STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview it was determined the facility failed to ensure food maintained appropriate temperature in accordance with professional standards for food service safety. This was evident during the surveyor's review of the kitchen task during the facility's recertification survey. The findings include:On 2/18/2026 at 2:36PM the surveyor conducted an interview of Resident #17 who reported to this surveyor that at breakfast time, their milk was cold, however it was sour and spoiled. On 2/24/2026 at 12:19PM the facility's Certified Dietary Manager (CDM) #12 provided a test tray for palatability testing to be performed by the survey team at which time the milk temperature was taken and observed to be 47.3F. On 2/24/26 at 12:30PM the surveyor conducted an observation of the facility's milk supply within the kitchen and asked CDM #12 to pull a milk carton from the facility's walk in refrigerator at which time the milk was immediately tested and found to be at 42F. At this time, the surveyor shared the concerns and conducted an interview of CDM #12 who stated to the surveyor that the temperature expectation for milk is to be between 39F and 41F. On 2/24/26 at 12:37PM the surveyor observed an open refrigerated well adjacent to the facility's steam table in which milk and other food items requiring refrigeration were being held. At this time the surveyor inquired to CDM #12 as to where the temperature monitoring was for the refrigerated well. CDM #12 observed and confirmed with the surveyor that there was no thermometer present for the monitoring of the well and after surveyor intervention, Regional Food Service Director (RFSD) #27 was observed directing CDM #12 to obtain and place a thermometer into the well. No temperature log was observed to be present for temperature monitoring of the well. The surveyor noted also that the facility's reach in refrigerator was not in working order and out of service.Reference to CMS 2567, F908.

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 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. Based on observation and interview it was determined the facility failed to: 1) Ensure professional standards for food service safety were followed. 2) Maintain a sanitary kitchen environment: Ensure thorough cleaning of kitchen, equipment, and areas where food is served and stored. Ensure surfaces used for food preparation, storage and serving were clean and in good repair. 3) Ensure the kitchen environment was pest free. 4) Ensure furniture for dining was clean and in good repair. This was evident during the surveyor's kitchen and dining tour during the facility's recertification survey.The findings include:The surveyor conducted an initial tour of the facility's kitchen on 2/18/26 beginning at 7:40AM.During the surveyor's initial tour of the facility's kitchen on 2/18/26 at 7:47AM the surveyor observed a food prep table with an unclean surface with a brown and white substance present on it with Food Services Director (FSD) #12. One metal cutting board holder rack was observed sitting on the food prep table with the unclean surface and the holder itself was observed with white and brown crusty debris present on it's surface which was holding several cutting boards. FSD #12 acknowledged the surveyor's concerns and directed a kitchen staff member to assist with cleaning of the concerns.On 2/18/26 at 7:49AM the surveyor observed the flooring surface below the two compartment sink across from a food prep table. The flooring area below the two compartment sink was observed to have an unclean appearance with darker areas of soiling and food crumbs present. FSD #12 observed the concern at this time with the surveyor and acknowledged the concern.On 2/18/26 at 7:49AM the surveyor observed the two tier food preparation table located across from the two compartment sink which was observed to have prepped pork meat on the top tier surface, and on the lower tier's surface numerous dark rod shaped pellets approximately the size of a grain of rice, scattered on the lower tier surface in addition to food debris and areas of yellow sticky liquid matter next to a bag of corn starch and next to containers which held flour, sugar, white rice, and thickener powder were observed. On 2/18/26 at 7:52AM the surveyor conducted an interview and dual observation of the concerns with FSD #12 and inquired as to if the facility kitchen had pest concerns at present. FSD #12 stated to the surveyor during the interview: We have had a problem in the building with mice in the last six months, the health department has been out several times investigating mice, we've changed exterminators in response to that but there are still some mice, we have been cleaning extra, but they haven't cleaned since the snow storm. During the dual observation with FSD #12, four out of four exterior surfaces of the containers which held food items on the lower tier were observed to be unclean with staining, food crumbs and cloudy appearing areas, and the inside of the container holding sugar was observed with a mounted scooper in which the handle and scooper was observed to have brown specks of matter present on it, and the inside of the container holding flour was observed with a mounted scooper in which the handle was observed to have a dark piece of debris present on it. On 2/18/26 at 8:00AM the flooring material leading to the walk in refrigerator was felt to be movable upon walking upon it, and upon closer observation by the surveyor, was observed to be movable.On 2/18/26 at 8:04AM the surveyor inquired as to where the designated staff area was for personal beverages etc, at which time FSD #12 stated: Unfortunately, we don't have one and showed the surveyor to the facility's reach in refrigerator which had exterior signage present on it dated December 2025 and Out of service. The interior thermometer of the reach in refrigerator was observed to be at 78F and a sign was observed for the lower shelf which was designated for staff food. During the interview FSD #12 informed the surveyor that the reach in refrigerator was also used to hold food items needed to carry out the tray line and that the current Administrator was aware that the facility bills were still being sent to the previous facility Administrator and that companies aren't coming to fix things until the bills are paid.On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. On 2/20/26 at 12:48PM (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the surveyor again reviewed concerns with the facility's Administrator. On 2/24/26 at 10:45AM the surveyor observed the second floor lounge area where the Resident food refrigerator was located. One wall was observed to have several areas of white spackling present with a layer of white powder observed to be present on the floor beneath the spackled areas, which was adjacent to dining tables. On 2/24/26 at 10:46AM the surveyor conducted an interview of Geriatric Nursing Assistant #28 who confirmed with the surveyor that facility Residents use the lounge and sometimes eat in the lounge. On 2/24/2026 at 10:54AM the surveyor conducted a dual observation with Unit Manager (UM) #29 at which time six out of seven dining chairs in the second floor lounge were observed with a layer of dark soiling present on the arm rests. At this time, the surveyor conducted an interview and shared concerns with UM #29, and after surveyor intervention, UM #29 stated: I'm gonna let maintenance know to come remove them, and housekeeping to clean once they are removed. During the observation, facility staff was observed assisting a Resident into the lounge area at which time UM #29 offered a different space to use.On 2/24/26 at 12:34PM the surveyor observed two out of two fan covers located within the facility's walk in refrigerator which had a dark gritty debris present on the surfaces. Similar dark gritty debris was observed present on the ceiling and along the piping in the walk in refrigerator with one area observed to have a steady dripping of clear liquid. During the observation FSD #12 observed and acknowledged the concerns.On 2/24/26 at 12:40PM the surveyor observed the tray line at which time the exterior surface of the equipment was observed to have a side panel which was grate like in appearance which was observed to be unclean with fuzzy grey colored matter present within it. At this time the surveyor shared the concern and conducted a dual observation of the concern with FSD #12 who acknowledged the concern. On 2/24/26 at 12:48PM the surveyor observed several rust colored areas present on the lower tier of the food serving steam table equipment located in the main dining area of the facility. Upon further surveyor observation of the food serving steam table equipment located in the main dining area of the facility on 2/24/26 at 12:52PM it was revealed that the food prep/tray line surface had black taping present between the metal surface of the steam table and the prep surface with food crumbs/debris present in between. At this time the surveyor conducted a dual observation of the concern with FSD #12 who after surveyor intervention, was observed removing the black taping which was observed to be holding food crumbs/matter within the surface. On 2/24/26 at 12:52PM the surveyor observed a long rectangular table present next to the food serving steam table equipment which was observed to have rough worn edges with exposed uncovered particle board type material. FSD #12 indicated to the surveyor that the table was used with regard to food service. At this time, the surveyor shared the concern with FSD #12 who acknowledged the concern. At the conclusion of the observation FSD #12 reported to the surveyor that they were going to notify maintenance staff of the walk in refrigerator fans which required cleaning.After surveyor intervention, on 2/25/26 at 8:50AM the surveyor observed that the food serving steam table equipment was clean in appearance and the table had been replaced with a table in which had a cleanable surface and the damaged table was marked with signage that read: do not use.Concerns were reviewed by the survey team at the facility's exit conference with Regional Director of Operations #18 and the facility's Director of Nursing on 2/25/26. Reference to CMS 2567, F804, F908.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview it was determined the facility failed to ensure the garbage area was maintained in sanitary condition. This was evident during the surveyor's initial tour of the facility for 1 out of 1 trash area observed during the facility's recertification survey.The findings include: On 2/18/26 at 8:13AM the surveyor conducted a dual observation of the facility's trash area with Food Service Director (FSD) #12 which was located exteriorly adjacent to an entrance to the facility's kitchen at which time the following observations were made:1.) One uncovered rolling trash container was observed parked in the dumpster area with copious food trash items and food debris present which were no longer contained within trash bags which included but was not limited to food cups, open food containers, food matter, open milk containers, rice, carrots, soda bottles, juice containers, protein shake cartons etc.2.) Trash items and pieces of food were observed scattered on the ground near to the container3.) Two broken overbed tables4.) Two sitting chairs5.) Numerous wooden pallets6.) numerous trash cans with broken equipment present7.) Bed mattresses8.) Several trash cans situated on their side9.) Broken mop bucket10.) Various pieces of wet cardboard11.) Various pieces of plastic and paper trash and bags of ice melt stacked up against vents leading into the facility's electrical room.At this time the surveyor shared their concerns with FSD #12 who acknowledged and confirmed understanding of the concerns and reported to the surveyor that, at times, raccoons are present in the garbage area and discussed their concerning behavior with this surveyor. This surveyor additionally noted signs indicative of a pest issue were observed to be present within the facility's kitchen during the initial tour of the facility's kitchen prior to the trash area observation. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing (DON) who acknowledged the surveyor's concerns with each stating: Okay, thank you. On 2/19/26 at 2:57PM the surveyor again shared concerns with the facility's Administrator, DON, Corporate Nurse #6, and Regional Nurse #5. On 2/20/26 at 2:29PM the surveyor conducted an interview of the facility's Director of Maintenance #13 who confirmed that the facility at present continued to have a pest issue with mice and after surveyor intervention, reported that the facility had brought in a flat bed because they didn't have enough trash can space to dispose of everything that needed disposed of. During the interview, Director of Maintenance #13 stated that facility staff were: not breaking down trash like they are supposed to, not breaking boxes down, causing trash cans to not have enough space. At this time, the surveyor shared the concerns with them at which time they acknowledged the surveyor's concerns. After the conclusion of the interview on 2/20/26, a receipt for a 20 yard container to remove the garbage dated 2/20/26 was provided to the surveyor. On 2/25/26 all concerns were reviewed by the survey team during the facility's exit conference with Regional Director of Operations #18 and the Director of Nursing.

