STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215074	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation during the initial tour of the facility and staff interviews, it was determined that the facility staff failed to ensure a resident had the call bell control by their side. This was evident for 2 (Resident #9 and #43) out of the 64 residents in the survey sample. The findings include: 1)During the initial tour of the facility on 07/15/2025 8:33 AM this surveyor entered Resident #43's room and observed that the call bell cord and plunger were on the floor to the right of the bed near the headboard and out of reach of the resident. The resident was unaware of the call bell's location. 2)On 07/15/2025 at 9:35 AM during the surveyor’s initial tour of the facility, an observation of Resident #9’s call bell (an item used to press and alert staff that a resident needed assistance) was on the floor and out of reach of the resident. On 07/15/2025 at 09:40 AM during an interview with staff #20 a Geriatric Nursing Assistant/Certified Medication Tech (GNA/CMA) stated the call light should be within reach and verified that Resident #9’s call light was not within reach. The facility was informed of the findings at the exit conference.

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of Resident Council meeting minutes and interview with facility staff, it was determined that the facility failed to have an effective system in place to demonstrate their response and rationale for concerns identified by the Resident Council. This was found to be evident based on review of 4 months of Resident Council meeting minutes.The findings include:The Resident Council is a group of residents that meets regularly on the behalf of all residents in the facility to discuss concerns about facility policies and procedures affecting residents' care, treatment, and quality of life. Facility staff are required to consider resident and family group views and act upon grievances and recommendations. This may include developing or changing policies affecting resident care and life. Facility staff should discuss their decisions with the resident and/or family group and document in writing its response and rationale. The facility must be able to demonstrate their response and rationale. On 7/21/2025 at 8:29 AM a review of the most recent 4 months' Resident Council meeting minutes was conducted. Review of the June 2025's Resident Council meeting minutes revealed a concern with medications not being refilled before they ran out. The Actions Taken section of the minutes revealed, All medications will be reordered on Friday. The Person Responsible was listed as Nursing and the Outcome section had 2 options, Resolved and Not Resolved with neither box checked and no further documentation as to the facility's response and/or rationale. Review of the March 2025 Resident Council meeting minutes revealed the following concern: Staff are not introducing their self before giving care. The Person Responsible was listed as Nursing. The Actions Taken section of the minutes failed to reveal any actions and the Outcome section had 2 options, Resolved and Not Resolved with neither box checked and no further documentation as to the facility's response and/or rationale. Review of the April 2025 Resident Council meeting minutes failed to reveal any evidence that this [March 2025] concern was acknowledged by Nursing nor any documentation as to the facility's response and/or rationale. Further review of the April 2025 Resident Council meeting minutes revealed the following concern listed in the Old Business Review section of the minutes [the same concern from last month]: Staff are not introducing their self before giving care. In the Status Update section, there was no information written nor any documentation as to the facility's response and/or rationale. Additional review of the April 2025 Resident Council meeting minutes revealed Residents are being discouraged from coming to Resident Council because they're not getting any responses from other departments. The Actions Taken section of the minutes revealed, The rec [Activities Director #11] staff will bring the resident council minutes to the morning meeting for a respond. Further review of the April meeting minutes failed to reveal any evidence that the resident council minutes were taken to the meeting. The Outcome section of the minutes had 2 options, Resolved and Not Resolved with neither box checked and no further documentation as to the facility's response and/or rationale. Review of the May 2025 Resident Council meeting minutes failed to reveal any evidence that the Activities Director had brought the Resident Council meeting minutes to the morning meeting for a response. Further review of the May minutes revealed the following concern [the same concern from last month]: Residents are being discouraged from coming to Resident Council because they're not getting any responses from other departments. Again, there was no outcome noted [Resolved or Not Resolved] and no further