MDS coordinator who confirmed the behavior was not captured.On 7/22/25 at 7:25 AM the MDS coordinator gave the surveyor a care plan that was initiated on 1/23/24 related to non-compliance with the plan of care/treatment plan. The MDS coordinator stated that they had a care plan that addressed the problem and since they had a care plan they did not need to code it on the MDS.Review of the RAI (Resident Assessment Instrument) manual, page E-16 documented that the intent of this item, is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being, or a choice made on behalf of the resident by a family member or other proxy decision maker.3) On 7/18/25 at 10:55 AM a review of Resident #108's medical record was conducted. Review of the 4/13/23 admission MDS, Section N medications, coded that the resident had received 3 injections. The MDS was coded as the resident did not receive any opioid medications.Review of Resident #108's April 2023 MAR documented that Resident #108 received 5 injections of the antibiotic Ceftriaxone and had received the opioid Methadone from 4/8/23 to 4/13/23. On 7/21/25 at 9:49 AM an interview was conducted with the MDS Coordinator. After review of Section N, the MDS Coordinator confirmed the errors. The MDS Coordinator was not at the facility during that time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and interview, it was determined the facility staff failed to hold care plan meetings to include the interdisciplinary team, resident and resident's representative for residents. This was evident for 5 (Resident #1, #4, #9, #67, and #75) of 64 residents reviewed during a recertification/complaint survey. The findings include: Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. 1)On 7/16/25 at 1:23 PM a review of Resident #67’s medical record was conducted. Review of progress notes in the medical record failed to produce evidence of care plan meetings in either the miscellaneous section of the medical record or in social work documentation. On 7/23/25 at 1:13 PM an interview was conducted with the Social Work Director #15. Staff #15 stated that she just started on 5/5/25. Staff #15 stated there was a care plan meeting on 5/21/25 but there was no sign-in sheet, and the notes were handwritten in her notepad book and not in the electronic medical record. Staff #15 also confirmed that there was no evidence of care plan meetings in February 2024, May 2024, November 2024, and February 2025. 2) On 7/18/25, at 11:30 AM, a review of Resident #9's medical records revealed they have resided in this facility since 2020. During his/her residency, the resident had been transferred to the hospital (staying 2-12 days) and subsequently readmitted to the facility. Further review of Resident #9's MDS assessments showed that the facility staff completed annual assessments on 02/27/24 and 01/25/25, and quarterly assessments on 04/24/24, 07/25/24, 10/25/24, 04/27/25, and 06/05/25. However, only two care plan meeting notes were documented in the resident's progress note: 02/05/25 and 05/07/25. 3)On 7/21/25, at 10:27 AM, a review of Resident #4's medical records revealed that he/she initially admitted in July 2023. The resident had been transferred to the hospital (6-10 days) and later readmitted . Further review of Resident #4's MDS assessments showed annual assessments completed on 05/03/24 and 12/10/24, and quarterly assessments completed on 01/17/24, 05/20/24, 08/20/24, 09/09/24, 11/07/24, 03/19/25, and 06/30/25. However, only three care plan meeting notes were documented in their progress note: 12/17/24, 04/29/25, and 07/01/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 7/21/25, at 11:35 AM, she stated that the facility's social worker arranges care plan meetings and documents the summary in residents' medical records. The DON also explained that care plan meetings are supposed to be held after each quarterly MDS assessment. The surveyor shared concerns that Resident #4 and #9 lacked documentation to support that care plan meetings were held after each MDS assessment, and the DON validated these concerns. 4)Review of Resident #75’s medical record on 7/22/25 revealed the Resident was admitted to the facility in July 2024 and had a quarterly MDS assessment on 11/9/24 completed by the facility staff. Review of the Resident’s care plan meetings in 2024 revealed no evidence a care plan meeting was held after the quarterly MDS assessment on 11/9/24. Interview with the Director of Nursing on 7/23/25 at 12:45 PM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #75 in November 2024. 5) On 07/24/2025 at 9:48 AM, a review of Resident #1’s medical records revealed they have resided in the facility since 2022. During his/her residency, the resident was transferred to the hospital emergency room (staying for observation <24) and subsequently readmitted to the facility. Further review of Resident #1’s MDS assessments showed that the facility staff completed Quarterly assessments on 10/6/2024, 10/30/2024, 02/04/2025, 05/07/2025, and an annual assessment on 01/07/2025. However, only two care plan meeting notes were documented in the resident’s progress notes: 10/08/2024 and 01/14/2025. On 07/24/2025 at 9:10 AM interview with the DON, she stated that residents care plan meetings are scheduled according to when the MDS is due. At this time DON was made aware of the concern of no evidence of care plan meetings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to provide treatment and care in accordance with professional standards of practice for residents (Resident #40, # 75, #106 and #113). This was evident for 4 of 64 residents reviewed during a recertification/complaint survey. The findings include:1.The facility staff failed to follow the nurse practitioner's instructions for Resident #40. Review of Resident #40's medical record on 7/22/25 revealed the Resident was admitted to the facility in March 2024 with a diagnosis to include hypertension. Hypertension (high blood pressure) is when the pressure in your blood vessels is too high. a) Further review of Resident #40's medical record revealed the Resident was seen by the Nurse Practitioner (NP) (Staff #47) on 7/7/25. Review of the NP's 7/7/25 note revealed the Resident was seen for a follow-up lab review. The NP documented the Resident continues on Lasix 20 mg daily for bilateral lower extremity edema and to monitor weights weekly. Lasix is a medication that can be used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease and other medical conditions. Review of Resident #40's medical record revealed the last documented weight on the Resident was 6/2/25. b) Further review of the NP's note on 7/7/25 for Resident #40 revealed the NP documented for Assessment and Plan for the Resident's diagnosis of hypertension: Not on blood pressure medications, monitor blood pressure daily. Review Resident #40's medical record revealed since 7/7/25 there is only one blood pressure documented on 7/17/25. Interview with the Chief Clinical Officer on 7/23/25 at 9:50 AM confirmed the facility staff were not weighing Resident #40 weekly and not monitoring the Resident's blood pressure daily. 