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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 observation and interview it was determined the facility failed to adhere to infection control practices and guidelines. This was found to be evident during observations made throughout the facility's annual Medicare/Medicaid survey. The findings include:1.) On 2/18/26 at 9:26AM the surveyor observed Resident #99 approach the floor two nutrition room door utilizing their rolling walker, and removed their hand from the walker's handle, opened the door and used their hand to scoop ice and fill a bath basin situated on their walker seat with ice. The surveyor observed their arm touching the inside surface of the ice cooler while scooping the ice, and no hand sanitization or other method of cleaning hands was observed to be performed prior to accessing the cooler. The surveyor observed Resident #99 leave the ice scoop and handle directly in the ice within the cooler. Several trash items were observed to be present on the floor surrounding the ice cooler. On 2/18/26 at 9:26AM the surveyor conducted an interview of Resident #99 who informed the surveyor: I use the ice for drinking and to keep my juice. On 2/18/26 at 9:39AM the surveyor conducted and interview and shared the concern with Licensed Practical Nurse #33 who stated: I can remove the scoop, and I'll let the ADON (Assistant Director of Nursing) know. 1b.On 2/18/26 at 9:51AM the surveyor observed Resident #97 approach the floor two nutrition room door utilizing their walker, removed their hands from their walker handles, opened the nutrition room door and was observed obtaining ice from the cooler using the scooper located within the ice and no hand sanitization or other method of cleaning hands was observed to be performed prior to accessing the cooler. The surveyor observed Resident #97 leave the ice scoop and handle directly in the ice within the cooler. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. 2) On 2/18/26 at 2:04PM the surveyor observed a mesh bag of laundry outside of Resident #10's room door, on the floor in the Resident hallway sitting up against a personal protective equipment (ppe) cart containing ppe and observed a contact precautions sign on Resident #10's room door. A floor caution sign was observed sitting on top of the mesh bag of laundry and against the ppe cart. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. 2b.) On 02/25/2026 at 7:06 AM the surveyor observed bagged laundry outside of room [ROOM NUMBER] on the floor in the Resident hallway. 2c.) On 02/25/2026 at 7:07 AM the surveyor observed bagged laundry outside of room [ROOM NUMBER] on the floor in the Resident hallway. On 2/25/26 concerns were reviewed during the facility's exit conference with the facility's Regional Director of Operations #18 and Director of Nursing. 2d.) On 02/18/2026 at 2:20PM the surveyor observed brown matter on the bed mattress of Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#4 at which time the surveyor requested and performed a dual observation of the concern with Licensed Practical Nurse #33 who observed and acknowledged the surveyor's concern. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. On 2/25/26 concerns were reviewed during the facility's exit conference with the facility's Regional Director of Operations #18 and Director of Nursing. 3) On 2/19/26 at 10:35AM the surveyor observed a clean linen cart situated in the Resident hallway outside of room [ROOM NUMBER]. The cart was observed with a green cover in severely worn condition with areas which no longer green with exposed white thread material. A hair comb was observed sitting on top of the linen cart with strands of hair in it. Within the linen cart, two regular sized Resident personal bottles of body wash approximately 3/4 of the way full, were observed with the linen and incontinence care products. One bottle of the personal body wash was observed resting on top of linens and up against the incontinence care products. On 2/19/26 at 10:37AM the surveyor shared the concern and conducted an interview with Geriatric Nursing Assistant #8 who confirmed the personal bottles of body wash belonged to room [ROOM NUMBER] and room [ROOM NUMBER] Residents and were used for their showers. On 2/19/26 at 10:44AM the surveyor shared the concerns with Assistant Director of Nursing #3 who confirmed understanding of the concerns. On 2/19/26 at 2:57PM the surveyor shared concerns with the facility's Administrator, Director of Nursing, Regional Nurse #5 and Corporate Nurse #6. 3b.) On 02/25/2026 at 6:49AM Geriatric Nursing Assistant (GNA) #32 was observed by the surveyor wearing a yellow personal protective equipment (ppe) gown with gloves on their hands in the Resident hallway obtaining linens from the linen cart. Two bags filled with trash were observed sitting in the Resident hallway on the floor next to the linen cart. GNA #32 was observed by the surveyor holding linens in one hand against their ppe gown and picking up two bags filled with trash off of the Resident hallway floor with their other hand. At this time, the surveyor conducted an interview of GNA #32 who stated I'm going into this room and confirmed it was Resident #85's room which was observed to have both contact and droplet precautions signage present. GNA #32 stated to the surveyor regarding the two bags of trash in the Resident hallway: This trash is from another room. 3c.) On 02/25/2026 at 7:09 AM the surveyor observed a trail of wet clear liquid drops on the flooring extending from room [ROOM NUMBER] into the Resident hallway. On 02/25/2026 at 7:11AM the surveyor conducted another interview of GNA #32 who reported to the surveyor: I came out to take some linen out. GNA #32 confirmed with the surveyor that they had came out of the Resident room which had both contact and droplet precautions signage present on the door. When the surveyor inquired as to why they were wearing ppe out of a room with precautions, GNA #32 stated: You're right, I didn't expect it, (the surveyor to be present) that's why I came out to take it (the linen). When the surveyor inquired to GNA #32 as to what their understanding was of why ppe was to be worn in a room with droplet and contact precautions, they stated: It's so the droplet will not get on me, the Resident I learned yesterday, has an infection, s/he is the last one (Resident) I did, I saw s/he was wet so I came to pick up linen. At this time the surveyor shared the concern with GNA (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#32 who acknowledged and confirmed understanding of the concern and stated to the surveyor: Okay thank you. On 02/25/2026 at 6:54AM the surveyor shared the concern with Unit Manager (UM) #29 who acknowledged and confirmed understanding of the concern. When the surveyor inquired as to if employees receive infection control training, UM #29 stated: Absolutely. UM #29 reported to the surveyor that they would be speaking with GNA #32 and would be addressing the issue. On 02/25/2026 all concerns were reviewed during the facility's exit conference with Regional Director of Operations #18 and the facility's Director of Nursing. 4.) On 2/24/2026 at 9:15AM, during medication administration observation on the Medbridge Unit, the Surveyor observed Registered Nurse (RN) #24 retrieve vital signs for Resident #126 using a blood pressure cuff and pulse oximeter connected to a portable vital signs monitor. RN #24 administered medication to Resident #126 and exited the room with the portable vital signs monitor with connections. The Surveyor did not observe disinfectant wipes on the portable vital sign monitor. RN #24 failed to disinfect the portable vital signs monitor including blood pressure cuff and pulse oximeter after use. 4b.) On 2/24/2026 at 9:36AM, during continued medication administration, the Surveyor observed RN #24 retrieve vital signs for Resident #184 using the same portable vital sign monitor with blood pressure cuff and pulse oximeter connections used for Resident #126. RN #24 administered medication to Resident #184 and exited the room with the portable vital signs monitor with connections. RN #24 failed to disinfect the portable vital signs monitor including blood pressure cuff and pulse oximeter after use. 4c.) On 2/24/2026 at 9:51AM, during continued medication administration, the Surveyor observed RN #24 retrieve vital signs for Resident #175 using the same portable vital sign monitor with blood pressure cuff and pulse oximeter connections used for Resident #126 and Resident #184. RN #24 administered medication to Resident #175 and exited the room with the portable vital signs monitor with connections. RN #24 failed to disinfect the portable vital signs monitor including blood pressure cuff and pulse oximeter after use. During an interview conducted with RN #24 on 2/24/2026 at 10:25AM, the Surveyor expressed the concern that they failed to ensure infection control by disinfecting the portable vital signs monitor including blood pressure cuff and pulse oximeter after use. The Surveyor asked if the medication cart contained disinfecting wipes to clean equipment after use. The Surveyor confirmed disinfectant wipes in the bottom drawer of the medication cart. RN #24 acknowledged the Surveyor concerns and stated that morning medication administration can be a long process and resident's may require assistance that may extend their time with them and lead to late medication administration; however, the expectation is to disinfect equipment used in between residents. During an interview conducted with the Assistant Director Of Nursing/ Infection Preventionist (ADON/IP) on 2/24/2026 at 2:47PM, the Surveyor expressed the concern that RN #24 failed to disinfect the portable vital signs monitor including blood pressure cuff and pulse oximeter after use. ADON/IP stated that the expectation is that any shared equipment used for residents should be disinfected after use for that resident and before entering the next room. Sanitizing wipes should be located on each medication cart and portable vital sign monitor that has a basket to place them in. