

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

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No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>215074                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Autumn Lake Healthcare at Homewood                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6000 Bellona Avenue<br>Baltimore, MD 21212 |                                                 |
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| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                 |
| F 0867<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on staff interviews and review of facility documentation it was determined the facility failed to ensure that a Performance Improvement Project (PIP) was identified and implemented through the facility's Quality Assessment and Assurance (QAA) committee and/or Quality Assurance Performance and Improvement (QAPI) program annually. This was found evident for 1 year of QAA/QAPI notes reviewed. Findings include: On 7/17/26 at 10:38 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated that the Assistant Director of Nursing (ADON) was responsible for running and coordinating the QAA committee. He further stated that the ADON was out of the country, and the Director of Nursing (DON) would answer any QAA/QAPI questions. On 7/17/26 at 10:43 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked for an example of a Performance Improvement Project (PIP). The DON stated she would review the QAA/QAPI notes and follow-up. On 7/17/26 at 11:36 AM, the surveyor requested and reviewed the QAA/QAPI binder/notes. The review revealed several months of data collection; however, there was no identified PIP or evidence of implementation of a PIP. On 7/17/26 at 12:02 PM, the surveyor reviewed the concern with the NHA about the absence of a performance improvement project.</p> |                                                                                         |                                                 |

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 0868<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview, it was determined that the facility failed to maintain and account for scheduled Quality Assessment and Assurance meetings. This was evident for 5 of the 11 months QAA meetings were held July 2025- June 2026. The findings include: On 7/17/26 at 10:38 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated that the Assistant Director of Nursing (ADON) was responsible for running and coordinating the QAA committee. He further stated that the ADON was out of the country, and the Director of Nursing (DON) would answer any QAA QAPI questions. The surveyor asked to see QAA attendance from the last 6 months of QAA meetings The review of the attendance revealed that the ADON was not in attendance from January 2026 through April 2026. The surveyor requested attendance sheets from July 2025 to December 2025. On 7/17/26 at 10:43 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor confirmed that ADON was the facility's QAA lead and designated to run the QAA committee and meetings. The surveyor reviewed the concern that the ADON was not in attendance for 4 of the 6 months of the 2026 committee meetings. She stated that the previous ADON left in April and that the new ADON started in April and had been in attendance in May and June. The surveyor requested to see the facility's QAA/QAPI documentation. On 7/17/26 at 11:36 AM, the surveyor reviewed the QAA/QAPI binder. No attendance forms were noted for August 2025-December of 2025. On further review, data was noted in several months however, no direct plan or leadership was identified based on the data. The months of May and June had no data in the binder. On 7/17/26 at 12:02 PM, the surveyor reviewed the concern with the NHA about the absence of documented attendance and the concern the lead for the QAA committee was only documented to be in attendance 2 out of the 11 months.</p> |                                                                                         |                                                 |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and resident's interview, it was determined that the facility failed to provide a safe, functional, sanitary, comfortable and homelike environment for residents. This was evident on 3 of 4 units and 1 of 1 observation of the courtyard during the survey. The findings include:</p> <p>On 07/13/2026 at 8:32 AM during the initial tour of the facility, the surveyor observed that residents in rooms 46-A and B still had dirty meal trays from the previous meal sitting on their tables. The surveyor observed as breakfast tray's were brought in by the aides and placed next to the dirty dishes without removing them.</p> <p>On 07/13/2026 at 8:35 AM The surveyor also observed in room [ROOM NUMBER]-A what appeared to be last night's dirty meal tray on the residents table as breakfast was served next to it.</p> <p>In an interview with Resident #49 on 07/13.2026 at 9:05AM s/he was asked about the dirty meal trays left at the bedside and they said those were from last night's dinner and not sure why staff did not remove them after meals.</p> <p>In another Interview with #32 a Certified Nursing assistant (CNA) on 07/13/2026 at 8:41AM, she was asked when dirty meal trays should be removed and by who? She said they are removed by the CNA's 30-45 minutes after the residents are done eating. She said the trays were left by night shift who should have removed them.</p> <p>Further observation of the resident's room on 7/13/2026 at 9:05AM revealed that in room [ROOM NUMBER]'s bathroom, the bottom of the toilet bowl was dark and the base board at the back of the toilet was coming off about 2-3 feet long. The grab-rail close to the sink was wobbly and the pipe covers behind the toilet and sink were rusty.</p> <p>In room [ROOM NUMBER], the bottom of the toilet bowl also had dark stains and the door leading to room [ROOM NUMBER] was stuck and would not open. The resident's occupying room [ROOM NUMBER] could not open the bathroom door. The surveyor later observed the bathroom door open but the door handle was loose, the door drags onto the floor when pulled outwards.