2. The facility staff failed to maintain Resident #75's tube feeding properly. Observation of Resident #75 on 7/15/25 at 8:52 AM, revealed the Resident's feeding tube pump alarming with code inactive 10 minutes. The tube feeding and water flush tubing were not dated. The tube feeding bottle was dated 7/14/25 at 4 AM. The syringe used for flushing the feeding tube is dated 7/13/25 at 4 AM. The Surveyor had the Unit Manager (Staff #19) come to the Resident's room on 7/15/25 at 8:55 AM and confirmed the Surveyor's observations. Review of Resident #75's medical record on 7/15/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include gastrostomy. Gastrostomy, often referred to as a G-tube, is a surgical procedure where a tube is inserted through the abdominal wall and into the stomach. Review of the facility's Flushing a Feeding Tube policy date 12/12/22 provided by the Director of Nursing states Change the 60 ml catheter tip syringe used every 24 hours or as needed. Review of the Resident's physician orders revealed the physician ordered on 5/23/25 for the tube feeding to hang up at 2 PM, take down 10 AM. Interview with the Director of Nursing on 7/24/25 at 11:10 AM confirmed tube feeding tubing, flush bag tubing and syringe should be dated and changed every 24 hours. 3. The facility staff failed to provide wound care to Resident #106 per physician orders.On 7/15/25 a review of Complaint 326122 was conducted. The complaint alleged Resident #106 did not receive proper wound care. Review of Resident #106's medical record on 7/15/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include open wound of left great toe and peripheral vascular disease. Peripheral vascular disease (PVD) is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel. Review of Resident #106's hospital Discharge summary dated [DATE] revealed it stated Exam at discharge: left great toe with dry gangrene and Wound care: paint gangrenous toes with Betadine daily. Review of Resident #106's November 2022 Treatment Administration Record revealed the facility staff did not administer Betadine to Resident #107's left gangrenous toe until 11/21/22, 3 days after admission. Further review of Resident #106's medical record revealed on 12/9/22 the Resident was seen by vascular surgery. Review of the vascular surgery's Report of Consultation dated 12/9/22 revealed the physician after visit instructions included left foot-apply small piece of xeroform over raw areas dorsal foot and anterior ankle. Paint gangrenous toes with Betadine, let air dry, then dry gauze between the toes, cover with rolled gauze. Betadine is a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes and burns. Review of Resident #106's December 2022 Treatment Administration Record revealed the facility staff did perform the dressings per the vascular surgery consult on 12/9/22. The Resident transferred to the hospital on [DATE]. Interview with Resident #106's representative on 7/17/25 at 8:47 AM, the Resident's representative stated when he/she came to visit the Resident at the facility the Resident never had dressing on his/her left foot. Interview with the Director of Nursing on 7/17/25 at 10:58 AM confirmed the facility staff failed to administer Betadine to Resident #106 from 11/18/22 until 11/21/22

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, observation, and interview, it was determined the facility failed to 1) ensure that fall precautions were in place, per the physician's orders, for a resident with a history of falls from the bed, 2) follow the resident's smoking plan of care, and 3) provide supervision for residents requiring supervision while smoking. This was evident for 4 (Resident #4, #1, #83, and #97) of 64 residents reviewed during the recertification/complaint survey.The findings include: 1)On 7/16/25 at 11:15 AM Resident #4’s medical record was reviewed and revealed Resident #4 was admitted to the facility in July 2023 with diagnoses that included cerebral infarction, symptoms and signs involving cognitive function following cerebral infarction, osteoarthritis of the right knee, and bipolar disorder. A 6/11/25 at 19:30 (7:30 PM) change in condition note documented Resident #4 had an unwitnessed fall from the fall from the bed. There were no visible injuries noted other than a skin tear on the right forearm. A 6/24/25 at 4:05 AM change in condition note documented Resident #4 rolled out of bed and landed on the fall mat on the right side of the bed. A skin tear to the right forearm was noted. A 6/26/25 at 22:58 (10:58 PM) general nurses note documented Resident #4 was found lying on his/her right side on the floor mat by the bed side. The resident was helped back to bed. There were no apparent injuries noted. Review of June 2025 physician’s orders revealed an order written on 6/24/25 for, “floor mat to be placed on left and right side of the bed for fall precaution every shift.” Review of Resident #4’s care plan, “Resident is at risk for falls r/t hx. (history) of falls, increased need for assistance with ADLs/transfers, medication use, poor safety awareness Date Initiated: 06/24/2025.” Intervention on the care plan, “floor mats as ordered.” On 7/16/25 at 11:00 AM observation was made of Resident #4 lying in bed sleeping. There was a fall mat on the resident’s right side of the bed standing up against the wall. There was a fall mat on the floor on the resident’s left side of the bed. On 7/16/25 at 11:32 AM an interview was conducted with Geriatric Nursing Assistant (GNA) #7. GNA #7 was shown the fall mat standing up against the wall. GNA #7 stated that she had not put the fall mat down yet because the resident had the over-the-bed tray table next to her and the table could not go on top of the fall mat. On 7/22/25 at 9:13 AM the observation was discussed with the Director of Nursing (DON) and the Assistant DON. The DON confirmed that the fall mat should have been on the floor. 2) During an observation on 07/15/2025 at 9:20 AM Resident #1, there were 3 lighters in the resident’s room. One lighter on the bedside table and 2 lighters on a low-level dresser in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #1’s medical record on 7/16/25, at 12:20 PM revealed that the “Smoking Safety Screen” form was completed on 7/02/25. The overall score was documented as 3, which is a high-risk category. The form, which has six questions, noted a Yes for question C (Dexterity). For question E (Safety), the box was checked indicating the resident follows the facility smoking policy (smokes in a designated area, follows a schedule, does not smoke with oxygen present, etc.). Continued review of Resident #1's care plan revealed that on 1/03/24 few interventions were listed regarding smoking: Resident is not to have smoking materials on her person, resident’s cigarettes are to be held on the nursing cart and given to Resident #1 as requested. Educated about the smoking policy and safety and how dangerous it can be if she sets herself on fire while smoking in bed. In addition, she is putting the building and all the residents at risk. She stated that it will not happen again. In an interview with Resident #1 on 07/15/2025 at 9:20 AM resident stated he/she kept his/her smoking materials (cigarettes and lighters) in his/her room. In an interview on 07/16/2025 at 12:59 PM, Staff #2, a Geriatric Nursing Assistant (GNA) stated that residents' smoking materials (cigarettes and lighters) were kept at the nurse’s station and residents were not able to keep smoking material on them. In an interview on 07/16/2025 at 1:03 PM, Staff #8, a Licensed Practical Nurse stated that residents' smoking materials were kept at the nurse’s station and residents were not to have smoking materials on them. In an interview on 07/16/2025 at 1:41 PM with the Nursing Home Administrator (NHA) stated that alert and oriented residents were able to keep smoking materials (cigarettes and lighters). In a second Interview on 07/16/2025 at 2:03 PM with the NHA, she/he clarified that residents were allowed to have cigarettes, but they were not allowed to keep lighters on them. NHA said, “Lighters are kept at the nurses’ station, and it is hard to check every resident that smokes because there are so many smokers and families will bring in lighters and cigarettes for them.” The surveyor shared concerns that Resident #1 kept his/her own smoking materials which was not allowed per the care plan. The NHA validated the concern. 