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview it was determined the facility failed to ensure essential kitchen equipment needed to manage functions of food service was maintained in safe operating condition. This was evident for: 1 out of 2 steamer compartments, 1 out of 1 single door reach in refrigerator, 1 out of 2 convection oven compartments, and 1 out of 6 steam table wells observed during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility's kitchen, on 2/18/26 at 8:04AM the surveyor inquired as to where the designated staff area was for personal beverages etc, at which time FSD #12 stated: Unfortunately, we don't have one and showed the surveyor to the facility's reach in refrigerator which had exterior signage present on it dated December 2025 and Out of service. The interior thermometer of the reach in refrigerator was observed to be at 78F and a sign was observed for the lower shelf which was designated for staff food. During the interview FSD #12 informed the surveyor that the reach in refrigerator was also used to hold food items needed to carry out the tray line and that the current Administrator was aware that the facility bills were still being sent to the previous facility Administrator and that companies aren't coming to fix things until the bills are paid.On 2/18/26 at 8:06AM the surveyor observed one of two electric convection steamer compartments to be operational, at which time FSD #12 reported that one of two steamers (compartments) was broken, and the kitchen was responsible for boiling food for up to over two hundred residents and that it was hard to keep up and discussed their concern for burn hazard regarding employees having to boil large quantities of food needed to support the facility's census. On 2/18/26 at 8:07AM the surveyor observed the food tray line at which time one out of six steam wells on the steam table was observed to be operational. The temperature knob below the fourth steam well was observed by the surveyor to have a copious amount of clear tape over it. When the surveyor inquired to FSD #12 as to why the tape was present, they confirmed the steam well was not in working order and stated: You can't turn it on because it will electrocute you. During the interview, FSD #12 confirmed with the surveyor that the bottom convection oven was unable to hold appropriate temperature and that they considered the broken pieces of kitchen equipment to be essential equipment needed to carry out the function of food service to the facility Residents. During the interview, it was confirmed by FSD #12 that the broken essential kitchen equipment had been placed in the facility's TELS maintenance system for approximately three months and they had repeatedly informed facility staff regarding the need for the equipment to be in working order. On 2/18/26 at 8:21AM the surveyor approached the door to the kitchen at which time a piece of metal was felt to be sharp and the door handle was observed to be missing revealing an open hole surrounded with sharp metal edges. At this time, the surveyor shared their concern with FSD #12 who observed and acknowledged the concern and stated: It broke yesterday. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough backup water supply for essential areas of the nursing home. Based on observation, interview and record review it was determined the facility failed to ensure onsite emergency water supply. This was evident during the surveyor's tour of the emergency water storage area during the facility's recertification survey.The findings include: On 2/18/26 at approximately 7:53AM the surveyor was provided with facility census documentation which documented that 168 Residents resided in the facility. On 2/18/26 at 8:17AM during the surveyor's initial tour of the facility's kitchen the surveyor conducted an interview of Food Service Manager (FSM) #12 and inquired as to where the emergency water was located in the building. FSM #12 reported to the surveyor regarding the emergency water supply, that it was not in the building and confirmed that is was not stored anywhere in the building. On 2/18/26 at 1:14PM the surveyor conducted an interview of the Administrator and asked them to show this surveyor where the emergency water supply was located within the building at which time the surveyor was taken to the floor where the kitchen was located and this surveyor observed the Administrator ask FSM #12 for the keys to the emergency water supply room at which time FSM #12 was observed retrieving a key. The Administrator reported to the surveyor during the interview that they did not think emergency water was needed onsite. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. On 2/18/26 at 1:16PM the surveyor conducted a dual observation of the facility's emergency water supply with FSM #12 and the Administrator at which time the following was revealed:1.) cardboard cases of gallon jugs of water in which appeared crushed inward2.) gallon jugs of water which were sitting opened and uncapped3.) several gallon jugs of water which were capped, but empty4.) cases of gallon jugs of water which were observed with a layer of white powder present5.) best by dates from year 2024 and 2025 were present on part of the supply of water6.) the supply amount of emergency water was observed to be inadequate for the amount of facility residents for three days in the event of an emergency.Roughly 250-300 gallons was observed to be present which was confirmed by the facility's Administrator and FSM #12 stated to the surveyor: It's not in condition to serve to Residents. Additionally FSM #12 explained that due to temperature changes in the emergency water supply room, gallons of water had exploded and reported that maintenance work was recently done in the room. The facility Administrator acknowledged during the observation that the supply was not enough to meet the emergency needs of the facility.On 2/24/26 at 12:08PM the surveyor was provided with the facility's emergency water supply policy dated as last revised on 1/3/26 which documented the following information under the section labeled policy explanation and compliance guidelines: The Dietary Manager maintains a three day supply of bottled water for drinking and cooking but no less than as specified by state regulations (3 gallons per resident, per day); This water is stored on the service level across the kitchen.Review of the facility's disaster and emergency response plan by the surveyor on 2/24/26 at 12:08PM revealed the following documentation under the section labeled emergency procedures: Food and Water: The facility has an emergency supply of water located in storage on the lower level of the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review it was determined the facility failed to ensure effective management of pest control. This was evident for all floors of the facility during surveyor review of environment during the facility's recertification survey.The findings include: On this surveyor's initial tour of the facility's kitchen the surveyor's observations on 2/18/26 at 7:49AM included the lower tier of a two tier food preparation table located across from the two compartment sink which was observed to have numerous dark rod shaped pellets approximately the size of a grain of rice, scattered on it's surface in addition to food debris and areas of yellow sticky liquid matter next to a bag of corn starch and next to containers which held flour, sugar, white rice, and thickener powder were observed. On 2/18/26 at 7:52AM the surveyor conducted an interview and dual observation of the concerns with FSD #12 and inquired as to if the facility kitchen had pest concerns at present. FSD #12 stated to the surveyor during the interview: We have had a problem in the building with mice in the last six months, the health department has been out several times investigating mice, we've changed exterminators in response to that but there are still some mice, we have been cleaning extra, but they haven't cleaned since the snow storm. During the dual observation with FSD #12, four out of four exterior surfaces of the containers which held food items on the lower tier were observed to be unclean with staining, food crumbs and cloudy appearing areas in addition to other observations made by the surveyor.On 2/18/26 at 8:13AM the surveyor conducted a dual observation of the facility's trash area with Food Service Director (FSD) #12 which was located exteriorly adjacent to an entrance to the facility's kitchen at which time the following observations were made: 1.) One uncovered rolling trash container was observed parked in the dumpster area with copious food trash items and food debris present which were no longer contained within trash bags which included but was not limited to food cups, open food containers, food matter, open milk containers, rice, carrots, soda bottles, juice containers, protein shake cartons etc. 2.) Trash items and pieces of food were observed scattered on the ground near to the container, 3.) Two broken overbed tables, 4.) Two sitting chairs, 5.) Numerous wooden pallets, 6.) numerous trash cans with broken equipment present, 7.) Bed mattresses, 8.) Several trash cans situated on their side, 9.) Broken mop bucket, 10.) Various pieces of wet cardboard, and 11.) Various pieces of plastic and paper trash and bags of ice melt stacked up against vents leading into the facility's electrical room. At this time the surveyor shared their concerns with FSD #12 who acknowledged and confirmed understanding of the concerns and reported to the surveyor that, at times, raccoons are present in the garbage area and discussed their concerning behavior with this surveyor. On 2/18/26 the following Residents reported observations of mice within the facility to the survey team member(s): Resident #11, #15, #18, #135 and additionally one family member of a Resident who wished to remain anonymous.On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. On 2/20/26 at 2:29PM the surveyor conducted an interview of the facility's Director of Maintenance #13 who confirmed that the facility at present continued to have a pest issue with mice and after surveyor intervention, reported that the facility