</p> <p>On 07/13/2026 at 9:26 AM In room [ROOM NUMBER], the bathroom had an opening in the ceiling measuring about 2.5 x 0.5 foot long and was depressed inward. The bottom of the toilet bowl was also covered with dark stains.</p> <p>In room [ROOM NUMBER]-B, the surveyor observed a recliner opposite the resident's bed. The leather covering on the recliner was torn at the footrest area, measuring approximately 1x 0.5 foot long exposing the white cloth film underneath.</p> <p>In room [ROOM NUMBER], the bathroom vent was observed hanging loose and about to fall off.<br/>(continued on next page)</p> |                                                                                         |                                                 |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>In room [ROOM NUMBER], the bottom of the toilet bowl was covered in what appeared to look like black stains.</p> <p>Further observation on 07/13/2026 at 9:43 AM reveals that in room [ROOM NUMBER]-A, the bedroom ceiling was coming off about 4 foot long.</p> <p>On 07/15/2026 at 2:02 PM The surveyor did a walk around with #19 the Maintenance director and the Nursing Home Administrator ((NHA). They were asked how they kept abreast of things that needed fixing in the facility. The maintenance director stated that they have a TEL's system and a binder at the nursing station for staff to communicate issues for maintenance to follow-up, which they check on a daily basis. The NHA also said maintenance do daily walk arounds and quarterly room checks which involves looking at floors, ceiling tiles, paints, beds, furniture, lights, call bells, etc. to see if they needed fixing. The administrator took pictures of the concerns and said they will be put in TEL's so it can be fixed, they acknowledged the concerns.</p> <p>On 07/14/2026 at 12:38 PM, an observation of the outside courtyard during the 12:30 PM smoke break revealed a large amount (approximately 100) of cigarette butts (the end of a cigarette) that were spread across a large portion of the courtyard.</p> <p>On 07/14/2026 at 12:49 PM, the surveyor observed Resident #34 toss a cigarette butt onto the patio.</p> <p>At the same time, further observation revealed two cigarette disposal stands in the courtyard where the residents smoke. On 07/14/2026 at 12:53 PM, an interview with Geriatric Nursing Assistant (Staff #20) who supervised the smoke break revealed he was not aware of any policy that the residents followed regarding disposal of the cigarettes.</p> <p>On 07/14/2026 at 1:01 PM, an interview with the Nursing Home Administrator revealed that housekeeping staff clean the courtyard periodically.</p> <p>At the same time, during a dual observation of the courtyard, the Nursing Home Administrator indicated that housekeeping would come out and clean the cigarette butts. The surveyor reviewed the concern.</p> |                                                                                         |                                                 |

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| F 0558<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation and interview it was determined the facility failed to ensure residents received reasonable accommodation of the call bell system. This was evident for 2 (Resident #5 and #32) of 24 residents observed during the initial screen process of the annual survey. The findings include: On 07/13/2026 at 11:17 AM, an observation of Resident #5 revealed their entire call light cord was rolled up hanging at the call bell wall port, out of reach of the resident. On 07/13/2026 at 11:19 AM, an observation of Resident #32 revealed their call light cord was on the floor, out of reach of the resident. On 07/13/2026 at 12:26 PM, a follow up observation of Resident #5 and #32 revealed the same status as noted above. On 07/13/2026 at 12:29 PM, the surveyor requested Licensed Practical Nurse (Staff #23) for dual observation of the follow up observation noted above. At the same time, an interview with Staff #23 revealed it was the expectation of staff to ensure resident call bells were within reach of the resident at all times. On 07/14/2026 at 1:43 PM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood. |                                                                                         |                                                 |

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| F 0636<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>Based on record review and interview, it was determined that the facility failed to complete an admission comprehensive Minimum Data Set (MDS) assessment within the required timeframe. This was evident for 1 (Resident #73) of 7 residents reviewed during the survey. The findings include: The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes. It is a tool nursing home staff use to gather information on each resident to evaluate clinical status, functional abilities, and care needs. On 7/15/2026 at 12:49 PM, surveyors reviewed Resident #73's MDS assessment. The admission assessment had an Assessment Reference Date (ARD) of 4/16/2026 and was completed on 4/24/2026, after the required completion timeframe. ARD refers to the specific endpoint for the observation periods and completion process. For an admission MDS assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days). On 7/17/2026 at 9:01 AM, surveyors interviewed MDS Coordinator #22. The MDS Coordinator stated that the assessment was completed on time, but the Regional Director of Clinical Services (RDCS) did not sign the assessment until 4/24/2026, which resulted in a late completion date. On 7/17/2026 at 9:11 AM, surveyors informed the Regional Administrator and Administrator that Resident #73's admission MDS assessment had been completed late.</p> |                                                                                         |                                                 |