3) During an observation on 07/16/2025 at 1:08 PM in the designated smoking area, two surveyors observed Resident #83 sitting in a wheelchair smoking and Resident #97 observed in a wheelchair leaning towards his/her left side with a lit cigarette in his/her left hand with no smoking apron on. There was no facility staff present. On 07/16/2025 2:24 PM of Resident #97's medical record an evaluation titled “Smoking Safety screen” completed on 07/02/2025 indicated resident requires supervision and an apron. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #97’s medication record plan of care related to smoking with a revision date of 07/04/2025 indicated a focus of, “history of unsafe smoking practices.” and an intervention indicating, “Cigarettes and lighting material will be kept at the nurses’ station, supervisor’s office or designated location.” On 07/16/2025 at 2:41 PM in review of Resident #83’s medical record revealed that the smoking evaluation dated 7/2/2025 stated that the resident required supervision with smoking. Further review of Resident #83’s medical record plan of care for smoking revised on 07/02/2025 indicated a Focus of, “may not smoke independently per smoking assessment.” and an intervention indicating, “supervise patient with smoking in accordance with assessed needs.” and “maintain patients' smoking material at nurses’ station.” In an interview with Staff #2 (GNA) on July 16, 2025, at 12:59 PM, she stated that residents who required smoking supervision would be supervised by whoever was available, including a GNA or sometimes Activities staff. In an interview on 07/16/2025 at 1:03 PM, Staff #8 (LPN), stated the GNA’s supervise residents requiring supervision during smoking and all residents supposed to keep their cigarettes and lighters at the nurses station. In an interview on 07/16/2025 at 1:10 PM with Resident #97, the resident stated he/she kept his/her cigarettes and lighter. In an interview on 07/17/2025 at 10:58 AM with the NHA, stated “supervision” is for a staff member to light the cigarette and observe the resident smoke from the time cigarette is lit until it is disposed of. She stated Resident #83 needed supervision because he/she was shaky and Resident #97 required supervision because he/she only has one good arm.” At this time the NHA confirmed Resident #83 and Resident #97 required supervision and was made aware of the concern of residents with smoking material (cigarettes and lighters) in their possession and residents identified as requiring supervision were observed smoking unsupervised.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident medical records and interviews with facility staff, the facility failed to 1) address a significant weight loss, and 2) follow the recommendations of the Dietitian for a resident. This deficiency was evident in 2 (Resident #9 and #116) of 2 residents reviewed for nutrition during this recertification/complaint survey. Findings included: 1)During a review of Resident #9's medical record on 07/16/25 at 11:52 AM, it was revealed that the resident was readmitted to the facility from the hospital on [DATE]. The resident's body weight was documented as: 06/02/25: 170.2 lbs (via Hoyer lift) 07/09/25: 158 lbs (via Hoyer lift, a loss of 12.2 lbs, 7.17%) 07/15/25: 163 lbs (via Hoyer lift) Further review of Resident #9's medical records showed that their nutrition evaluation was documented on 06/03/25. However, there was no additional evaluation regarding this significant weight loss. In an interview with Licensed Practical Nurse (LPN) #8 on 07/16/25 at 12:55 PM, she stated that the Geriatric Nurse Aide checks residents' body weight at least monthly (or as per provider's order), and nurses enter the data into the system. When asked about residents receiving hospice care, LPN #8 confirmed that even hospice residents require regular weight checks unless a hospice team order specifies otherwise. LPN #8 also explained that if a resident's weight changes are noted, staff should re-weigh the resident, notify the dietitian and provider, and document it as a change in condition in the system. During an interview with the Director of Nursing (DON) on 07/16/25 at 1:46 PM, she stated that if a resident's weight loss is noted, she expects nursing staff to re-weigh the resident and initiate treatment (including physician's orders and dietitian's interventions). She indicated, those should be documented in progress notes and risk meeting. The surveyor reviewed Resident #9's body weight changes with the DON, who confirmed that there was no documentation regarding the resident's weight loss noted on 07/09/25. The DON validated the concern. 2) Review of Resident #116’s medical record on 7/17/25 revealed the Resident was admitted to the facility in June 2024 with a diagnosis to include malnutrition and dysphagia. Malnutrition occurs when the body doesn't get enough nutrients. Dysphagia is the difficulty swallowing of foods and liquids. Further review of Resident #116’s medical record revealed the Dietitian (Staff #58) assessed the Resident on 6/19/24 and recommended the following interventions: offer pudding and shakes twice a day for additional calories. Review of Resident #116’s physician orders revealed the Resident was not ordered pudding and shakes after the nutritional assessment on 6/19/24. Further review of Resident #116’s medical record revealed the Resident was admitted to hospice care on 6/14/24 and died in the facility on 7/6/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 7/17/25 at 3:05 PM confirmed the facility staff failed to follow the recommendations of the Dietitian for Resident #116.