had brought in a flat bed because they didn't have enough trash can space to dispose of everything that needed disposed of. During the interview, Director of Maintenance #13 stated that facility staff were: not breaking down trash like they are supposed to, not breaking boxes down, causing trash cans to not have enough space. Director of Maintenance #13 reported to the surveyor during the interview that at first, there was a strong issue with mice for a good three months and the pest control problem was not handled correctly and the pest control company the facility utilized was changed to a different company. Director of Maintenance #13 reported that the pest control company handles the bait and traps while maintenance staff are responsible for handling pest entry points and that they last visited the facility the day prior. At this time, the surveyor shared the concerns with them at which time they acknowledged the surveyor's concerns. After the conclusion of the interview, (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a receipt for a 20 yard container to remove the garbage dated 2/20/26 was provided to the surveyor on 2/20/26. On 2/20/26 at 2:51PM the surveyor conducted a review of pest control log documentation which revealed pest control concerns logged which included current active concerns. Documentation in the pest control logs included the following dates in which pest control concerns were documented: 6/9/25, 6/12/25, 6/15/25, 7/3/25, 7/29/25, 7/30/25, 10/16/25,10/25/25,10/28/25, 11/19/25,12/17/25, 12/19/25, 12/23/25, 12/24/25, 12/28/25, 1/3/26, 1/29/26, 1/31/26, 2/1/26, 2/2/26, and 2/20/26.On 2/20/26 2:53PM the surveyor observed the trash area adjacent to the facility's kitchen with several dumpsters in which were overfilled with trash visible above level of the top of dumpsters. On 2/20/26 at 2:10PM the surveyor observed the facility's activity room at which time numerous dark rod shaped pellets approximately the size of a grain of rice were observed scattered on areas of the flooring.On 2/24/26 at 8:54AM the surveyor conducted a review of the pest control company documentation which revealed documentation which included the following information: 1.) Logbooks were recommended by the pest control company to be utilized on the 10/23/25 service inspection report and also on the 12/11/25 and 12/28/25 service inspection reports, 2.) The 12/31/25 service inspection report documented Observed poor sanitation and several large voids, and recommended deep cleaning of a room and maintenance to seal voids as soon as possible, 3.) The 1/8/26 service inspection report documented Observed minor dead mice activity in tin cats next to the loading dock exit doors in the basement next to the kitchen, 4.) The 1/22/26 service inspection report documented reports of mice within the facility's kitchen and recommended Behind cooking machines and underneath tables against baseboards would benefit from improved sanitation, Checked in with (facility Administrator), 5.) The 1/29/26 service inspection report documented Treated along the exit doors and loading dock area to prevent further activity, 6.) The 2/4/26 service inspection report documented confirmed pest activity within the facility's kitchen and documented having spoken with the facility Administrator, and 7.) The 2/19/26 service inspection report documented confirmed pest activity behind the facility's ice machine.On 2/25/26 concerns were reviewed by the survey team during the facility's exit conference with Regional Director of Operations #18 and the Director of Nursing.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure a Resident (#97) had the capability of safe self administration of a medication and failed to ensure the interdisciplinary team was aware of the Resident's self administration of the medication. This was evident for 1 (#97) out of 2 Residents reviewed for quality of care during the facility's recertification survey. The findings include: On 2/19/26 at 10:05AM the surveyor conducted an interview with Resident #97 and observed them retrieve a bottle of magnesium citrate from the drawer which had a prescription label on it. Resident #97 showed the bottle to this surveyor and informed this surveyor that they needed more of the medication and that they had asked Licensed Practical Nurse Supervisor (LPNS) #9 for more of it three to four weeks ago and were told that they would get it but had not yet been given it. Resident #97 explained to this surveyor that they keep the medication for emergencies for a problem with constipation. On 2/19/26 at 10:09AM the surveyor conducted an interview with LPNS #9 who reported to this surveyor that (Resident #97) likes to keep his/her stuff, it's prn (as needed) for him/her so when s/he is constipated we give him/her the bottle to use it when s/he needs it. At this time, the surveyor shared the concern with LPNS #9 and after surveyor intervention, LPNS #9 was observed removing the medication bottle from the Resident's room.On 2/19/26 at 10:15AM the surveyor shared the concern and conducted an interview of Medical Director Physician (MDP) #7 who reported to this surveyor that Resident #97 was confused about it and stated that the medication was always available in the medication cart when s/he needs it. At this time, the surveyor shared the concern with MDP #7 who was unaware that Resident #97 had the medication in their possession and and that staff leave the medication with him/her. The surveyor confirmed during the interview that Resident #97 had not been safely assessed for self administration of their medication. On 2/19/26 this surveyor shared the concern with the facility's Assistant Director of Nursing (ADON) who acknowledged understanding of the surveyor's concern. This surveyor also shared the concern with the facility's [NAME] President of Operations Registered Nurse.On 2/20/2026 at 1:09PM the surveyor conducted an interview with ADON #3 who confirmed that medication should not have been left with Resident #97 and stated to the surveyor that the bottle of medication was removed from Resident #97 and Resident #97 was told that when they need medication, to request it from the nurse and they will follow up with them. When the surveyor inquired as to if the facility had taken any measures at the current time to address medication being left with a Resident who was not assessed for safe self administration, ADON #3 stated: It would be education with the nurse, and all staff education, I'll go check.On 2/20/2026 at 1:34PM the surveyor conducted an interview with the facility's Director of Nursing who stated during the interview to the survey team: I have to check, I don't know if s/he had a self administration of medication assessment. On 2/20/26 at 1:49PM the surveyor conducted a review of the medical record of Resident #97 and noted that no medical order or documentation of an assessment for self administration of medications for the Resident could be found. On 2/24/26 at 9:32AM the surveyor conducted an interview of the facility's Director of Nursing (DON) who stated to the survey team regarding Resident #97: S/he is going to be assessed for capability of self medication administration, if s/he is safe to have it in the room. Additionally after surveyor intervention, the surveyor was provided with documentation of in service education provided to facility staff in response to the surveyor's concern which was dated 2/18/26 and documented review of the following: Medication Administration; no medication should be left in Resident's room at any time. Additionally, the surveyor was provided with a disciplinary action form for LPNS #9 dated 2/18/26 with signatures present for LPNS #9 and ADON #3 which stated the following information regarding the details of occurrence: When administering medications nurses should assure medication is taken by patients, and No medications should be left in patient's rooms. The surveyor noted that both the education documentation and the disciplinary action forms were all dated as having been performed on 2/18/26, however, the date of the concern observed by the surveyor was not until (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/19/26.All concerns were reviewed during the facility's exit conference on 2/25/26 with the facility's Regional Director of Operations #18 and the Director of Nursing.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to ensure a resident received showers according to personal preference. This was evident for 1 (Resident #104) out of 1 resident reviewed for preference in shower schedule.The findings include: During observation of Resident #104's wound dressing change on 2/20/26 at 2:50 PM the resident stated that he/she was supposed to get two showers twice a week in the evening but doesn't always get one. Staff #15 who was doing the dressing change offered that the resident was supposed to get showers on the 3-11 shifts. Resident said he/she wanted showers on the 7-3 shift and has told nursing staff that he/she wants showers on day shift because he/she wants the showers before wound dressings are changed not after. The resident said even if the old dressing got wet it would have to come off anyway so getting wet would not matter. The resident then stated that they did not get a shower on Tuesday, 2/17/26.This surveyor interviewed the Director of Nursing (DON) on 2/24/26 at 3:05 PM. This surveyor explained the resident's concerns and preference for shower times. The DON said she understood and would talk with the nurses on the unit to make necessary changes.A review of the facility's Documentation Survey Report on 2/24/26 revealed that the resident did not receive scheduled showers on 12/2/25, 12/5/25, 12/19/25, 12/22/25, 12/26/25, 12/30/25, 1/9/26, 1/13/26, 1/16/26, 1/20/26, 1/23/26, 1/27/26, 2/6/26, 2/13/26, 2/20/26. The resident was marked as having received a shower on 2/17/26 but the resident denied receiving one. The resident's sister was interviewed on 2/25/26 at 11:43 AM. She was asked about the resident's showers. She said that he/she has complained to the nursing staff about not getting showered and nursing staff tell him/her that he/she has to get showered at night even though he/she has told them he/she prefers to get showers during the day.