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| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interviews and record review it was determined that the facility failed to develop and implement a comprehensive care plan to meet the needs of a Resident. This was found evident of 1 (Resident #13) out of 45 residents reviewed during the survey. The findings include: On 7/13/26 at 9:42 AM, the surveyor observed Resident #13 resting in bed with supplemental oxygen via nasal cannula in his/her hand along with a BiPAP (Bilevel Positive Airway Pressure) machine noted in a bag on the side rail of Resident #13's bed. A BiPAP machine is used to treat sleep and respiratory conditions by delivering pressurized air through a mask to keep airways open. Resident #13 stated he/she had concerns with the bed and falling; However could offer no other details into these concerns. On 7/15/26 at 9:11 AM, the surveyor reviewed Resident #13's medical record. The review revealed that Resident #13 had no respiratory or oxygen care plan or fall care plan. On further review it was revealed that Resident # 13 had orders that started on 7/13/26 for both supplemental oxygen as well as BiPAP at night and while resting during the day. Also noted a fall assessment date 7/3/26 that rated Resident #13 as a high fall risk. On 7/16/26 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that appropriate care plans for Resident #13's were not reinitiated after the resident returned from a recent hospital stay and should have been.</p> |                                                                                         |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>215074                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/17/2026 |
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| F 0657<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interviews and review of medical records it was determined that the facility failed to:1) update a care plan, 2) involve the Resident in the interdisciplinary care planning process. This was evident of 2 (Resident #7 and Resident #11) out of 45 residents reviewed during the survey. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. 1) On 7/13/26 at 8:50 AM, the surveyor conducted an interview with Resident #7. During the interview Resident #7 stated that he/she could not recall having a recent care plan meeting. On 7/14/26 at 9:00 AM, the surveyor conducted an interview with Unit Manager (UM) #5. During the interview UM #5 stated that she participated in care plan meetings about once a month. She further stated that the social worker arranges them. When asked if she could recall if Resident #7 recently had a care plan meeting she could not remember. On 7/14/26 at 11:23 AM, the surveyor reviewed the last care plan sign-in sheet with the Nursing Home Administrator (NHA) and asked why Resident #7 was not part of the May 2026 care plan meeting. Resident #7 was not listed in attendance. Next the NHA shared the care plan meeting note written by the Social Worker (SW #41) that stated, SW met with the Resident in his/her room during lunch for a care plan meeting. On 7/14/26 at 11:38 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that a care plan meeting should involve an interdisciplinary team and should not take place in the resident's room during lunch with only the social worker. 2) On 7/14/26 at 8:48 AM, the surveyor reviewed Resident #11's medical record. The review revealed a urology consult note written after a on 5/6/26 after a suprapubic catheter exchange that stated Resident #11 and a Urinary Tract Infection (UTI) in February however, no antibiotics indicated due to absence of UTI symptoms. On 7/15/26 at 8:38 AM, the surveyor reviewed Resident #11's care plan. The review revealed that Resident #11 had a care plan initiated on 6/24/25 that stated Resident # 11 had bladder incontinence with one intervention to encourage fluids during the day to promote voiding response. Additionally, a care plan that stated Resident #11 was on Intravenous (IV) antibiotics due to a UTI, last revised on 2/6/26. Next the surveyor reviewed the care plan with the Director of Nursing (DON). During the interview the DON confirmed that the care plan was not revised and up-to-date and confirmed that Resident #11 was not on antibiotics and was not voiding or currently incontinent.</p> |                                                                                         |                                                 |

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| F 0676<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on observation and interview, it was determined that the facility failed to ensure finger nail care was provided to residents. This was evident for 2 (Resident #24, and #71) of 2 residents observed for nail care. The findings include: On 07/16/2026 at 8:28 AM, an observation of Resident #24 revealed their finger nails were long. On 07/16/2026 at 1:42 PM, an observation of Resident #71 revealed their finger nails were long. On 07/17/2026 at 8:26 AM, a follow up observation of Resident #24 revealed their finger nails were long. At the same time, an interview revealed they felt their nails were long and would like for them to be cut down. On 07/17/2026 at 8:28 AM, a follow up observation of Resident #71 revealed their finger nails were long. At the same time, an interview revealed they would like for their nails to be cut down. On 07/17/2026 at 8:30 AM, an interview with Licensed Practical Nurse (Staff #4) revealed it was the expectation of all staff to monitor resident finger nails for length. On 07/17/2026 at 9:13 AM, an interview with the Director of Nursing revealed Resident #24 and #71's finger nails had been trimmed and acknowledged it was after surveyor intervention. The surveyor reviewed the concern.