documentation as to the facility's response and/or rationale. On 7/24/25 at 11:46 AM in an interview with Activities Director #11 when asked about the Resident Council process, she stated, I just take the minutes, that's it. When asked how long she has performed that duty, she stated, I've been here 26 years in October [2025]. So, for about 25 years, I've been taking the notes. During the interview, when asked what she does after the meeting ends, she stated she had to type up the notes because she hand writes them during the meeting. Then, she prints them out and puts them in a book. After that, she emails all the department heads of the department that the resident council's concern falls under. For example, if it is a nursing concerns, she emails that concern to the Director of Nursing (DON). She stated she was looking for a response from the department head within 72 hours and if she does not receive one, she verbally informs the Nursing Home Administrator (NHA). Finally, she said when she gets a response/resolution, she shares it at the next Resident Council meeting. On 7/24/25 at 12:32 PM in an interview with the Grievance Officer, the NHA, she stated, I am the grievance officer for the facility. When asked about the grievance process she stated, when residents share a concern she gives it to that department head to do the investigation and then follow up with the resident/family. During the interview she stated, if it is something customer service, not clinical, then she generally takes it. Then she writes it up, investigates, and follows up with the resident/family. When asked

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed to ensure 1) a baseline care plan was completed and 2) a summary, including a current list of medications, was provided to the resident. This was evident for 1 (Resident #101) out of 3 closed records reviewed during the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 7/23/25 at 11:41 AM review of Resident #101's medical record revealed that he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP.On 7/23/25 at 2:27 PM in an interview with the Director of Nursing (DON) when asked who initiates and completes the BLCP, she stated that the admitting nurse initiates it and each disciplines has a part to put in. During the interview, when asked for the timeframe of completion, the DON stated as soon as possible, but she believed it was within 72 hours. When asked why the BLCP is completed, she stated to set the type of care that is going to be rendered to the residents. When asked where it was located in the medical record, the DON stated it is in the Evaluations tab, and it is called baseline care plan. When asked if a copy is provided to the resident and/or resident representative, she stated yes. When asked if this was documented in the medical record, the DON stated she would not say that she has seen it documented. On 7/23/25 at 2:36 PM in a dual observation on the surveyor's computer, the surveyor asked if the DON could show where Resident #101's BLCP was located and/or evidence that the resident had received a copy of his/her BLCP. The DON was unable to and stated if she found a copy, she would provide it. On 7/23/25 at 3:20 PM in an interview with the DON she stated the surveyor would not find a BLCP for Resident #101 because one was never completed for him/her.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility staff failed to ensure a care plan was developed to address a resident's catheter use. This was evident for 1 (Resident #80) out 64 residents that were part of the survey sample. The findings include: A Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. A review of Resident #80's clinical record on 7/22/25 at 9:00 AM revealed that the resident's primary physician ordered on 3/11/25 that the resident have an indwelling urinary catheter. The Resident's Admissions MDS was completed on 3/16/25. It had a Care Area Assessment (CAA) that noted the Interdisciplinary team (IDT) agreed to complete a care plan to address the ordered catheter. The Quarterly MDS completed on 5/3/25 scored the resident as having a catheter. The clinical record did not have a care plan addressing the use of a catheter. This surveyor interviewed the Director of Nursing (DON) on 7/22/25 at 9:08 AM. This surveyor stated the above findings and explained the need for a care plan. The DON asked for clarification as to what the deficient practice was. I stated the facility did not develop a care plan for catheter use even though the facility staff said they would. She said she would review the clinical record and come back with any new information. The DON was interviewed on 07/22/2025 at 11:41 AM. She had provided a copy of a care plan for catheter use to address neurogenic bladder (loss of bladder control). The surveyor pointed out that the care plan was initiated on 6/20/25 but the resident had been admitted on [DATE]. This meant that the resident went for three months without a care plan that the facility staff agreed to develop. The DON acknowledged the findings.