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and medical record review, it was determined that facility staff failed to provide respiratory care to meet the needs of residents. This was evidenced by: absence of physician orders indicating the use of oxygen for residents, failure to maintain nasal cannulas in a sanitary manner, and failure to administer oxygen according to the prescribed settings. This was evident for three residents (#1, #3, and #13) reviewed for respiratory care during the recertification/complaint survey. The findings include:1) Review of Resident #13’s medical record on 7/17/25 revealed the Resident was admitted to the facility with diagnosis to include chronic respiratory failure and obstructive sleep apnea. Obstructive sleep apnea (OSA) is a common sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage of the airway. BiPAP, or bilevel positive airway pressure, is a type of non-invasive ventilation used to assist breathing, particularly for individuals with sleep apnea or other respiratory conditions. A review of a complaint was conducted on 7/17/25 regarding respiratory services for the Resident in November 2022, January 2023, November 2024 and June 2025. a) Review of Resident #13’s November 2022 Treatment Administration Record (TAR) revealed the facility staff failed to document the administration of the Resident’s BiPAP on 11/2, 11/3, 11/7 and 11/8/22. The Resident was transferred to the hospital on [DATE] and returned on 11/17/22. Review of the Resident’s November and December 2022 TAR’s the facility staff did not include the BiPAP administration to confirm if the BiPAP was administered. b) Review of Resident #13’s January 2023 Medication and Treatment Administration Record revealed the facility staff did not document the administration of the Resident’s BiPAP on 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/23 and 1/27/23. c) Review of Resident #13’s November 2024 TAR revealed the facility staff did not include the BiPAP administration from 11/1/22 until the Resident’s hospitalization on 11/9/22 to confirm if the BiPAP was administered. d) Review of Resident #13’s medical record revealed the Resident’s BiPAP was not administered on 6/10/25 due to malfunction. An interview with the Director of Nursing on 7/23/25 at 2:20 PM confirmed the Surveyor’s findings for the administration of Resident #13’s BiPAP in November 2022, December 2022, January 2023, November 2024 and June 2025. 2) During an observation on 7/21/2025 at 12:05 PM Resident #1 was receiving O2 via NC (nasal cannula) and the setting was at 3L (liters per minute). On 07/21/2025 at 12:10 PM a review of Resident #1 medical record revealed that there was a Physician order dated 03/04/2025 for Oxygen at 2L/min via NC as needed. However, there was no indication for Oxygen therapy documented in the order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/21/2025 at 12:20 PM with Staff #19, Licensed Practical Nurse (LPN), the staff stated nurses identified the amount of Oxygen should be on the Physician order. Nurses were the ones who adjusted the O2 Liters. Staff #19 verified the Oxygen settings for R#1 was set at 3L/min. She confirmed that it should have been on 2L/min. per Physician orders. Also, she verified there was no indication for use on the Physician order for the Oxygen, stated, doesn't say exactly why; there is no indication of use.” 3) During an observation on 07/15/2025 at 10:37 AM Resident #3 was lying in bed with O2 (oxygen) via NC (nasal cannula), the O2 tubing was dated 07/09. Another observation on 7/21/2025 at 12:25 PM, it was noted that Resident #3 O2 tubing was dated 07/09 and Oxygen setting was at 2.5L/min. On 07/17/2025 at 12:30 PM in review of Resident #3’s Physician orders dated 6/20/2025 revealed “Oxygen at 2L/min via Nasal Cannula continuously. Every shift Post Tx: Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds” However, there was no indication documented for the Oxygen use. Continued review of Resident #3 Physician orders dated 6/26/2025 revealed Oxygen tubing change weekly Label each component with date and initials. Every night shift every Thursday Label each component with date and initials Continued review of Resident #3 Respiratory care plan revised on 06/23/2025 indicated altered respiratory status and resident is on Oxygen therapy at 2L/min(minute) via nasal canula. Further review of Resident #3 TAR(Treatment Administer Record) review for the month of July had a Physician order dated 06/20/2025 for Oxygen tubing change weekly, label each component with date and initials every Thursday. Signatures were signed on the TAR as being completed for the following dates of 07/03/2025, 07/10/2025, and 07/17/2025. In an interview on 07/21/2025 at 12:26 PM Interview with Employee #18, the Unit Manager verified the O2 tubing for Resident #3 was dated 7/9 and stated O2 tubing should be changed weekly and on Thursdays. Also verified Resident #3’s O2 setting was at 2.5L/min. and the oxygen Physician order was for 2L/min. In an interview on 07/21/2025 at 1:21 PM with the Director of Nursing clarified that a Physician order for oxygen should include the indication for use, the tubing should be dated and changed weekly, and Oxygen settings should be according to the Physician order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints, medical record review, and staff interview, it was determined the facility failed to 1) provide timely medication to meet the needs of the residents, and 2) ensure that narcotic medications were consistently reconciled by two nurses at change of shift. This was evident for 3 (#67, #108, #111) of 64 residents reviewed, and 4 halls ([NAME], [NAME], [NAME], and [NAME]) of 4 halls of narcotic and controlled substance log binders reviewed for accuracy and completeness of controlled medication storage and documentation during the recertification/complaint survey. The findings included: Narcotic (controlled) medication, due to its potential for abuse and addiction, is required to be thoroughly tracked and accounted for by the facility. This includes but is not limited to an accounting of all narcotics in storage whenever a change of shift among nursing staff occurs. This medication count must be performed by two nursing staff at the same time to verify the counts being conducted. Any discrepancy in the count from what is expected to be found must be addressed immediately. 1a) On 7/16/25 at 1:23 PM a review of complaint 326172 alleged that Resident #67 was not receiving medications timely. A review of Resident #67’s medical record was conducted and revealed a physician’s order for, “Nicotine Transdermal Patch 24 Hour 14 MG/24HR (Nicotine)”. The order stated to remove the old patch prior to administering the new patch. Review of nursing notes and the Medication Administration Record (MAR) showed a pattern of the Nicotine Patch, that was to be applied every day, was not being given consistently due to issues with reordering and waiting for pharmacy delivery. A 12/28/24 at 10:14 AM note documented, “is being delivered today.” A 12/29/24 at 9:43 AM documented, “Nicotine Patch, did not apply one on 12/28/24.” A 1/7/25 at 11:06 AM note documented, “had to reorder.” A 2/3/25 at 10:44 AM note documented, “had to be reordered.” Two notes were written on 2/4/25 that documented that the provider and RP (responsible party) were notified of the missed dose and that the medication was delivered last night. A 3/18/25 at 10:46 AM note documented, “had to reorder.” A 3/19/25 at 10:44 AM noted documented, “did not have yesterday.” On 4/7/25 at 9:53 AM a note documented, “awaiting med from pharmacy.” A 4/8/25 at 10:54 AM note documented, “had to be reordered.” A 4/10/25 at 10:39 AM note documented, “there was none there.” On 7/16/25 at 12:17 PM a note documented, “had to reorder.” A 7/17/25 at 10:35 AM note documented, “had to reorder on yesterday.” (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/25 at 1:56 PM an interview was conducted with Certified Medicine Aide (CMA #35). CMA #35 was asked when she re-ordered medications and she said usually when there are 4 left or when she looks at the date. CMA #35 stated, “sometimes the nurse may give the meds if I am not here and then it doesn’t get reordered so when I get back I have to look through the cart to make sure they get reordered.” On 7/24/25 at 7:51 AM an interview was conducted with the Director of Nursing (DON). The DON was informed about the availability of the Nicotine patch and what CMA #35 stated about it not being ordered timely. 