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on resident interview and staff interview, it was determined that the facility staff failed to provide a resident with a quarterly statement for a personal funds account. This was evident for 1 (#104) out of 2 residents reviewed for a personal funds account.The findings include:During the initial tour of the facility on 2/18/26 this surveyor interviewed Resident #104 at 2:51 PM. Resident #104 informed the surveyor that they do not get a quarterly statement telling them how much is in their personal funds account. Staff #18 was interviewed on 2/25/26 at 2:59 PM. This surveyor requested a copy of the quarterly statements provided to Resident #104 and signed by the resident indicating that the resident received the statements.The quarterly statements with signatures were not provided to the survey team at the exit conference. This surveyor's business card was provided to Staff #18 at the exit conference so that the facility staff could email copies to this surveyor. Copies were provided via email on 3/2/26 at 10:38 AM but they were not signed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with resident's and facility staff, it was determined the facility failed to ensure Resident's room furniture and the resident's environment was clean and well maintained for residents residing in the facility . This was evident during the surveyor's initial tour of the facility for two Resident rooms (#208, and #210) located on the second floor, observations of Resident # 19 Room and for Room # 309 during the facility's recertification survey.The findings include:1.On 2/18/26 at 9:02AM the surveyor observed Resident room [ROOM NUMBER] at which time the nightstand furniture was found to be in disrepair with wood located at the base of one of the nightstand observed to be broken in half with areas present in which the wood stain was worn off. A white substance was observed smeared across the front of one of the nightstand drawers. Further observation of the furniture in Resident room [ROOM NUMBER] revealed a wooden dresser with multiple worn and chipped areas in which the wood stain was worn off. A metal heat unit was observed within the room with grey scrapes across the surface with rust colored areas also present. One wall located near to the heat unit was observed to have an area of square patching affixed to the surface of the wall with a broken area present which revealed an opening which was present between the wall and the cove molding. A broken area of corner wall molding was also observed to be present. A wall within the room adjacent to the bathroom was observed to have several holes and scrapes present with a bubbled appearance. The surveyor noted that the heat unit and bedside nightstand was observable from the facility hallway. 2.On 2/18/26 at 9:07AM the surveyor observed the flooring within room [ROOM NUMBER] from within the Resident hallway at which time numerous areas of scraping and white colored staining was observed to be present. During the observation, Resident #97 requested to speak with this surveyor. On 2/18/26 at 9:07AM the surveyor conducted an interview of Resident #97 who expressed to the surveyor that their walker was scraping the floor area within their room and they had reported their concern to staff who attempted to clean the areas, however cleaning did not work and their concern was not resolved yet by the facility. Resident #97 reported having asked facility staff to address the walker with equipment to mitigate the scratching however, had not been provided with a solution to that concern. On 2/18/26 at 4:19PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who acknowledged the surveyor's concerns with each stating: Okay, thank you. 3.During a meeting with resident # 19 on 2/18/26 at 2:20 PM an observation was made of the resident room and there were crumbs and trash noted on the resident floor. There was also a strong urine odor present in the room. At this time, the resident stated that s/he was planning to get back into bed, but the bed was wet and not changed. The nurse who was present in the room, removed the linen from the resident bed and placed clean linen on the bed. The DON was made aware of the concern that the resident room was not clean, and the bed was not changed at the time the resident wanted to get into bed in the afternoon. 4.This surveyor observed on 2/25/26 at 1:15 PM that room [ROOM NUMBER] had a hole in the drywall on the righthand side wall as one entered the room. The hole was behind door at ankle height and just above the molding. There was also a scratched area on the wall at waist height that was also (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behind the door. There was also an area on the left side wall near the entrance at ankle height below the duct that was scraped and chipped. The Unit Manager (Staff #21) was shown the areas and interviewed on 2/25/26 at 1:18 PM. He confirmed the findings and took pictures of the areas. He then said it was a problem and he would address it immediately with maintenance and ask that they fix it. All concerns were discussed with the Administration team at the exit conference on 2/25/26.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review it was determined the facility failed to ensure Resident #4's personal funds was appropriately managed. This was evident for 1 out of 2 Residents reviewed for personal funds during the facility's recertification survey.The findings include:On 02/18/2026 at 2:15PM the surveyor conducted an interview of Resident #4 who expressed to the surveyor that they had sought Social Security for themself and learned that they had been approved for disability benefit, and in approximately October or November of 2025 they had received a check that came in their mail which was in their own name and made payable to only them. Resident #4 stated to the surveyor: The Administrator took my check, it was for $19,780.00 and then s/he supposedly put $2000.00 in an account for me, I don't get a statement or anything. During the interview Resident #4 continued to express to the surveyor that they did not understand why the check was taken from them when it was payable to their name, and was not made payable to the facility. Resident #4 stated they had wished to use the money from the check to facilitate them moving out of the facility and back into the community. Resident #4 reported during the interview that facility staff had informed them that the money was taken to pay for their care at the facility.On 02/25/2026 at 1:38PM the surveyor conducted an interview of the facility's Regional Director of Operations (RDO) #18 regarding Resident #4. RDO #18 stated during the interview to surveyors that Resident #4 received payment for disability which was back pay and they had been on Medicaid and were not approved right away for disability. RDO #18 stated to surveyors: The income was owed to us. RDO #18 reported to surveyors that the personal needs allowance was subtracted from the amount of money the Resident received and that approximately $2000.00 was placed in a Resident fund management service (RFMS) account for them. At this time, the surveyor requested to RDO #18 for them to provide billing statements for the Resident's care, RFMS account statements and documentation of it having been issued to the Resident, and the copy of the front and back of the check that the Resident had received for their back payment.On 02/25/2026 at approximately 2:13PM the surveyor was provided with Resident #4's Social Security Administration Retirement, Survivors, and Disability Insurance notice of award letter which documented information which included: You will receive $19,780.00 around October 8, 2025.On 02/25/2026 at approximately 2:13PM the surveyor was provided with a RFMS account statement which documented the date of opening of the account was 1/8/24 however, the statement documentation history provided began on the date of 11/19/25. At this time RDO #18 indicated that there was no other account statement history.Another interview was conducted by the survey team on 02/25/2026 at 2:21PM with RDO #18 who stated that the Resident was receiving an RFMS statement and reported that Medicaid had approved the Resident and the Resident did not have any income at that time and disability was not approved at that time, and that Medicaid was paying for the Resident's care based on zero income. The survey team again requested for RDO #18 to provide the billing statements for the Resident's care.On 02/25/2026 at 2:59PM the survey team conducted an interview of RDO #18 who reported to surveyors that Medicaid had paid in full, and when they do a sweep, they let Medicaid know they got it. RDO #18 confirmed the facility had Resident #4's money and reported to surveyors that Medicaid hadn't retrieved it back yet. RDO #18 stated: We let Medicaid know the money came. At this time, the surveyor requested for RDO #18 to again provide the outstanding requests for documentation and additionally to provide documentation regarding the facility's notification to Medicaid.On 02/25/26 all concerns were reviewed with the facility's RDO #18 and Director of Nursing during the facility's exit conference and the survey team noted that at the time of exit, no further outstanding documentation which was previously requested multiple times by the survey team had been provided by the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide written information regarding transfers to the hospital and discharge to; the resident and/or the resident's responsible party (RP), and the local Ombudsman. This was evident for 6 (# 94, # 181, # 179, # 12, #140, # 7) of 6 residents reviewed for transfer / discharge.The findings include: 1.On 2/18/26 at 2:45 PM a medical record review was conducted and upon review it was revealed Resident # 94 was transferred to the hospital on [DATE]. The resident has cognitive impairment and is not their own RP. At this time the survey team requested documentation of the written notification of the hospital transfer documentation and bed hold policy that was provided to the resident responsible party. The facility provided 2 documents to the survey team for Resident # 94. Review of the first page titled, Notice of Acute Emergent Discharge or Transfer Form had a listed reason for resident # 94 hospital transfer. There was no area on the form for resident and/or RP signature, and it was not signed by the RP. Review of the second page titled, Bed Hold, did not have the resident name listed, no payment amount, and in the space titled Patient signature, or RP signature, it was blank. At the bottom of the form there were two staff signatures with a date, however, no signatures were present by the RP that the document was offered. An interview was conducted with the Director of Nursing (DON) on 2/20/26 at 12:55 PM and she explained that the nurse is responsible for ensuring that the form is completed. The nurse then gets another person to sign the document. The DON confirmed that the facility was unable to provide documentation that the resident and/or the RP received a written copy of the document, and she also confirmed that the Ombudsman did not receive written notice of the transfer. All concerns were discussed with the Administration team at the exit conference on 2/25/26. 