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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 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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Autumn Lake Healthcare at Homewood	6000 Bellona Avenue Baltimore, MD 21212

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review, resident and staff interview, it was determined that the facility failed to 1) properly assess for pain, 2) have parameters for pain medications used for pain management, 3) provide nonpharmacological intervention for a resident's reported pain, 4) received PRN (as needed) pain medication according to the Physician order set parameters (a specific instruction given for administration of medication), and 5) failed to administer a scheduled pain medication according to a Physician order. This was evident for 2 (Resident #1 and # 2) out of 2 residents reviewed for pain during this recertification/complaint survey.The findings include: Oxycodone is a strong short acting prescription pain medication classified as an opioid, used to manage moderate to severe pain. Oxycontin is a long-acting pain medication classified as an opioid that is specifically formulated as a controlled-release tablet designed to deliver oxycodone over a 12-hour period, providing sustained pain relief for chronic or constant pain that requires around-the-clock pain management. 1) Interview with Resident # 2 on 07/16/2025 at 9:02 AM revealed that s/he did have pain on the right side of his/her body. This resident further stated that the staff did medicate him/her, as needed, for pain. Review of the resident’s medical record on 7/15/18 at 09:13 AM revealed a care plan in place for potential alteration in comfort related to acute illness/Chronic Morbidities with interventions to monitor for pain daily using 0-10 pain scale, pain assessment every shift and as needed, and administer analgesic medication as ordered. On 07/16/2025 at 1:05 PM A review of the resident's medical record revealed an order to monitor pain every shift, however, the Medication Administration Record (MAR) had documentation only for the Day shift with a “0” pain level documented for the months of May 2025, June 2025, and July 1-16, 2025. 2)Further review of Resident #2’s medical record on 7/16/2025 at 1:09 PM revealed an order for oxycodone 5 mg every 6 hours as needed for 5-10 pain written on 4/18/2025 to 6/22/2025. A review of the Medication Administration Record (MAR) revealed Oxycodone was administered on 5/17/25, 5/21/25, 5/25/25, 5/31/25, 6/9/29/25, 7/3/25, and 7/5/25. The pain parameter was not included in the oxycodone order written after 6/22/2025. 3a) On 7/16/2025 at 1:22 PM a record review for Resident #2 revealed an order for Non-Pharmacological Interventions to be attempted prior to administering any as needed pain medication. There was no documentation of attempted interventions for the months of May 2025, June 2025, or 1-16 July, 2025. During an interview with the DON on 07/18/2025 at 11:23 AM, when asked about pain assessment, nonpharmacological interventions for pain management, and parameters for pain medication, the DON stated that pain assessment should be done on every shift, non- pharmacological interventions should be attempted prior to giving as needed pain medications, and parameters should be written as part of the order for as needed pain medication. On 07/18/2025 at 11:23 AM DON was made aware of the concern for pain management, and she agreed with the findings. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3b) On 7/18/2025 at 2:07 PM review of Resident #1’s MAR for the month of July revealed Oxycodone pain medication as needed was administered a total of 17 times from 07/01/2025 through 07/18/2025. However, there were no non- pharmacological interventions documented on the MAR prior to the administered Oxycodone. On 07/18/2025 at 1:56 PM Interview with the facility’s Director of Nurses (DON) she stated, Non-pharmacological Interventions are documented on the MAR and should be offered prior to administration of a PRN pain medication. At that time she verified MAR for Resident #1’s Oxycodone was administered for the incorrect parameters and there were no non-pharmacological interventions documented. 4) On 7/18/2025 at 2:07 PM in review of Resident #1’s medical record revealed Physician orders pain medications as: Tylenol 325 mg give 3 tablets by mouth every 8 hours as needed for pain (1-5) started date as 1/03/2025. Oxycodone HCl 10mg give 1 tablet by mouth every 6 hours as needed for pain, however there were no set perimeters for this medication. Started date as 03/13/2025. Oxycontin ER 12-hour 15 MG give 1 tablet by mouth two times a day for Chronic Pain. Started date of 03/31/2025. Non-Pharmacological interventions attempted prior to administering any PRN pain medication as needed. Document the number that corresponds to the Non-Pharmacological Interventions attempted; started date of 01/29/2025: i) warm beverage offered, ii) repositioned, iii) soft music played, iv) lights dimmed, and v) other (document in progress note), and vi) resident refused NPI. On 07/18/25 at 2:10 PM, Resident #1’s medical record review revealed that that resident had a PRN (as needed) pain medications, Tylenol and Oxycodone: The Tylenol order had a parameter pain score 1 to 5, however, Oxycodone order did not have any parameter. Further review of Resident 1’s Medical record revealed Medication Administration Record (MAR) for the month of July of 2025 revealed there were no signed administration doses for the Tylenol 325 mg give 3 tablets by mouth every 8 hours as needed for pain level range of 1-5, and facility staff administered Oxycodone instead of Tylenol for the following dates and pain levels: 07/02/2025 at 7:15 PM for a pain score of 5 07/03/2025 at 5:14 AM for a pain score of 4 07/05/2025 at 2:44 AM for a pain score of 0 07/07/2025 at 2:48 AM for a pain score of 5 07/10/2025 at 9:47 PM for a pain score of 5 07/15/2025 at 9:13 AM for a pain score of 5 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/18/2025 at 3:15 AM for a pain score of 4 07/18/2025 at 3:10 PM for a pain score of 0 On 07/18/2025 at 1:56 PM in an interview with the facility’s Director of Nurses (DON) she stated, if a medication had 2 pain medications that are PRN, an example of Tylenol and something else. The Tylenol would be to give 1-5 and the other medication parameter would be 6-10. 