</p> |                                                                                         |                                                 |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record reviews and interviews it was determined that the facility failed to provide treatments and appropriate follow-up for a resident's condition. This was found to be evident of 2 (Resident #92 &amp; #11) out of 45 residents reviewed during the survey. The findings include: 1) On 7/13/26 at 9:14AM, the surveyor conducted an interview with Resident #11. During the interview Resident #11 stated that he/she had missed two of his/her urology (urinary system specialty) appointments due to transportation issues the facility arranged. On 7/14/26 at 9:09 AM, the surveyor conducted an interview with Unit Manager (UM) #5. During the interview UM#5 stated that when residents return from outside appointments with recommendations for follow-up appointments, the unit clerk is responsible for scheduling and further stated that she was not aware of any resident missing appointments. On 7/14/26 at 9:15 AM, the surveyor reviewed a consultation note from Resident #11's urology appointment, dated 6/22/26, that stated; need to be rescheduled related to transportation issues. It further stated rescheduling for 7/9/26 at 3:20 PM and named the location. Additionally in Resident #11's medial record was a reminder note dated 7/2/26 of the upcoming appointment on 7/9/26 at 3:20PM. On 7/14/26 at 9:59 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that Resident #11 had to have two urology appointments rescheduled. She stated that the Certified Nursing Assistant (CNA) that was scheduled to go with Resident 11 on both visits would be able to speak as to why the consultations were not done. On 7/14/26 at 11:39 AM, the surveyor conducted an interview with CNA #12. During the interview CNA#12 stated Resident #11 went to his/her appointment on 6/22/26 but when they got there the clinic was not exactly sure why the resident was there and that the resident could not be transferred off the stretcher at that location. She further stated for the second appointment on 7/9/26 she was not at the building when transport came, due to transportation showing up early. CNA #12 stated that on 7/9/26 the transportation company left because they timed out of their transportation window. CNA #12 recalled Resident # 11's scheduled pick up with transportation at 7:30 however, the transportation company came around 7AM. The surveyor noted that the appointment time for the 7/9/26 appointment was 3:30 PM. Following the interview the surveyor conducted an interview with the DON. The surveyor reviewed the concern that Resident #11 had missed two appointments related to transportation issues in which the facility arranged and requested transportation documentation. At the time of exit no additional documents were provided. 2) On 7/15/26 at 11:09 AM, the surveyor reviewed intake #3064017. The complaint alleged that Resident #92 was not receiving proper wound prevention and treatment care. On 7/16/2026 1:56 PM, the surveyor reviewed Resident #92's Treatment Administration Record (TAR) for April and May of 2026. The review revealed Resident #92 had orders for wound treatments for a mid sacral wound (to be done daily) and a coccyx wound (to be done twice a day). Additionally, a weekly skin check was completed to evaluate the wound areas. On 4/11/26, 4/18/26 and 5/4/26 the mid sacral wound care was left blank. On 4/18/26 9AM, 4/19/26, 9PM, 4/20/26 9PM, 5/4/26 9AM the coccyx wound care was left blank. On 4/22/26 the skin check list documented no skin impairments even though the wound care team evaluated Resident on 4/21/26- documenting the mid sacral wound and coccyx wound. On 7/17/26 at 9:15 AM the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor showed the blank documentation for wound care and asked if the would care was provided as ordered on the days there is no documentation. The DON stated she would review the record to see if the cares were documented in other areas but that the expectation is if cares are provided they should be documented. The surveyor also reviewed the concern about inaccurate skin check documentation. At the time of exit no additional documents were provided.</p> |                                                                                         |                                                 |

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| F 0689<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of medical records and interviews it was determined that the facility failed to adequately assist a dependent resident during Activity of Daily Living (ADL) cares. This was found evident for 1 (Resident #11) out of 6 residents reviewed for accidents. The findings include: On 7/13/26 at 9:20 AM, the surveyor conducted an interview with Resident # 11. During the interview Resident #11 stated that a few months earlier he/she was transferred by two staff members without the use of a Hoyer lift and noted knee pain after the transfer, however an x-ray revealed no fracture. On 7/14/2026 at 9:33 AM, the surveyor reviewed Resident 11's progress notes. A progress note written on 12/6/25 documented that an order for a left knee x-ray was obtained to rule out a fracture. On 12/9/25 a provider evaluated Resident #11 and wrote Resident #11 was seen for follow up for reported left knee pain and swelling a few days ago. It further stated that the Resident #11 reported the injury to the left knee happened during a transfer with a Hoyer lift. Next, the surveyor reviewed Resident #11's care plans. Resident #11 had an Activities of Daily Living (ADL) self-care deficit care plan established on 4/12/25. One of the interventions was transfer resident with mechanical lift and the assistance of 2 initiated on 6/9/26. On 7/14/26 at 10:44 AM, the surveyor reviewed the Minimum Data Set (MDS) assessment dated [DATE] and noted Resident #11 was coded as dependent for both chair to bed transfers and toilet transfers. On 7/14/26 at 11:34 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that the transfer in December of 2025, in which Resident #11 complained of knee pain, was done by two staff members standing the resident and pivoting rather than using a Hoyer lift. She validated that a Hoyer lift should have been utilized. She further stated that a staff member should have been aware of the mode of transfer by referring to the Resident's TASK record.</p> |                                                                                         |                                                 |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to ensure respiratory care was provided in accordance with physician orders. This was evident for 3 (Resident #72, #20 &amp; #73) of 4 residents observed during the recertification survey. The findings include:</p> <p>1). Observation of resident #72 on 07/13/2026 at 8:31AM revealed that s/he was receiving oxygen at 2 Liters via a nasal cannula connected to a humidifier which helps add moisture to air by decreasing dryness to the nose caused by the supplemental oxygen. The O2 tubing and humidifier were not labelled with a change date.