2.On 2/20/2026 at 11:00AM, a review of Resident #181's electronic medical record revealed that the resident was transferred to the hospital on 1/10/2026. On 2/20/2026 at 11:30AM, a review of Resident #179's electronic medical record revealed that the resident was discharged from the facility on 12/17/2025. On 2/20/2026 at 11:40AM, the Surveyor requested, from the Director of Nursing (DON), documentation of the notification of discharges and transfers sent to the local Ombudsman for December 2025 and January 2026. On 2/20/2026 at 1:06PM, the DON was unable to provide documentation to verify the local Ombudsman was notified of Resident #181's transfer to the hospital on 1/10/2026 and Resident #179's discharge from the facility on 12/17/2025. During an interview conducted with the DON, the Surveyor asked if the Social Work Department informs the Ombudsman, at least monthly, of the transfers and discharges from the facility. The DON stated that the Social Work Department does not send resident transfer/discharge notification to the local Ombudsman and was unable to verify any other department sent it. The Surveyor expressed the concern that the local Ombudsman does not (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive information regarding the transfers and discharges from the facility. 3. On 2/20/2026 at 11:33AM, during a review of Resident #12's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] and transferred to the hospital on 2/12/2026. On 2/20/2026 at 1:00PM, during an interview conducted with the DON, the Surveyor was informed that when a resident is transferred to the hospital, the following documents, but not limited to, should be sent with the resident: Change of Condition (if done) Face Sheet MOLST Physician Orders Labs Provider Note Bed hold Policy On 2/25/2026 at 12:20PM, a review of the Change in Condition/Concurrent Review evaluation, Section O Documents Sent to Provider, the following items must be sent with resident for receiving provider: Comprehensive Care Plans Face Sheet Current Medication List or Current MAR Change in Condition progress note (if completed) Advanced Directives Advance Care Orders (MOLST) Printed Vaccination Record Most recent History and Physical Recent Hospital Discharge Summary Relevant Lab Results (from last 1-3 months Relevant X-rays and other Diagnostic Test Results (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recent MD/NP/PA Progress Notes Transfer Form A further review of Resident #12's Change in Condition/Concurrent Review evaluation, Section O Documents Sent to Provider, failed to reveal comprehensive care plans, a current medication list or Current MAR (medication administration record), a printed vaccination record, most recent history and physical, and recent hospital discharge summary was sent with the resident. 4.Resident #140 was transferred to the hospital on 4/30/25. Review of the medical record did not reveal that the resident was provided with a written copy of the discharge or transfer documentation. The facility provided a copy of a discharge/transfer from which indicated that two personnel verified that a copy of the bed hold policy was offered to the resident. Review of the medical record revealed that Resident #140 is cognitively intact (BIMS score of 15). During an interview on 2/20/26, the resident stated that s/he never received and /or offered any form during the hospital transfer. 5.Resident #7 was transferred to the hospital on 1/14/26. Review of the medical record did not reveal that the resident's responsible party was provided with a written copy of the discharge or transfer documentation. The facility provided a copy of a discharge/transfer form, which indicated that two personnel verified that a copy of the bed hold policy was offered to the resident. Review of the medical record revealed that Resident #7 is not cognitively intact (BIMS score of 3, indicating severe cognitive impairment). During an interview on 2/20/26 at 3:00 PM, the Director of Nursing stated that the facility provides the discharge/transfer form to residents but was unable to explain why Resident #140 and Resident #7's responsible party were not provided with the form at the time of their hospital transfers.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview it was determined the facility failed to ensure resident minimum data set assessments were completed timely. This was evident for 2 out of 2 Residents (#34 and #17) reviewed for the Resident Assessment task during the facility's recertification survey.The findings include:1.) On 2/25/26 at 11:49AM the surveyor conducted an interview of Minimum Data Set Coordinator RN (MDSC-RN) #20 and reviewed Resident #34's minimum data set assessment record with them. MDSC-RN #20 reported to the surveyor during the interview that Resident #34's annual minimum data set assessment with an assessment reference date of 1/10/26 was completed, however, It is already late, we signed it on 2/10/26. During the interview, MDSC-RN #20 indicated that the assessment was to have been completed within fourteen days from the assessment reference date of 1/10/26 and additionally stated: We usually make sure it is completed, but I can't remember why we missed this one, it was not within the fourteen day timeframe. On 2/25/26 at 12:01PM MDSC-RN #20 reported to the survey team that the Resident's assessment had been both signed and submitted late. On 2/25/26 at 12:38PM the surveyor reviewed the medical record of Resident #34 and observed the minimum data set annual assessment with an assessment reference date of 1/10/26 with signatures on section Z0400 for administration of assessment by Regional Director of Clinical Services (RDCS) #25 dated 2/22/26 and signatures by MDSC-RN #20 dated 2/10/26. Section Z0500 was observed to have the signature of RDCS #25 under the area for signature of RN assessment coordinator verifying assessment completion with a date of 2/22/26. Concerns were again reviewed by the survey team with the facility's Regional Director of Operations #19 and Director of Nursing during the facility's exit conference on 2/25/26.2.)On 2/25/26 at 12:34PM the surveyor reviewed the medical record of Resident #17 and observed their minimum data set annual assessment with an assessment reference date of 1/23/26 with signatures on section Z0400 for administration of assessment by MDSC-RN #20 dated 2/20/26, Licensed Practical Nurse #26 dated 2/19/26. Section Z0500 was observed with the signature of MDSC-RN #20 under the area for signature of RN assessment coordinator verifying assessment completion with a date of 2/20/26. On 2/25/26 at 12:58PM the surveyor conducted an interview of Minimum Data Set Coordinator RN (MDSC-RN) #20 who reported to the surveyor that the timeframe for timely minimum data set assessment was fourteen days to complete and fourteen days to lock and submit the assessment from the date of the Resident's assessment reference date. On 2/25/26 at 1:06PM the surveyor conducted an interview of MDSC-RN #20 who reported that Resident #17's annual assessment reference date was 1/23/26 and should have been completed by 2/5/26 and should have been locked by 2/19/26, and stated to the survey team: signing is not locking, it was locked (submitted) on 2/24/26 which is late. Concerns were again reviewed by the survey team with the facility's Regional Director of Operations #19 and Director of Nursing during the facility's exit conference on 2/25/26.