5)During an interview with Resident #1 on 07/21/2025 at 12:55 PM, the resident reported he/she did not receive his/her OxyContin over the weekend. On 07/21/2025 at 1:15 PM, the surveyor reviewed Resident #1’s MAR for July 2025. The review revealed that on July 20th, 2025, at 9:00 AM for Oxycontin 15mg was documented as “9” which indicated a medication administration note was placed in the progress notes. Further review of Resident #1’s medical record revealed on 07/20/2025 at 2:29 PM a Progress Note of: Oxycontin Oral Tablet ER 12 Hour 15MG give 1 tablet by mouth two times a day for chronic pain not available, pharmacy contacted, processing, awaiting delivery. On 07/21/2025 at 2:00 PM, an interview with DON stated the nurses should look in their medication carts and order any medication prior to the last dose of medication being used. At this time, she stated that she was aware Resident #1 did not receive his/her scheduled dose of Oxycontin on 07/20/2025 at 9:00 AM. On 07/24/2025 8:48 AM interview with Staff # 28 (LPN Agency) stated nurses order new medications before a resident uses the last dose of a scheduled pain medication, it is a nursing judgement, scheduled pain medications we try to order timely, as we may need a C2 form (a form that the Physician has to sign for Narcotic pain medication) filled out by the Physician which takes time.” Staff #28 also said, [name of Resident #1] is very sensitive with his/her pain medications, we are very careful with his/her ordered pain medication.” On 07/24/2025 at 9:04 AM the DON was made aware of concerns related to pain medications given for the incorrect parameter, non-pharmacological interventions not documented prior to administration of a PRN pain medication, and pain medication not given according to the physician order.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of employee records and interview with facility staff, it was determined that the facility failed to 1) conduct annual performance reviews of Geriatric Nursing Assistants (GNAs) and 2) provide regular, in-service education based on the outcome of those individual performance reviews. This was evident for 5 (GNA #49, GNA #50, GNA #1, GNA #51, GNA #52) of 5 randomly selected GNAs' records reviewed during the facility's recertification survey. The findings include:Performance reviews are to be completed for every GNA at least every 12 months to identify specific in-service education based on the outcome of those individual performance reviews. On 7/22/25 at 9:15 AM in an interview with the Director of Nursing (DON) when asked who conducted performance reviews for the GNAs and nurses, she stated the Unit Managers. When asked where they were stored, she stated, We were in the process of getting them done when you came in. Additionally, she stated, From my understanding, they have not been done for quite some time. On 7/22/25 at 1:02 PM, a review of 5 GNAs' randomly selected records revealed the following:GNA #49 was hired on 10/30/23 and there were no performance reviews observed in his/her employee file.GNA #50 was hired on 8/8/22 and there were no performance reviews observed in his/her employee file.GNA #1 was hired on 2/3/24 and there were no performance reviews observed in his/her employee file.GNA #51 was hired on 4/27/11 and there were no performance reviews observed in his/her employee file.GNA #52 was hired on 2/18/24 and there were no performance reviews observed in his/her employee file.On 7/23/25 at 10:31 AM in a dual observation with the DON, the DON flipped through the employee files for GNA #49, GNA #50, GNA #1, GNA #51, GNA #52. When asked if there were any performance reviews for any of these employees, she stated no, there were no performance reviews. The surveyor shared the concern that there were no performance reviews for any of the employees and asked how the facility provided regular in-service education to these GNAs based on the outcome of their performance review if performance reviews were not being conducted. The DON stated the trainings cannot be based on a performance review if a performance review had not been conducted.