</p> <p>A review of resident #72's physician's order revealed an order written on 5/26/26 that reads: Oxygen at 2L/M as needed for COPD, O2 Concentrator at Bedside.</p> <p>6/23/26: Oxygen Equipment - Change tubing every 7 days every night shift.</p> <p>2). On 07/13/2026 at 8:43 AM the surveyor also observed Resident #20 receiving oxygen via nasal canula (a tube that delivers supplemental O2) at 2liters. Further observation failed to reveal a label to indicate when the O2 tubing was last changed. The humidifier bottle was empty, and the O2 tubing was not dated.</p> <p>A review of the physician's order revealed an order dated 2/15/24 that reads: 2L of Oxygen via nasal cannula nightly every night shift for Shortness of breath (SOB).</p> <p>4/9/25: Oxygen tubing, change weekly, Label each component with date and initials. Every night shift, every Thursday, Label each component with date and initials.</p> <p>On 07/13/2026 at 8:55 AM the License Practical Nurse (LPN) #37 confirms the findings. He was asked the process for changing O2 tubing and he said it's supposed to be labelled including the humidifier as soon as it was placed on the resident or whenever the tubing is changed per order, he said he will change it and label them.</p> <p>In a separate Interview with the unit manager #3 on 07/14/2026 at 9:17 AM. She was asked about the process for changing and dating O2 tubing. She said that tubing is changed once a week on Thursdays by 11-7 shift. That staff are supposed to date the tubing together with the humidifiers when they change them. She explained that humidifiers should be changed whenever they're running low. She was made aware of the above concerns regarding resident #20 and #72. She validated the concern.</p> <p>On 07/15/2026 at 8:36 AM the Director of Nursing (DON) was also made aware that this was a concern, she said she will follow up.</p> <p>3). On 7/13/2026 at 9:22 AM, surveyors observed Resident #73 receiving oxygen at 2.75 liters (L), as indicated by the flow meter positioned between 2.5 L and 3 L.<br/>(continued on next page)</p> |                                                                                         |                                                 |

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| F 0695<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>On 7/14/2026 at 8:32 AM, surveyors observed Resident #73 receiving oxygen at 2 L. Resident #73 stated that the oxygen was supposed to be set at 3 L. Review of Resident #73's Treatment Administration Record (TAR) documented a physician's order for oxygen at 3 L.</p> <p>On 7/14/2026 at 8:34 AM, surveyors interviewed Staff #4 regarding the oxygen setting. Staff #4 reviewed the physician order and confirmed that oxygen was to be delivered at 3 L. Staff #4 obtained a pulse oximetry reading of 94 percent (%), increased the oxygen flow rate to 3 L, and at that time, the oxygen equipment produced a whistling sound.</p> <p>On 7/14/2026 at 9:15 AM, surveyors notified Staff #5 that Resident #73's oxygen was set below the ordered level and that the oxygen equipment produced a whistling sound when the flow rate was increased to 3 L. Staff #5 stated that malfunctioning equipment was to be replaced without delay.</p> |                                                                                         |                                                 |

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| F 0711<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>Based on record review and interviews with staff, it was determined that the primary medical provider failed to review and revise the total program of care. This was found evident for 1 (Resident #28) out of 45 residents reviewed during the survey. The findings include: On 7/13/26, 7/14/26, 7/15/26, 7/16/26 and 7/17/26 the surveyor observed Resident #28 close to the nurses' station at some point in the day with multiple observation of staff utilizing a communication board to communicate with Resident #28. On 7/15/26 at 7:33 AM, the surveyor reviewed Resident #28's medical record. The review revealed that Resident #28 had a urology consultant at the facility on 6/29/26 related to urinary retention. The note stated that urinary retention was noted at the hospital, that the patient was unable to communicate voids, Resident #28 had diapers that were dry on assessment, and that silent retention was a concern. The plan stated to check bladder scan for post void residual (scan bladder to evaluate volume after urination) now and at reasonable intervals to establish a trend. If further stated to continue straight catheterization for urinary retention per facility's policy. On further review it was noted that a provider wrote a progress note on 7/13/26 and noted, urology evaluation on 7/1/26 noted no acute concern for retention and recommended monitoring Urinary Tract Infection (UTI) or retention symptoms. Further in the note under the urinary retention plan it stated, use bladder scan for discomfort or poor voiding and trend volumes. No where in the note did it acknowledge the recommendation for straight catheterization on retention. On 7/15/26 8:25 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked why the provider did not address all the recommendations of the urology consult. The DON stated that the facility did not have a bladder scan machine and would not be able to provide the recommendation. She further stated that if you don't have a bladder scan number you cannot note retention and wouldn't straight catheterize without a reason. She stated the facility utilized bladder ultrasounds if they need to evaluate retention. The surveyor asked if the resources were not available, was it the expectation of the provider to reach out to urology and provide an alternative plan. The DON confirmed that would be her expectation.