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and interviews with staff, it was determined that the facility failed to administer medication according to professional standards of practice. This was evident for 1 (Resident #126) out of 7 residents observed for medication administration during the annual recertification survey.The findings include: House Stock medications are a supply of commonly used non-prescription (OTC-over the counter) medications, not assigned to a specific resident. On 2/24/2026 at 9:30AM, the Surveyor observed Registered Nurse (RN) #24 preparing medications for Resident #126. RN #24 retrieved Vitamin B-1 100mg from a medication bottle with a pharmacy label with another resident's name on it. The Surveyor expressed the concern that Resident #126's name was not on the medication bottle and another resident's name was on the medication. RN #24 stated that the medication is a house stock medication and is the same medication, route of administration, and dosage that Resident #126 is ordered for. RN #24 stated they don't know why the pharmacy labeled the house stock medication bottle with a resident's name. On 2/24/2026 at 2:47PM, during an interview conducted with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), the Surveyor expressed the concern that RN #24 administered Resident #126's Vitamin B-1 100mg, considered a house stock medication, from a Vitamin B-1 100mg medication bottle with a pharmacy label with another resident's name on it. The ADON/IP informed the Surveyor that medications, including medications considered house stock, that are labeled for a specific resident must not be used as house stock for other residents. That means the medication was dispensed by the pharmacy for that specific resident. The ADON/IP acknowledged the Surveyor's concern and stated appropriate education will be provided to nursing staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to Ensure a resident had their wound dressing changed according to physician's order for 1 (#104) of 1 resident wound dressing observation, and to ensure medications were administered as ordered by the physician for 1 (#140) of 1 resident reviewed for medication administration. The findings were evident during the facility's annual Medicare/Medicaid survey.The findings include: 1.) This surveyor observed Resident #104's wound dressing on the resident's left leg on 2/18/26 at 2:20 PM. The dressing was dated 2/17/26 which told the observer that was when the dressing was put on the resident's leg. This surveyor observed on 2/20/26 at 2:50 PM the wound dressing being changed. The nurse (Staff #15) doing the wound dressing change showed this surveyor the dressing prior to removing the dressing and treating the leg. The old dressing that was being removed had a date of 2/17/26 on it. Staff #15 confirmed the date and that she was the one who put the dressing on the resident's leg on 2/17/26. The date indicated that the dressing had not been changed for six shifts over a two-day period. A review of Resident #104's clinical record revealed that the resident's primary physician wrote an order of the wound dressing to be changed every day during the day shift. It also revealed that there was an order for diabetic foot care checks. The nursing staff were ordered to check the feet and ankles of the resident. Staff signed off that they checked the feet and ankles. Any staff checking the foot and ankle would have seen the date on the dressing. The Director of Nursing (DON) was interviewed on 2/24/26 at 3:05 PM. The observation was explained to her. She said she understood that the dressing should have been changed according to the physician's order. She said she would investigate the observations. 2.) Review of the medical record on 2/20/26 for investigation of complaint #2641772, which alleged Resident #140 did not receive medications as ordered by the physician, revealed the following: On 2/20/26 at 11:00 a.m., review of the medical record revealed: Medications scheduled for 10/10/25: Oxybutynin Chloride Oral Tablet 5 mg by mouth for overactive bladder, scheduled for 8:00 a.m. Midodrine HCl Oral Tablet 5 mg by mouth for low blood pressure (Do not give after evening meal or within 4 hours of bedtime. Hold if systolic blood pressure greater than 130), scheduled for 8:00 a.m. Review of the Medication Administration Record (MAR) audit revealed both medications were not signed off as administered until 12:22 p.m., approximately four hours after the scheduled administration time. Tizanidine HCl Oral Tablet 4 mg, give 4 mg by mouth one time a day for muscle spasms, scheduled for 9:00 a.m. Review of the MAR audit revealed this medication was not signed off as administered until 12:20 p.m., approximately three hours after the scheduled administration time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications scheduled for 10/14/25: Eliquis (Apixaban) Oral Tablet 2.5 mg, give one tablet by mouth at 5:00 p.m. for atrial fibrillation. Review of the MAR audit revealed the medication was not signed off as administered until 8:22 p.m., more than three hours after the scheduled time. Oxybutynin Chloride Oral Tablet 5 mg and Midodrine HCl Oral Tablet 5 mg, scheduled for administration at 4:00 p.m. Review of the MAR audit revealed both medications were not signed off as administered until 8:21 p.m., more than four hours after the scheduled time. There was no documentation in the medical record to indicate the medications were held per physician order, refused by the resident, or delayed for a clinical reason. There was no documentation of physician notification regarding the delayed administration. During an interview with Staff #30 on 2/20/26 at 1:00 p.m., and during an interview with the Director of Nursing on 2/20/26 at 1:30 p.m., neither individual was able to provide a reason or documentation explaining why the medications were signed off as being administered late.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review and interviews with facility staff it was determined the facility failed to ensure that a resident was kept safe and free from accidents after observing the resident to be in distress. This was found to be evident for 1 (Resident #2) of 5 residents reviewed for accidents and observations made during the facility's annual Medicare/Medicaid survey.The findings include:Resident # 2 has the following but not limited diagnosis; Tracheostomy (opening in the neck leading to windpipe to help a person breathe), Epilepsy (convulsions) and Gastrostomy (opening through the stomach for insertion of a feeding tube). An interview was conducted with resident # 2 family member on 2/18/26 at 1:15PM and the family member stated that they were concerned about a fall that the resident had in March of last year and asked how this was possible considering the resident status. During a medical record review on 2/20/26 at 9:35AM of the change in condition/concurrent review form dated 3/5/25, it revealed the following summary regarding resident # 2: Around 8:45 AM nurse was administering patients' medication by gastrostomy tube. While in the room giving the medications, the patient noted with a strong cough reflex. Nurse went to the medication cart to check if the patient had any nebulizer medications due, and while outside of the patient's door a loud noise was heard in the patient's room. Upon the nurse's entrance into the patients' room, resident # 2 was noted with Barri bed bolsters (designed for fall prevention) and laying on the floor mat on left side. Resident # 2 was noted to have a laceration to left corner of eye, above left eyebrow and bruising to corner of left eye lid. Review of resident # 2 care plan on the same date revealed, resident is at risk for falls related to history of falls, poor safety awareness and strong cough reflexes. An interview was conducted with the DON and NHA on 2/20/26 at 9:55 AM and the DON was asked to explain the incident surrounding the resident fall. The DON confirmed that resident # 2 has a tracheostomy tube in place and at the time of the fall the resident was having a strong cough episode and or/cough reflex. She went on to say that the nurse, who is the current Assistant Director of Nursing (ADON) noted that the resident was in distress and coughing. She then went out to the medication cart to see if the resident was due to receive a nebulizer treatment to help with the cough. The DON stated that suctioning equipment is kept at the resident's bedside and that during this time the resident should not have been left unattended. The DON also confirmed that the resident care plan notes that the resident has a strong cough reflex and to ensure the resident's safety during this time. All concerns were discussed with Administration at the exit conference on 2/25/26.

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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 resident interview, staff interview, observation, and clinical record review it was determined that the facility failed to ensure a resident's pain management was adequately addressed. This was evident for 1 (#104) out of 1 resident being reviewed for wound care.The findings include:This surveyor observed Resident #104 having a wound dressing changed on 2/20/26 at 2:50 PM by a nurse (Staff #15). While the nurse was changing the resident's dressing, Resident #104 stated that he/she asked for some pain medication at 2:30 PM but did not get any before wound care started. Staff #15 interjected and said she was doing another resident's dressing change so she could not give him/her any pain medication before she started. She asked the resident if they were in pain and the resident replied that they are in pain all of the time. She said she would give him/her pain medication as soon as she finished. The resident said that was acceptable.A review of Resident #104's clinical record on 2/24/26 revealed that the primary physician ordered on 2/4/26 Oxycodone 15 mg by mouth every 4 hours as needed for pain 5-10 on a 1-10 scale. This surveyor interviewed the Director of Nursing (DON) on 2/24/26 at 3:05 PM. The findings were explained to the DON. She confirmed that the pain medication should have been administered prior to the would care. She said she would get back to the survey team with any needed follow up.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure a pain medication was administered according to the physician's order. This was evident for 1 (#104) out 1 resident reviewed for pain medication.The findings are:A review of Resident #104's clinical record on 2/24/26 revealed that the primary physician ordered on 2/4/26 Oxycodone 15 mg by mouth every 4 hours as needed for pain 5-10 on a 1-10 scale. A review of the Medication Administration Record revealed that: on 2/6/26 at 8:25 PM the resident's pain level was 4 but medication was administered, on 2/10/26 at 10:37 AM and 5:55 PM the resident's pain level was 4 but medication was administered, on 2/11/26 at 1:50 AM the resident's pain level was 4 but medication was administered, on 2/13/26 at 9:17 PM the resident's pain level was 4 but medication was administered, on 2/14/26 at 1:30 AM and 6:05 AM the resident's pain level was 4 but medication was administered, and on 2/15/26 at 4:33 PM and 8:55 PM the resident's pain level was 4 but medication was administered.Pain medication was administered when the pain level was 4, outside the parameters of the physicians order. The Director of Nursing (DON) was interviewed on 2/24/26 at 3:05 PM. She was informed of the findings and she agreed that the medication should not have been administered. She said she would talk to the nurses involved.