1b) On 7/18/25 at 10:55 AM a review of complaint 316136 alleged that Resident #108 did not receive medications as prescribed. The complaint alleged that Resident #108 did not receive the IV (intravenous) medication Vancomycin on 7/8/23 and in the morning on 7/9/23. IV Vancomycin is a powerful antibiotic used to treat serious bacterial infections. Vancomycin has a narrow therapeutic window, therefore has to be monitored by frequent blood draws to ensure the medication is both effective and safe. Review of Resident #108’s medical record revealed Resident #108 was admitted to the facility in April 2023 with diagnoses that included, but were not limited to, bipolar disorder, phlebitis and thrombophlebitis of the deep vessels of the lower extremity, local infection of the skin and subcutaneous tissue, bacteremia, cellulitis of the right upper limb, sepsis, acute hematogenous osteomyelitis of the right ankle and foot, and opioid abuse. Review of physician’s orders revealed the order, “Vancomycin HCl in NaCl intravenous Solution 1.25-0.9 GM/250 ML) use 1.25 gram intravenously two times a day related to bacteremia.” This was ordered on 6/23/23. Review of a nursing note dated 7/8/23 at 18:00 (6 PM) documented, “No IV Vancomycin available from pharmacy or in Pyxis. Spoke with on call pharmacist at [name] whom stated it would arrive to facility by 0600.” A 7/9/23 at 6:44 AM medication administration note documented that the Vancomycin was not administered and pharmacy was called, and they stated that they would deliver the medication that morning. A 7/17/23 at 18:14 (6:14 PM) eMAR administration note documented, “waiting for pharmacy to deliver. ” Review of the July 2023 Medication Administration Record (MAR) had a blank space for 7/8/23 at 6:00 PM and had a “9” with the nurse’s initials on 7/9/23 at 6:00 AM. A “9” indicated that the medication was not administered and there was a nursing note to state the reason. On 7/17/23 at 6:00 PM there was a “9” that indicated the medication was not administered. On 7/18/25 at 11:17 AM an interview was conducted with the DON who stated that she was not employed at the facility during that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) On 7/21/25 at 2:00 PM a review of complaint 326146 alleged the facility didn’t have Resident #111’s medication. The complaint alleged that blood pressure medications and pain medications start the resident’s day. Review of Resident #111’s medical record revealed Resident #111 was admitted to the facility in January 2024 with diagnoses that included nontraumatic intracerebral hemorrhage in cerebellum, hypertension, and acute kidney failure. Review of Resident #111’s February 2024 MAR revealed on 2/5/24 at 6:00 AM the blood pressure medication Captopril 100 mg, that the resident was to receive 3 times per day, was not available as evidenced by the nurse’s initials and the number 9 which indicated that the medication was not given and there was a corresponding note. Review of the 2/5/24 at 6:39 AM eMAR note documented, “awaiting order from pharmacy.” On 7/22/25 at 12:25 PM an interview was conducted with the DON, who was previously the Assistant Director of Nursing. The DON confirmed that they have issues with staff not ordering medications on time for residents. Review of the Medication Reordering Policy, that was given to the surveyor by the DON on 7/22/25 at 1:06 PM documented that the policy was implemented on 12/14/22. The policy documented #3. “Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting.” On 7/24/25 at 11:59 AM an interview was conducted with the DON as review of resident council meetings minutes revealed issues with other residents not receiving medications timely. The DON stated she was aware that medications were running out, but the issue had not been taken to Quality Assurance meetings. On 7/24/25 at 12:32 PM an interview was conducted with the NHA, as acting grievance officer of the facility. The NHA was informed that one of the concerns that was raised at the June 2025 resident council meetings, according to the minutes, was 2 specific residents’ medications had not been refilled before they ran out. The surveyor showed the NHA the resident council minutes where it stated the resolution was that all medications would be reordered Friday, but in July, there were still residents whose medications were running out and not available. When asked if she would say that the issue has been resolved, the NHA stated, “no.” The NHA stated that the previous DON was not addressing the grievances timely, but she and the new DON were working on the issue. The surveyor shared this was a concern that issues brought up last month were still an issue. The NHA stated, “I know I get it.” 2)During the medication storage facility task on 7/22/25 at 10:13 AM, the surveyor reviewed the narcotic and controlled substance log binders for June 2025 and July 2025, for [NAME], [NAME], [NAME], and [NAME] medication carts. During the review, it was noted that signatures were missing for the following changes of shift: 2a) For [NAME] – Month of June 6/9/25, 11-7 shift: missing Off-Going and On-Coming nurse signatures (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For [NAME] – Month of July 7/2/25, 11-7 shift: missing On-Coming nurse signature 7/5/25, 7-3 shift: missing Off-Going nurse signature 7/11/25, 11-7 Shift: missing Off-Going nurse signature 7/12/25, 7-3 shift: missing Off-Going nurse signature 7/14/25, 3-11 shift: missing Off-Going nurse signature 2b) For [NAME] 20’s Hall – Month of July 7/8/25, 7-3: missing Off-Going nurse signature 7/11/25, 3-11: missing On-Coming nurse signature 7/21/25, 3-11: missing On-Coming nurse signature 7/21/25, 11-7: missing Off-Going nurse signature For [NAME] 30’s Hall – Month of July 7/2/25, 3-11: missing Off-Going nurse signature 7/5/25, 3-11: missing On-Coming and Off-Going nurse signature 7/11/25, 11-7: missing Off-Going and On-Coming nurse signatures 2c) For [NAME] – Month of June 6/3/25,7-3: missing On-Coming nurse signature 6/18/25, 11-7: missing On-Coming nurse signature 6/19/25, 7-3: missing Off-Going nurse signature For [NAME] – Month of July 7/1/25, 3-11: missing Off-Going nurse signature 7/13/25, 11-7: missing On-Coming nurse signature 7/14/25, 7-3: missing Off-Going nurse signature 7/16/25,7-3: missing Off-Going nurse signature (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2d) For [NAME] – Month of July 7/13/25, 11-7 Shift: missing Off-Going nurse signature 7/19/25, 7-3 shift: missing Off-Going nurse signature During an interview, on 7/22/25 at 10:55 AM with staff # 29 and staff # 24 both indicated that the narcotic and controlled substance shift to shift count sheets were to be signed by on coming and off going nurses. A current facility policy, titled Controlled Substance Administration and Accountability,” dated 12/16/21 and revised on 4/8/24 stated in the inventory verification section that For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. On 7/22/25 at approximately 11:13, The DON was aware of the findings when he/she explained that the expectation was that at the end of the shift the oncoming and off going nurse must sign off on the narcotic and controlled substance shift to shift count sheet indicating that a narcotic inventory count was conducted and that the count was correct.