</p> |                                                                                         |                                                 |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a complaint #3055819, record review and staff interviews, it was determined that the facility failed to provide evidence that accounts for some narcotic drug record use and reconciliation. This was evident for 1 of 3 nursing units reviewed for alleged narcotic misappropriation during the annual survey. The findings include On 7/13/2026 at 9:00AM, review of a complaint incident #3055819 alleged that the night supervisor was misappropriating the patient's narcotic and signing out narcotics without administering them to the residents. The residents are stating they did not receive their medications. In an interview with Resident #75 on 7/13/26 at 9:05 AM, S/he stated that they were not receiving their Suboxone as ordered, for drug dependency and that staff are not renewing their medication timely, when it runs out. Review of Resident #75's Medication orders on 7/13/26 at 9:18AM revealed orders written as: Suboxone Sublingual Film 8-2 MG (Buprenorphine HCl-Naloxone HCl Dihydrate) Controlled Drug Give 2 tablet sublingually two times a day for Opioid dependency. On 07/15/2026 at 11:22 AM Review of resident's Medication Administration Records (MAR) from May to July 2026 did not reveal any discrepancies with Suboxone administration. However, reviews also included other narcotic medications which the resident was on such as Oxycodone. The surveyor found orders written on 6/1/26 as: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 4 tablet by mouth every 4 hours as needed for severe pain level 6-10. Further review of the narcotic and controlled substance shift to shift count sheet from February 2026 reveal different days when the shift-to-shift counts were not performed. The days included: February 2, 7, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 30th. The shift-to-shift count reconciles discrepancies with narcotic administrations and prevents misappropriation. Continuing review of the narcotic and controlled substance shift to shift count sheet also failed to reveal the count sheet for the month of May 2026. The Unit Manager #3 was asked to provide the missing document. On 07/16/2026 at 8:04 AM, License Practical Nurse (LPN) #38 an Agency nurse was asked in an interview the process for narcotic count at change of shift. He stated that the count is done by 2 nurses, the incoming and the outgoing nurse. They count the total number of all narcotic cards including liquids and Fentanyl patches and write them down. Afterwards, they do individual resident's card count which both nurses sign to indicate the count was accurate. He said this must be done every change of shift. He was asked to explain the significance of the process. He said that the count is done to avoid drug diversion, creation of discrepancies and mitigate medication shortages. On 07/17/2026 at 11:37 AM the Unit Manager #3 came back with a binder that has all the narcotic sign out sheets from Jan to July from the [NAME] station. May 2026 was still missing, she said she could not find it. She was asked if anyone provides oversight to make sure nurses are doing the narcotic reconciliation and safeguarding the documents. She said it is the responsibility of the unit managers but was not employed with the facility as of the time of the missing document. She was made aware that this was a concern. She acknowledged the concern and said she will follow up.</p> |                                                                                         |                                                 |

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| F 0756<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on observation, record reviews and staff interviews, it was determined that the facility failed to carry out Pharmacist recommendations on three different occasions following the monthly medication regimen review (MRR). This was evident for 1(#6) of 5 residents reviewed for unnecessary medications. The findings include On 7/14/26 at 9:15 AM The facility was asked to provide the Pharmacist MMR from June 2025 to July 2026 for Resident #6. Review of the document which identifies irregularities discovered by the Pharmacist dated 3/27/25 revealed recommendations to review and change Risperidone to GT or PEG administration in PCC. This was not done by the facility. The same recommendation was noted again on next month's pharmacy review on 4/10/26 but was not acted upon. A 3rd recommendation was noted again regarding the same issue on 6/27/26. The facility still did not act on it or indicate why they did not. Review of the physician order revealed an order written on 11/20/24 that reads: Risperidone Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth two times a day for Schizophrenia. This was the order the Pharmacist was referencing. On 7/15/26 at 10:50 AM, the surveyor brought this concern to the attention of the Director of Nursing (DON) and the Nursing Home Administrator (NHA). On 07/15/2026 at 4:10PM In an Interview with the DON regarding Med reg review policy and process, she was asked to explain the process. She stated that after review by the Pharmacist, an email of the irregularities found with recommendations are sent to her email and that of the Unit Managers. Either she or the Unit Managers print out the recommendations and forward it to the Physicians. After physician's review, they are returned to the Unit Managers to take off any physician's orders. The DON was made aware of the concerns, she acknowledges and said she will work on it.</p> |                                                                                         |                                                 |

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| <p>F 0757</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on record review and staff interviews, it was determined that the facility failed to ensure that physicians' orders are followed. This was evidenced by staff giving as needed narcotics outside of the recommended parameters for 2 (Resident #42 and #75) of 5 residents reviewed for unnecessary medications during the annual survey.</p> <p>The findings Include.</p> <p>1). On 07/15/2026 at 4:37 PM Review of the June 2026 Medication administration records (MAR) revealed that Resident #75 was getting their PRN (as needed) narcotic pain medication when their pain level was documented as zero on 6/3, 6/7, and 6/11. The order was to give oxycodone HCL oral tablet 5MG- Give 4 tablets by mouth every 4 hours as needed for severe pain level of 6-10.