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on clinical record review and staff interview it was determined that the nursing staff failed to monitor behavior of a resident. This was evident for 3 (Resident #3, #6, and #45) out of 64 residents assessed for behavior monitoring during this recertification/complaint survey.The findings include:1)The surveyor conducted an initial interview with Resident #3 on 7/15/25 at 10:35 AM. During the interview the resident became tearful, expressing sadness stating a family member had passed away a few weeks ago. On 07/21/2025 at 10:40 AM in review of Resident #3’s medical record revealed the following physician orders dated 05/05/2025: Bupropion HCl ER oral tablet Extended Release 24-hour 300 MG (Bupropion HCl) give one tablet by mouth one time a day for depression. Sertraline HCl Oral tablet 100 MG give 1 tablet by mouth one time a day for Depression. Trazadone HCl Oral Tablet 50 MG give 25 MG by mouth at bedtime for Depression. Continued review of Resident # 3's medical record revealed that there was a care plan dated 05/06/2025 for use of antidepressant medication related to depression. With an intervention to monitor/document/report to Physician for signs and symptoms of depression and side effects of medications to treat depression. Further review of Resident # 3’s Medical record revealed that there was no Physician order indicating monitoring for signs and symptoms of depression or side effects of receiving the medication. In an interview on 07/22/2025 at 9:31 AM with the Director of Nursing (DON), she confirmed that any resident receiving an Antidepressant medication should have a Physician order for monitoring for signs and symptoms of depression and there should be monitoring of the medication for side effects. At this time the DON validated signs and symptoms of depression including the monitoring of side effects that were not in place prior for this resident and a Physician order that was just placed on 07/22/2025 when Surveyor had voiced concern. 2) On 7/23/2025 at 10:00 AM, a review of Resident #45’s medical record revealed an order to monitor target behaviors, such as agitation, restlessness, wandering, withdrawal, combativeness, verbal outbursts, refusal of care, tearfulness, anxiety, paranoia, and other behaviors not yet identified every shift. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review on 7/23/2025 at 10:14 AM the care plan initiated on 7/22/22, noted that Resident #45 had behavior problems including: refusing showers, refusing incontinent care after bowel movement, refusing meals prepared by the facility, refusing to get out of bed for therapy, refusing continuous positive airway pressure (CPAP) machine, refusing to allow weights, and accusing staff of wrongful doing. An intervention was to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. On 7/23/2025 at 12:30 PM review of the Treatment Administration Record (TAR) revealed no documentation of behavior monitoring for May 2025, June 2025, and documentation of monitor for target behavior initiated on 22 July 2025. On 7/23/2025 at approximately 12:25 PM the DON was made aware of the findings and was informed of the concern. The DON shook head in agreement. 3) A review of Resident #6's clinical record on 07/23/2025 at 1:36 PM revealed that the resident's primary physician ordered on 10/16/24 that the nursing staff monitor certain identified behaviors. These behaviors included: agitation, restlessness, wandering, withdrawal, combativeness, verbal outbursts, refusal of care, tearfulness, anxiety, paranoia, and other behaviors not yet identified. Staff are to enter numbers that correspond to these behaviors onto the Medication Administration Record (MAR). Review of the July MAR revealed no behavioral monitoring. Further review revealed the resident had a care plan to address the use of psychotropic medications for behavior management related to schizophrenia. The interventions included Monitor/record occurrence for target behavior symptoms I.e., pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol. The care plan was initiated on 6/26/24. The target behavior symptoms were not on the July MAR. The facility administrative staff were informed of the findings at the exit conference.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure medications were held according to the physician orders. This was evident for 1 (Resident #43) out of 64 residents in the survey sample. The findings include: A review of Resident #43's clinical record revealed that the resident had an order for Midodrine 5mg three times a day for orthostatic hypotension and to hold if systolic (top number) blood pressure is above 130. A review of the July Medication Administration Record revealed that on 7/2/25 at 6:30 AM the blood pressure was 132/74, but the medication was still given. A review of the June Medication Administration Record revealed that on 6/2/25 at 6:30 AM the resident had a blood pressure of 132/75, but the medication was still given. On 6/8/25 at 11:30 AM the resident had a blood pressure of 136/72, but the medication was still given. On 6/15/25 at 6:30 AM the resident had a blood pressure of 136/70, but the medication was still given. On 6/16/25 at 11:30 AM the resident had a blood pressure of 134/68, but the medication was still given. On 6/17/25 at 6:30 AM the resident had a blood pressure of 134/81, but the medication was still given. The Director of Nursing (DON) was interviewed on 7/18/25 at 1:58 PM. This surveyor showed her the June and July MAR's. The Surveyor and DON then went through the MAR's starting with July and counted the times the medication was administered when it was supposed to be held.