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a tour of the kitchen, staff interview and observation, it was determined that the facility staff failed to 1) ensure proper disposal of foods no longer safe to consume, and 2) store food in accordance with professional standards for food service safety. This was evident for 2 out of 3 kitchen tours and observation of a nourishment room during the recertification/complaint survey. The findings include: 1)During the initial tour of the kitchen on 7/15/25 at 7:34 AM these items were found in the walk-in cooler: 4 - 4 packs of yogurt (2 strawberry yogurt cups and 2 vanilla yogurt cups per pack), 2 loose containers of strawberry yogurt, and 1 loose container of vanilla yogurt that had best by dates of 7/2/25. The Dietary Manager (Staff #53) was interviewed on 7/15/25 at 7:40 AM. This surveyor showed her the yogurts and their dates. She replied by saying that they needed to be thrown out. She then took the items off of the shelf to be discarded. During a tour of the kitchen on 7/22/25 at 8:10 AM this surveyor observed an open case of tomatoes on the shelf of a rack that was on the right-hand side of the walk-in cooler. There were about 12 tomatoes in the box and 4 of those tomatoes had white fuzzy material around the stems. Staff #53 was interviewed on 7/22/25 at 8:13 AM. This surveyor showed her the tomatoes and explained finding the white fuzzy material. She replied that the tomatoes were bad. She then picked up the box of tomatoes and said she was throwing all of the tomatoes out. 2) On 7/24/25 at 10:10 AM observation was made of the Nourishment room next to the nurse's station and across from room [ROOM NUMBER]. There were 2 vinyl gray floor tiles lying sideways in front of the ice machine that was dripping water. There was a puddle of water on top of one of the tiles. There were black specs that appeared to be a moldlike substance on the wall and floor base molding by the ice machine. There were no caution signs in the Nourishment rooms by the puddle of water. Observation was made of the under the counter cabinets which were dirty. There was a butcher knife with a 2-inch blade on the bottom shelf of the cabinet that was located in front of the ice machine. There were water spill marks, a red solo cup laying sideways, a plastic plate cover lid, and a zip lock back with pink envelopes of sweetener in the middle cabinet. Observation of the freezer section of the nourishment refrigerator had at least a 1 inch ice build-up on all walls of the freezer. On 7/24/25 at 10:23 AM the Nursing Home Administrator (NHA) was shown the areas of concern. The NHA stated that the floor tile issue had just happened and she was in the processing of having it repaired. The NHA was shown the knife and the response was, what is that doing in there? The NHA was then shown the other objects in the cabinets and the freezer. The NHA stated that she had told them to make sure the refrigerator was clean the other day.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 3 (Resident #67, #75, and #108) of 64 residents reviewed during an recertification/complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) Review of Resident #75’s medical record revealed the Resident was admitted to the facility in July 2024 and after a hospitalization was readmitted to the facility on [DATE]. Review of Resident #75’s hospital discharge summary on 5/23/25 stated Patient was subsequently discharged in stable condition. All non-essential medications from a palliative standpoint were discontinued. Further review of Resident #75’s medical record revealed the Resident was admitted to hospice care on 5/25/25. Review of the Physician notes for Resident #75 on 5/27/25 and 6/24/25 revealed the Physician (Staff #48) documented the Resident was on Pravastatin 20 mg nightly for secondary stroke prevention. Review of Resident #75’s physician orders revealed the Resident was not on Pravastatin 20 mg since readmission to the facility on 5/23/25. Interview with the Chief Clinical Officer on 7/23/25 at 8:00 AM confirmed the Physician’s documentation of Pravastatin for Resident #75 on 5/23 and 6/24/25 was an error and the Resident is not supposed to be on Pravastatin. 2) On 7/18/25 at 10:55 AM a review of complaint 316136 alleged that Resident #108 did not receive medications as prescribed. Review of Resident #108’s July 2023 Medication Administration Record (MAR) had several blank spaces for several medications. On 7/12/23 at 9:00 PM there were blank spaces for the administration of Seroquel, Metformin, Pregabalin, and Senna. On 7/13/23 at 9:00 PM there were blank spaces for the administration of Seroquel, Metformin, Pregabalin, Senna, and Trulicity. On 7/8/23, 7/12/23, and 7/13/23 there were blank spaces for the injection Enoxaparin. On 7/13/23 in the evening there was a blank space for the Normal Saline Solution flush. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/23 at 4:30 PM, on 7/13/23 at 11:30 AM and 4:30 PM the Humalog insulin sliding scale spaces were blank. On 7/12/23 at 4:00PM, 7/13/23 at 9:00 AM and 4:00 PM, there were blank spaces for the application of sliver sulfadiazine external cream. On 7/12/23 and 7/13/23 there were blank spaces for the Normal Saline Flush 5 ml with Heparin flush 5 ml on the 3-11 shift. On 7/18/25 at 11:17 AM an interview was conducted with the Director of Nursing (DON). When asked about the blank spaces on the MAR, the DON stated, “if it is blank then I would take that as the medication was not given and signed off.” The DON stated it could not be determined if the medication was given. 