</p> <p>Further review of July 2026 MAR revealed a second PRN order for narcotic pain medication written as: Oxycodone HCL oral tab 5MG: give 3 tablets by mouth every 4 hours as needed for moderate pain 1-5. This medication was being administered when the resident's pain level was greater than 5. The dates include: 7/2 and 7/5- Pain level was 10. On 7/9- Pain level was 8 and on 7/12 and 7/14, the pain level was 7.</p> <p>2). On 07/16/2026 at 8:34 AM a review of Resident #42's physician order reveals an order dated 8/31/25. It reads: oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug*Give 1 tablet by mouth every 6 hours as needed for pain 6-10.</p> <p>Further review of Resident #42's June 2026 MAR reveal that this medication was given to the resident on 6/8 for a pain level of 3. On 6/15 and 6/17 for a pain level of 4, and on 6/30 for a zero-pain level which was outside the recommended 6-10 parameters</p> <p>In an interview with The License Practical Nurse (LPN) #38 on 07/16/2026 at 8:38 AM- he was asked about the process for administering PRN pain medications with parameters. He stated that residents are first assessed for pain to determine their pain level which is measured on a scale of 1-10, prior to administering the medication. The pain meds are administered if it falls within the ordered parameters and should not be given when the pain level is at zero. He was asked the implication of administering the PRN pain medication when not indicated. He stated that if given when out of parameters, the resident may become dependent on the narcotic or develop respiratory failure or become constipated from overuse.</p> <p>On 07/16/2026 at 4:15 PM The Director of Nursing (DON) was made aware that staff are not following the doctor's order and are giving PRN narcotics outside the prescribed ranges. She said the orders are spelled out on the MAR, yet staff are not doing it, she will provide more education.</p> |                                                                                         |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>215074                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Autumn Lake Healthcare at Homewood                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6000 Bellona Avenue<br>Baltimore, MD 21212 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                 |
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| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, record reviews and staff interviews, it was determined that the facility failed to 1), store and serve food in a manner that prevents foodborne illness and 2), failed to date and label resident's food stored in the nourishment refrigerator. This was evident during the annual survey. The findings include 1). On 07/13/2026 at 06:56 AM an observation of the facilities kitchen refrigerator revealed food stored without a date or labels on them. They include: A container with diced carrots in an aluminum container covered with a transparent film. A Big jar of Sysco reliance Barbecue sauce 3/4 empty-not dated Three one-liter water jugs, filled with pink juice and four one-liter jugs, filled with lemon juice- not dated. Further review of the Food temp log on 07/13/2026 at 7:23 AM revealed that: on 7/3/26, breakfast food temperature was not taken or documented. on 7/6/26 breakfast and lunch food temperature was not taken or documented. In an Interview with the district manager (CDM)#35 on 07/15/2026 at 8:23 AM, he was asked about their Policy for food storage, and he said that anything placed in the fridge that is open should be labelled and dated. He was asked what plans he had in place to ensure that foods kept in the fridge are labelled and he said it's everybody's responsibility to make sure foods kept in the fridge are labelled. He Stated that he has instructed the kitchen managers to do a morning walk through and check everything to ensure that the foods left there are labelled. He was made aware that this was a concern. 2), On 07/14/2026 at 11:48 AM, an observation of the nourishment refrigerator located on the unit where foods brought in by residents or visitors are kept revealed a plate of spaghetti in a black bowl covered with a white lid dated 7/13/26 with no name on it. A white /creamy liquid in an 8 Oz plastic cup and a second 8 OZ plastic cup 3/4 filled with pink liquid with no date or name on it; A bottle of life H2O about 1/3 full with no name or date on it. At 11:52AM the staffing manager #36 was made aware of the findings, she verified that they were not labelled or dated and stated that she would discard them. On 07/14/2026 at 4:12PM In an interview with the Director of Nursing (DON), she was asked about their policy for food kept in the nourishment refrigerator. She said that any food kept there should not stay for more than 3 days. It must be labelled with a name, room number and the date it was put in the refrigerator. She was made aware of the above concerns. She said she will follow up.</p> |                                                                                         |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>215074                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Autumn Lake Healthcare at Homewood                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6000 Bellona Avenue<br>Baltimore, MD 21212 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                 |
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| <p>F 0839</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a complaint #3055819, record review and staff interviews, it was determined that the facility failed to employ a Registered Nurse (RN) in accordance with Maryland State laws. This was evident for 1 (Staff #2) of 3 employee files reviewed during the annual survey.</p> <p>The findings include</p> <p>On [DATE] at 9:30 AM review of a complaint incident #3055819 alleged that the Director of Nursing's (DON) RN license was supposed to be from Florida and her MD LPN License was inactive with the MD Board of Nursing. The surveyor requested Staff #2's employee files.</p> <p>Review of staff #2's employee files verified that the employee has a valid compact RN license from Florida and that she resides in Maryland. However, the surveyor was unable to verify staff #2's Maryland license from the MBON website, and there were no copies of their MD license on file.