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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 clinical record review, observation, and staff interview, it was determined that the facility staff failed to ensure a resident received routine and follow-up dental care. This was evident for 2 residents (#9 and # 180) out of 2 residents reviewed for dental care during the facility's annual Medicare/Medicaid survey.The findings include:1.During the initial tour of the facility on 2/18/26 at 8:31 AM Resident #9 was observed to have few if any teeth. A review of the clinical record on 2/20/26 revealed that the resident has not had a dental consult in over a year. The resident was required to receive, but not limited to, an annual inspection of the mouth and jaw for signs of disease as well as a diagnosis of any dental disease. The Director of Nursing (DON) was interviewed on the morning of 2/24/26. This surveyor informed her of the finding and asked if she could provide evidence that the resident has either gone to the dentist or has had a dentist assess the resident at the facility. The DON was interviewed on 2/24/26 at 12:00 PM. She confirmed that she could not find a dental consult or examination in the clinical record. This surveyor asked when the last dental consult was. She replied that the resident has not been seen by a dentist and/or dental company since 2023. 2.On 2/24/2024 at 8:00AM, during a review of a complaint received concerning Resident #180, it was reported that the resident is missing teeth and cavities, and the facility was unable to provide information regarding when the resident received routine dental services since their admission in May 2024. During a review of Resident #180's electronic medical record on 2/24/2026 at 8:15AM, the Surveyor discovered that [Dental Company] attempted to see the resident on 8/20/2024; however, the resident was not in the room or hallways; a dental exam was completed on 9/17/2024, with notation of (Nv prophy-next visit prophylaxis or routine cleaning); a dental hygiene encounter was attempted on 10/17/2024; however, the resident could not be seen due to isolation, and a dental exam was completed on 10/31/2025, with notation of (Nv prophy-next visit prophylaxis or routine cleaning). Additional review failed to reveal documentation of a rescheduled dental hygiene encounter after the resident was unable to be seen on 10/17/2024's dental hygiene visit. Further review of Resident #180's electronic medical record revealed a change in condition nursing note dated 10/25/2025 which stated tooth came out, left upper molar, the resident spit the tooth out while talking. No bleeding or pain noted. The resident was ordered to be seen by dental services. On 2/25/2026 at 11:30AM, an interview with the Director of Nursing (DON) revealed the facility does provide dental services to residents. The DON stated that the [Dental Company] comes in monthly to see active residents. The facility can refer residents for dental services as needed. The Surveyor expressed the concern that Resident #180 was unable to be seen for a recommended dental hygiene appointment on 10/17/2024 and it was never rescheduled. The last dental visit was documented, 10/31/2025, after the left upper molar tooth fell out on 10/25/2025 and the resident was ordered to be seen by dental services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to maintain medical records in accordance with the accepted professional standards and practices for complete and accurate records. This was evident in 3 (#94, #97, #165) of the 51 residents' records reviewed. The findings include: 1) During observation rounds conducted on [DATE] at 1:46 PM Resident # 94 was observed and the resident complained to this surveyor of experiencing pain. The resident stated that pain has been ongoing for approximately two weeks. The nurse (Staff #23) who was at the nurse station at this time was made aware of the resident's pain concerns and assessed the resident. During medical record review on the same date, it was revealed the resident has an order for Morphine Sulfate Concentrate (give 0.25 ml(milliliter) every 4 hours PRN (as needed). Resident #94 received morphine on [DATE] at the following times: 0446, 0943, and 1429. There was no documentation on the medication administration record that the resident's pain level was being documented as assessed prior to each administration of the medication. During an interview with the DON on [DATE] at 1:30PM she was made aware that Resident # 94 complained of pain to the left side and that the pain was ongoing for two weeks. The DON was also made aware that the resident's pain level was not documented on the Medication Administration Record (MAR) at the time of administration of morphine. The DON stated that staff are expected to document the resident's pain score on the MAR when signing that the medication was administered and that education will be provided to staff. The DON also stated that the residents' current PRN orders will be reviewed. All concerns were discussed with the Administration team at the exit conference on [DATE]. 2.) On [DATE] at 10:02 AM Resident #97 reported to the surveyor that approximately 3-4 months ago Activities Director #14 took money from his/her account to buy them clothing and they did not receive any clothes. The surveyor conducted an interview of Activities Director (AD) #14 on [DATE] at 11:35 AM who reported to the surveyor that Resident #97 requested two pairs of jeans and one pair of sweat pants to be purchased and confirmed that they had purchased the items for the Resident and that the money came from their account, however, the Resident had accepted the items, but the jeans didn't fit and were returned and another order had been placed for two pairs of replacement jeans. AD #14 stated to the surveyor that s/he gave the two replacement pairs of jeans to Resident #97 and they had received them. AD #14 further reported to the surveyor during the interview that Resident #97 does understand his/her orders and such usually and also that s/he was not aware of the Resident's concern. On [DATE] at 12:12PM the surveyor reviewed Resident #97's medical record including the hard chart on the unit and only one inventory sheet was present and observed by this surveyor to be dated [DATE] and was not reflective of any clothing items having been received by Resident #97 since that date. On [DATE] at 12:13PM the surveyor reviewed Resident #97's funds account statement which revealed a purchase was made from a clothing company in the amount of $70.94 which was dated as posted on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the receipts provided by the facility to the surveyor on [DATE] at 12:47PM revealed that clothing purchases had been made for Resident #97 in October and November of 2025, however, no updated documentation of personal inventory was present to reflect the Resident's recent purchases. On [DATE] at 12:48PM the surveyor shared the concern with the facility's Administrator who acknowledged understanding of the concern. All concerns were reviewed during the facility's exit conference on [DATE] with the facility's Regional Director of Operations #18 and the Director of Nursing. 3.) MOLST is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. On [DATE] at 11:10AM, during a review of Resident #165's paper chart, the Surveyor discovered a completed MOLST form signed and dated [DATE] and another completed MOLST form signed and dated [DATE]. On [DATE] at 11:15AM, during an interview with Licensed Practical Nurse (LPN) #22, the Surveyor confirmed that Resident #165 had 2 MOLST forms within their Paper medical record. The Surveyor was informed that if there are multiple MOLST forms in a resident's chart, the most recent MOLST form should be used in the event of cardiac/pulmonary arrest. However, after a new MOLST form is completed by the physician, the old MOLST form should be voided by drawing a diagonal line through the form, writing void, and the date it was voided. Resident #165's MOLST form dated [DATE] should have been voided. LPN #22 stated they were going to take the MOLST forms to the unit manager to be reviewed and updated by voiding the MOLST dated [DATE]. On [DATE] at 12:05PM, during an interview with Unit Manager (UM) #21, the Surveyor informed the UM of their findings. UM #21 stated there should be 1 MOLST form in a resident's medical record for staff to refer to. If there is more than 1, the most recent MOLST form should be used in the event of a cardiac/pulmonary arrest. Resident #165's MOLST form dated [DATE] should have been voided. On [DATE] at 12:11PM, during a conversation with the Director of Nursing (DON) and the Regional [NAME] President of Operations (RVPO), the Surveyor expressed the concern that Resident #165 had a completed MOLST form signed and dated [DATE] and another completed MOLST form signed and dated [DATE]. The DON and the RVPO informed the Surveyor that after the Surveyor's findings, the facility was conducting audits of all residents MOLST forms within their medical records.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment for residents on 2 of 2 units observed (Somerset and Arcadia Memory Care). This had the potential to affect all residents residing on these units.The findings include: 1. Somerset Unit During observation rounds on 2/18/26 at approximately 9:00 a.m., the following concerns were identified: room [ROOM NUMBER]: Dirty clothing was observed on top of the resident's bedside table. The room had a strong odor resembling urine. The central supply cart on the unit was noted to have a large dark stain on the side. room [ROOM NUMBER]: Clothing was observed piled in the corner of the resident's room between both closets. The bathroom contained a dark yellow sticky substance and an odor resembling urine. room [ROOM NUMBER]: The dresser drawer was hanging off the track, and chipping wood was observed behind the resident's headboard. room [ROOM NUMBER]: A large amount of clothing was observed on top of the resident's bedside table. The room had an odor resembling urine. At approximately 9:30 a.m., Staff #21 observed the above findings with the surveyor and stated that housekeeping would be notified. 2. Arcadia Memory Care Unit During observation on 2/18/26 at approximately 10:30 a.m., the following concerns were identified: The hallway floors contained several dark black stains throughout. Several resident room entrances were noted to have a dark black substance on the floor at the doorway. The shower room door lock (interior side) had chipped wood, and the lock was broken. The toilet in the shower room was cracked at the base, and the floor surrounding the toilet was wet. The second shower room labeled Bath Hall contained a large bag of dirty clothing. Paper towels, masks, and toilet paper were observed scattered on the floor. Ceiling tiles throughout the unit contained a large brown substance. During an interview at approximately 11:00 a.m., Staff #30 stated that housekeeping and maintenance (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be notified of the concerns. Staff #30 toured the unit with the surveyor and verified the findings. 3. On 2/25/26 at 8:50AM the surveyor observed the glass door in the facility's main dining area with several elongated cracks present within the door's glass pane. On 2/25/26 at 12:50PM the surveyor conducted a dual observation of the concern and shared the concern with Food Service Manager (FSM) #12 who observed and acknowledged the concern at which time the surveyor conducted an interview of FSM #12 who reported that they would notify the maintenance department. On 2/25/26 concerns were reviewed during the facility's exit conference with the facility's Regional Director of Operations #18 and Director of Nursing.