3) On 7/16/25 at 1:23 PM a review of Resident #67’s medical record was conducted. Review of progress notes in the medical record failed to produce evidence of care plan meetings in either the miscellaneous section of the medical record or in social work documentation. On 7/23/25 at 1:13 PM an interview was conducted with the Social Work Director #15. Staff #15 stated that she just started on 5/5/25. Staff #15 stated there was a care plan meeting on 5/21/25 but there was no sign-in sheet, and the notes were handwritten in her notepad book and not in the electronic medical record. Since the notes were handwritten in a notepad, the notes were not available for other disciplines. On 7/24/25 at 7:51 AM the Director of Nursing and Nursing Home Administrator were informed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, observation of resident rooms, common shared areas, interviews, and documentation review, it was determined that the facility staff failed to 1)follow infection control practices and guidelines to prevent the development and transmission of infection and disease, 2) ensure staff donned appropriate personal protective equipment (PPE) for enhanced barrier precautions during medication administration to resident with a Gastrostomy tube and post appropriate Enhanced Barrier Precautions (EBP) signage, 3) place order for contact precaution and care plan for a resident with an infectious disease, 4) place precaution order and signage on the door for EBP residents. This was evident on 3 of 3 hallways observed, 5 (Residents #11, #128, #12, #27, and #44) of 7 residents reviewed for Infection Control during the recertification/complaint survey.The findings include: TBP definitions: Transmission Based Precautions (TBPS) (a set of infection control measures used in addition to standard precautions when patients are known or suspected to be infected with pathogens that can be transmitted through specific routes. These precautions are designed to prevent the spread of infection and are implemented based on the mode of transmission of the infectious agent.) EBP definitions: Enhanced Barrier Precautions (EBP) (An infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP and TBP require the use of PPE (Personal Protective Equipment) of gloves, gown, mask, and/or eye shields depending on the type of infection and risk for exposure to prevent the spread of infections. 1)On 7/15/25 at 9:30 AM a review of complaint 326160 alleged there was mold in the building. The following were several infection control concerns that were observed during the annual survey from 7/15/25 to 7/24/25. On 7/15/25 at 7:45 AM observation was made on the [NAME] Unit of the storage closet. There was a small gray basin on the floor under the storage cart. Under the storage cart there were multiple spoons, debris, toothbrushes, torn tissues, straws, and diapers. On 7/16/25 at 11:00 AM observation was made in room [ROOM NUMBER] of soiled clear plastic gloves on the cart under the television. In the bathroom there was a white urine hat on the floor behind the toilet. The urine hat was not labeled. There were black specs on the blind slats of the ac unit that had the appearance of mold. In the utility room on the [NAME]/[NAME] unit were plastic cup lids lying on the floor. In room [ROOM NUMBER] there were 3 basins sitting on the toilet tank lid which was 1 dark pink basin, 1 salmon colored basin, and 1 gray basin. The basins were not labeled or dated. There was a white urine hat on the floor by the toilet that was not labeled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In room [ROOM NUMBER] there was a round gray basin on the floor in the corner behind the toilet that was not labeled. In room [ROOM NUMBER] there were 3 round gray basins sitting on the toilet tank that were not labeled. There was a urinal hanging on the toilet grab bar and 1 square gray basin on the floor under the sink that were not labeled. In room [ROOM NUMBER] there was a gray bed pan and a gray basin under the sink on the floor that was not labeled. It was noted that this was a shared bathroom with room [ROOM NUMBER] where there was an enhanced barrier precaution sign hanging on the door. Observation was made in the Human Resources Director’s (HR) office of black specs which appeared to be a moldlike substance on the window blinds and covering the slats of the air conditioning unit which also had condensation around the unit. An interview was conducted with Staff #5 who confirmed there was mold growing in the office and that she had reported it. In the shower room on the [NAME] nursing unit by the first and second stall was a moldlike substance appearing in the grout of the ceramic tile. In the shower room on the [NAME]/[NAME] unit were soiled washcloths on the floor and on top of a bariatric shower chair. There was moldlike substance appearing in the grout of tile on the right-side stall that was approximately one foot in height from the corner. In the activity room office, there was a corner ceiling tile that was totally covered in what appeared to be black mold and appeared sunken like it was caving in. The Director of Activities stated it had been like that for a month. On 7/22/25 at 9:13 AM the infection control concerns were discussed with the Director of Nursing (DON) and the Assistant DON. The DON stated that the basins, urinal, and urine collection hats should have been labeled and not stored inside of each other. The DON stated she was aware of a mold issue in the building, especially in the shower rooms where there was increased humidity. On 7/22/25 at 1:06 PM a review of the Disinfection of the Bedpans and Urinals policy that was given to the surveyor by the DON and was implemented on 12/15/22 documented, #1. Bedpans and urinals are for single resident use only. [NAME] with the resident's name or room number and discard upon discharge. #2. Store bedpans and urinals in the resident's bedside cabinet or drawer after placing in a plastic bag or as per facility policy. On 7/24/25 at 10:43 the Nursing Home Administrator (NHA) was shown the areas of concern. The NHA stated they had a problem with the gutters on that side of the building where the activities office was located and she stated the ceiling tile was supposed to have been replaced. 2) During observation of medication administration on 7/22/2025 at 8:10 AM, staff # 8 failed to put on Personal Protective Equipment (PPE) while administering medication to Resident # 11 with a Gastrostomy tube (Gtube). The surveyor noted that Resident #11 also had a foley catheter and there was no Enhanced Barrier Precaution (EBP) signage on the resident’s door or inside of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On record review 7/22/2025 at 11:06 AM there was an order for Enhanced Barrier Precaution, and it was also noted in the Care Plan. Records provided by the facility of all residents on EBP identified Resident #11 as resident on EBP for foley catheter, have sign on door, EBP on GNA task, and care plan in place and updated. An interview was conducted on 07/22/2025 at 11:26 AM with Staff #28 who stated that PPE should be worn when administering medication via G Tube. On 07/22/2025 at 11:54 AM during an interview DON stated that staff must wear PPE during medication administration to residents who have a Gtube and there should be an EBP sign on the door for residents with Gtube and or a foley catheter. On 7/22/2025 at 11:56 AM, DON was made aware of the findings and agreed that staff should have put on PPE for the medication administration and that an EBP sign should have been on the resident’s door. 3) On 07/22/2025 at 08:30 AM in a review of Resident # 128 medical records revealed that a Discharge Summary from the hospital printed on 07/17/2025 indicating Resident #128 was sent to the hospital. He/she was found to have Sepsis (a life-threatening condition) with several infections. Further review of Resident #128’s medical record revealed a Progress Note effective date of 07/17/2025 at 6:59 PM written by on-call physician note that indicated a complicated UTI (Urinary tract infection) ESBL (Extended-spectrum beta-lactamase) versus infected necrotic sacral wound. In an interview on 07/22/2025 at 09:03 AM with the Director of Nursing (DON), the surveyor asked about the facility’s TBP status (details about who required each precaution). She stated that there was one resident, Resident #128, that required contact precautions needed related to MRSA (Methicillin-resistant Staphylococcus aureus: a type of bacteria that is resistant to many common types of antibiotics), E. coli (a bacteria), and other things. 