</p> <p>In an Interview with the Human Resources (HR) Director #30 on [DATE] at 12:01PM the HR director was asked about their process for verifying the validity of a nurse's license. She stated that she verifies it through the Maryland board of Nursing (MBON) website. The HR Director was asked if she hires staff who are not licensed in MD. She stated that some staff do have Multistate RN-MD licenses. They are hired as long as it's a compact multi state license. She was asked if she ensures that those nurses get an active MD License if they Physically reside in MD and she said she does. She was asked if not licensed in MD, can they work with a Compact license and she said yes. She was asked if she was aware that in Maryland a nurse is required to have an active license in the State of their primary residence. She said she was not aware. She was asked to provide a list of Nurses with RN compact license.</p> <p>On [DATE] at 12:36 PM- the HR Director #30 brought a list that showed that the DON was the only one working in the facility with a Florida compact license and an expired License Practical Nurse (LPN) license (expired [DATE]). The HR director was made aware that the staff (DON) needs to have an MD license in the state of primary residence, she said she will follow up.</p> <p>On [DATE] at 1:45PM: the DON was made aware of the concern. She was told that state law requires a nurse to have an MD license to work in the state of MD if the person resides physically in MD and claims their W2 from the state. MD state law requires that their W2 should match their state of licensure. She said she claims dual state residency in MD and Florida but has just finished her bachelor's degree and will get the MD license.</p> <p>The Nursing Home Administrator (NHA) was there during the discussion and acknowledged the concern.</p> |                                                                                         |                                                 |

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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |                                                 |
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| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to separate the clean and soiled laundry areas with a closed barrier to prevent the potential for cross-contamination and failed to maintain a process to identify residents who required Enhanced Barrier Precaution (EBP). This was evident in the laundry room and 3 (#40, #44, and #54) out of 10 rooms observed for precaution signage. The findings include: 1) On 07/14/2026 at 10:25 AM, the surveyor observed an opening between the clean and dirty areas of the laundry. Staff #9 stated that the opening needs to be there for maintenance of the dryer area and there was no way to close the opening. On 07/14/2026 at 10:35 AM, the Administrator acknowledged the concern and stated the facility would explore solutions. 2) On 07/14/2026 at 10:40 AM, the survey observed 10 rooms with Enhanced Barrier Precaution (EBP) signage. Orange dots were found on 7 rooms identifying which bed the precautions were needed. Rooms #40, #44, and #54 did not have an orange dot identifying which resident needed precautions. On 07/14/2026 at 10:45 AM, Licensed Practical Nurse (LPN) # 8 was asked how to identify which resident was on precautions for rooms [ROOM NUMBER]. LPN #8 stated, I'm not sure who is on EBP without the dot. When asked who is responsible for placing the orange dots on the signage, LPN #8 stated s/he thought the supervisors were responsible for putting the orange dot on the sign and the expectation is that every room that has an EBP sign would have an orange dot next to the name of the resident requiring precautions. On 7/15/2026 at 11:51 AM, the Director of Nursing acknowledged the confusion regarding the signage, stated the former Assistant Director of Nursing implemented the process, and noted the facility needed to clarify the procedure to staff. |                                                                                         |                                                 |

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| F 0925<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that there was an effective pest control program in place at the facility to be free from pests. This was evident for several observations throughout the annual survey. The findings include: On 07/13/2026 at 11:34 AM, during an interview with Resident #9, a fly was flying around the room. Resident #9 swatted the fly away. At the same time, Resident #9 indicated that he/she had seen flies frequently in their room and that they had landed in their food and on objects around the room. On 07/13/2026 at 1:00 PM, an observation revealed a gnat (small fly) in the surveyor conference room. On 07/14/2026 at 7:30 AM, an observation revealed fly in the surveyor conference room. On 07/14/2026 at 8:05 AM, the surveyor caught and disposed of the fly. On 07/14/2026 at 10:50 AM, an observation revealed a fly in the surveyor conference room. On 07/15/2026 at 10:15 AM, an observation revealed a fly in a fresh cup of coffee in the surveyor conference room. On 07/15/2026 at 1:24 PM, an observation revealed a fly in the surveyor conference room. On 07/16/2026 at 7:44 AM, an observation revealed a fly in the surveyor conference room. On 07/16/2026 at 8:28 AM, during an observation of Certified Medication Aide (Staff #42) administer medication, there was a fly. At the same time, an interview with Staff #42 revealed she would observe a fly at least once a shift. On 07/17/2026 at 7:51 AM, an observation revealed a gnat in the surveyor conference room. On 07/17/2026 at 6:42 AM, an interview with the Nursing Home Administrator revealed he noticed the flies and gnats more during the week of the current annual survey. He further indicated the facility had pest control come frequently. The surveyor requested the last 3 months of pest control visit logs. On 07/17/2026 at 11:15 AM, review of the last 3 month pest control logs revealed that pests were addressed during several visits. On 07/17/2026 at 12:34 PM, at the time of the survey exit conference, the surveyor reviewed the concern to the Nursing Home Administrator.</p> |                                                                                         |                                                 |