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, documentation review, and interview with resident and staff, it was determined that the facility staff failed to 1) properly store medication by leaving a narcotic medication on the bedside table in the resident's room, and 2) keep treatment carts locked when unattended and discard medications/biologicals when expired. This was evident for 1 (Resident # 40) of 29 residents bedroom areas observed, and 1 of 3 nursing units observed during random observations made during the recertification/complaint survey. The findings include: 1) On [DATE] at 09:40, Resident #40 informed the surveyor that his/her medication was left on his/her bedside table. The surveyor observed a small bottle of medication labeled Methadone 115mg on the resident’s bedside table. An interview was conducted on [DATE] at 09:43 with Staff # 12 who stated that s/he was administering medication and resident was getting care and she left the medication on his/her bedside table. Staff #12 stated that it was not the right thing to do. On [DATE] at 8:56 AM, an interview with the DON revealed that his/her expectation is that when staff administered medication they must ensure that the resident took the medication at that time unless there is an order to leave medication at bedside. DON was made aware of the finding on [DATE] at 9:02 AM and agreed that the Methadone should not have been left at the bedside. 2) On [DATE] from 9:30 AM to 9:45 AM observation was made of an unlocked and unattended treatment cart sitting in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. The surveyor was able to open the top drawer. In the top drawer were prescription creams, lotions, ointments, Famotidine (heartburn/indigestion) suspension, Diclofenac gel (for pain), and Benadryl ointment. In the second drawer was Nystop powder for fungal infections, prescription ointments and creams. In the third drawer was Lidocaine cream, Aspercream, gauze, and iodoform packing strips. In the fourth drawer there were (2) Nystatin Zinc (Greers Goo) tubs for Resident #18. In the fifth drawer were supplies for dressing changes. Observation of the Integrity Medical Iodoform Packing Strips, Lot #03174 had an expiration date of [DATE]. A second packing strip, Lot #04119, had an expiration date of [DATE]. Observation of the Nystatin Zinc (Greers Goo) tubs for Resident #18, that were in the third drawer, had an expiration of [DATE] and a second Nystatin Zinc had an expiration of [DATE]. Observation of a 473 ml. opened bottle of Dakins solution NDC 0436-0672-11 that was one eighth full in the bottom drawer did not have a cap on the bottle and was wide open for any debris to enter the container. The surveyor stood at the treatment cart until Staff #17; an agency nurse came down the hall. At that time the surveyor informed her of the findings, and she said, I did not check that cart this morning. I am agency. I don't work here that much. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Storage Policy that was implemented on [DATE] and given to the surveyor by the Director of Nursing (DON) on [DATE] at 1:06 PM documented under General Guidelines, b. Only authorized personnel will have access to the keys to locked compartments. On [DATE] at 9:13 AM the concern was reviewed with the Director of Nursing and the Assistant Director of Nursing who stated the treatment cart should have been locked.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interviews, and medical record review, it was determined that the facility failed to arrange for dental services within a reasonable time frame following the dental consultant recommendation. This was evident for 1 of 2 residents (#45) selected for dental complaints during this recertification/complaint survey process.The findings include:On 07/15/2025 at 12:20 PM Resident #45's Son stated that the resident often complained of tooth pain. The son stated that the resident had a dental consultation, but there had been no follow up. An interview was conducted with the resident on 07/16/2025 at 10:06 AM and when asked if the resident had dental pain, the resident showed surveyor his/her teeth and stated, I have no teeth on top, or bottom and it hurts when I eat. The surveyor observed resident missing teeth to top and bottom of mouth with 2 side teeth on the top of the mouth.A review of the resident's care plan on 7/16/25 at 12:02 PM revealed that the resident had oral/dental health problems as evidenced by broken teeth/likely cavity. Date Initiated: 07/22/2022 Revision on: 07/22/2022. Staff were to monitor/document/report to MD as needed with any sign or symptoms of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Further medical record review on 07/16/2025 at 1:12 PM noted documentation from a dental consult dated 4/9/2025 stating that a Periapical radiograph taken of upper anterior which revealed presence of root tip #8 and #9 below the gum line and fractured tooth #7 and #10. The patient's son was contacted and left a message to review findings. Patient's Power Of Attorney (POA) to be notified that extractions to be completed outside of the facility if family wants to proceed with recommended treatment plan. An additional note stated that the patient's POA was to be notified that the extractions are to be completed outside of the facility if the family wants to proceed with the recommended treatment plan.An interview was conducted with the DON on 07/17/2025 at 8:56 AM who stated that she thought that the son was supposed to make arrangement, but we usually make the appts.The DON phoned the unit manager, who confirmed that an appointment was not set up for the resident's dental extractions. On 07/17/2025 at 11:45 AM the DON provided surveyor with email from the facility dental service provider National Preventive Solutions (NPS) that there was no referral for this resident. The email further added we can have our dentist see the resident again and the family member can be there to discuss options.07/17/2025 12:05 PM The DON was made aware that this was a concern because there was no follow up for the resident's dental issue until after the surveyor‘s intervention. The DON agreed and stated that the facility will place the resident on the NPS dental follow up list.