7/22/25 at 9:05 AM, review of Resident #128’s medical record revealed there was no order for contact precaution for the resident, nor a care plan regarding his/her infection status. Additionally, an observation on 07/22/2025 at 9:10 AM of Resident #128's room showed that there was no evidence in the room that PPE was being used related to no waste/trash container present in the room for disposal of PPE. In an interview with Staff #24 (Licensed Practical Nurse) on 07/22/2025 at 09:15 AM, she said, I was not sure why Resident # 128 is on Contact Precautions. But thought it may be related to the resident's wound. The surveyor asked if a resident had contact precaution what they required to set for PPE. Staff #24 stated that the resident should have a garbage can to dispose of PPE used for donning and doffing and at that time verified that there was no garbage can in room for disposal of PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a second interview with the DON on 07/22/2025 at 1:26 PM, she stated staff should know contact precautions because it was in the computer as a Physician Order and a sign would be posted outside the door of a resident’s room, she would expect staff to use PPE of a gown and gloves. There were regular trash bins in residents' rooms for disposal of PPE. At this time DON was made aware of the concerns related to Resident #128 that included, one of their staff did not know the reason for contact precautions, there was no order for contact precautions, which DON stated she knew, that the physician order was placed on 07/22/2025, after the surveyor's intervention. There was no care plan for contact precautions, and no trash bin in the room for disposal of PPE. 4) On 07/22/2025 at 08:00 AM, the surveyor requested a list of residents that required Enhanced Barrier Precautions (EBP). Review of the list revealed the list had 43 residents that required EBP including Resident’s #12, #27, and #44. 4a) On 07/23/2025 at 07:30 AM in review of Resident #12’s medical records revealed that the resident was an EBP candidate for ESBL and MRSA. However, there was no order for EBP from the provider. 4b) On 07/23/2025 at 07:45 AM in review of Resident #27 medical records it revealed that the resident was an EBP candidate related to having a Suprapubic Catheter (a flexible tube inserted through a small incision in the abdomen, just above the pubic bone, to drain urine from the bladder). 4c) On 07/23/2025 at 08:00 AM in review of Resident #44 medical records revealed that the resident was a candidate for EBP related to a Gastrostomy tube (a surgically placed tube that provides a direct route for delivering nutrition, fluids, and medications into the stomach used for individuals unable to swallow) and a Colostomy (a surgical procedure that creates an opening (a stoma) in the colon, bringing a portion of the colon to the surface of the abdomen to allow for the elimination of stool) On 07/23/2025 at 08:15 AM during an observation of Resident’s #12, #27, and #44 room there was no signage on the door that indicated the need for Enhanced Barrier Precautions. On 07/23/2025 at 8:30 AM Interview with the Assistant Director of Nursing (ADON) stated residents that are on EBP should have a Physician order and signage on the door. On 07/23/2025 at 8:43 AM the ADON verified with surveyor there was no signage on the doors indicating EBP for Resident’s #12, #27, and #44 and Resident #12 had no order for Enhanced Barrier Precautions. On 07/24/2025 at 9:07 AM DON was made aware of the concerns of residents that require EBP, no physician order or signage on the door to alert staff of the precautions needed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of restrooms for residents and visitors, a nursing station, a public shower room, and facility staff offices, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, visitors, and staff as identified. This was evident in 2 staff bathrooms observed on 2 nursing units, 2 of 2 shower rooms, and 2 staff offices observed during the recertification/complaint survey. The findings include:On 7/15/25 at 9:03 AM observation was made in the Human Resources Director's (HR) office of black specs which appeared to be a moldlike substance on the window blinds and covering the slats of the air conditioning unit which also had condensation around the unit. An interview was conducted with Staff #5 who confirmed there was mold growing in the office and that she had reported it to administration. On 7/24/25 at 9:00 AM and 10:20 AM observation was made of the bathroom in the [NAME] unit nurse's station. The base molding was pulled away from the wall to the left of the toilet exposing debris and the open area behind the plasterboard. The gap was approximately 3-4 inches wide, and the length was about 2 to 4 feet long. The toilet paper roll was sitting on top of the toilet paper holder as there was no rod in the toilet paper holder to hold the toilet paper. There was no gooseneck faucet at the sink. The Nursing Home Administrator (NHA) was with the surveyor for the observation. The NHA appeared surprised to see the condition of the base molding and she acknowledged the condition of the bathroom. Observation was then made of the shower room on the [NAME] nursing unit. There appeared to be a mold type substance in the grout in the first and second stalls along with chipped ceramic tile. The NHA was with the surveyor and confirmed the findings. On 7/24/25 at 10:24 AM observation was made of the bathroom on the [NAME]/[NAME] unit in the hallway across from the nurse's station that was used for residents, staff, and visitors. The faucet at the sink was not a gooseneck faucet. Observation was made in the shower room on the [NAME]/[NAME] unit. In the shower stall on the right there were (2) ceramic tile corner pieces broke about 1 1/4 inches and the mastic was exposed. There was molded grout approximately 1 foot high on the corner. The shower stall on the left had 2 cracked ceramic base tiles. The back shower stall had (3) broken ceramic tiles on the corner. There were soiled washcloths on the floor and in a bariatric shower chair. The ceiling had cracks in the central area of the room. The NHA was with the surveyor at the time and confirmed the findings. In the activity room observation was made of a corner ceiling tile that was totally covered in what appeared to be black mold and appeared sunken like it was caving in. The Director of activities stated it had been like that for a month. The NHA was with the surveyor at the time of the observation on 7/24/25 at 10:43 AM. The NHA stated they had a problem with the gutters on that side of the building. She stated the ceiling tile was supposed to have been replaced.