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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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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on medical record reviews and staff interviews, it was determined that the facility staff failed to ensure timely updates to the residents' hospice status. This was evident for 1 (Resident #9) of 2 residents reviewed for hospice care during this recertification/complaint survey. Finding includes: During a review of Resident #9's medical record on 07/16/25, at 2:32 PM, it was revealed that a document from a contracted company in their hard copy chart indicated hospice care began on 03/29/25 and was discharged on 05/29/25.However, a review of Resident #9's care plan on 07/17/25, around 9:00 AM, showed an active care plan for hospice care. The Minimum Data Set (MDS) Section O (Special Treatments, Procedures, and Programs), dated 06/20/25, also indicated the resident was in hospice care.Additionally, during an interview with Staff #10 (Rehab Director) on 07/17/25, at 11:36 AM, they stated that the resident was not evaluated for a rehabilitation program due to being under hospice care.In an interview with the Director of Nursing (DON) on 07/16/25 at 2:50 PM, she confirmed that Resident #9 was discharged from hospice care on 05/29/25. She further stated that this information should have been updated in the MDS, care plan, and the list of rehabilitation candidate residents. The surveyor shared concerns about Resident #9's hospice care, and the DON validated these concerns.

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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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	215074	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Homewood	6000 Bellona Avenue Baltimore, MD 21212

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to provide education regarding the risks versus benefits of the pneumonia vaccine. This was evident for 2 out of 5 residents (Resident #1 and #5) whose immunization records were reviewed during this recertification/complaint survey. Finding included: Pneumococcal vaccine help prevents pneumococcal disease, which is any type of illness caused by streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for age [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention- vaccines and preventable disease) On July 22, 2025, at 8:46 AM, immunization records for five randomly selected residents were reviewed. The immunization tab in the electronic medical record documented that both Resident #1 and Resident #5 refused the pneumonia vaccine. However, there was no documentation indicating when the facility offered the vaccine or provided education about its benefits and risks. During an interview with the Director of Nursing (DON) on July 22, 2025, at 1:26 PM, she stated that the facility offers vaccines to residents and that any refusals should have education. The surveyor requested further documentation to confirm Resident #1 and #5 received education regarding the pneumonia vaccine. The DON confirmed that the facility did not have such education documentation and validated the surveyor's concern.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interviews, it was determined that the facility failed to ensure residents' COVID-19 vaccination status was properly monitored. This was evident for one (Resident #5) of five residents whose COVID-19 vaccination records were reviewed during this recertification/complaint survey. The findings include: A COVID-19 vaccine is designed to provide acquired immunity against severe acute respiratory syndrome coronavirus 2, the virus that causes coronavirus disease. On July 22, 2025, at 8:46 AM, immunization records for five randomly selected residents were reviewed. Resident #5, who was admitted in July 2024, this resident had no evidence of COVID-19 vaccination, neither historical data nor an offer from the facility. During an interview with the Director of Nursing (DON) on 7/22/2025, at 1:26 PM, she stated that the Infection Preventionist typically monitors residents' vaccination status (e.g., Pneumonia, Flu, and COVID-19) upon admission. When informed there was no information for Resident #5's COVID-19 vaccination status, the DON validated the concern.