| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215084 | A. Building<br>B. Wing | 02/09/2026 |

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| Patapsco Healthcare | 9109 Liberty Road<br>Randallstown, MD 21133 |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to ensure the care and services it delivers meet acceptable standards of quality, maintain documentation on how the facility obtains feedback, collects data, monitors adverse events, identifies areas for improvement, identifies improvement activities, implements corrective and preventative action, tracks performance, and conducts performance improvement projects. The was found to be evident by repeated citations from the previous annual survey and for QAPI review during the current annual survey.The findings include: According to the Centers of Medicare and Medicaid Services (CMS), QAPI stands for Quality Assurance and Performance Improvement, a systematic, data-driven, and proactive approach to maintaining and improving the safety and quality of care in nursing homes, as mandated by the Affordable Care Act. It combines Quality Assurance (QA), which sets and ensures standards for care, and Performance Improvement (PI), which involves continuously studying and improving processes to prevent problems and enhance services and quality of life for residents. The QAPI framework involves staff, residents, and families in identifying problems and implementing solutions through comprehensive programs and detailed plans. On 2/9/2026 at 4:15PM, the Surveyor reviewed the facility's most recent Quality Assurance Performance Improvement (QAPI) plan dated 10/12/2022. On 2/9/2026 at 4:30PM, a review of QAPI committee meeting documentation from 10/30/2025, 11/21/2025, 12/26/2025, and 1/29/2026, provided by the NHA, failed to reveal how data was obtained to identify areas of concern with facility systems, the process for identifying and correcting deficiencies, and how the facility used the data to track and trend those areas of concern for improvement, implement corrective actions, and evaluate effectiveness. The facility failed to establish goals for the next review period, prioritize quality deficiencies to develop a performance improvement project (PIP), and ensure progress toward correction or improvement is achieved and sustained. The facility failed to maintain meeting agendas, minutes, attendance records, and QAPI program progress reports for January 2025 through [DATE]. During an interview conducted with the Nursing Home Administrator (NHA) on 2/9/2026 at 4:40PM, the Surveyor was informed that the NHA was the QAPI Coordinator. The Surveyor was informed that the facility had been conducting continuous audits for the deficiencies the facility acquired during the last recertification survey. The Surveyor expressed the concern that the facility's action plan did not resolve the quality deficiencies identified during the last recertification survey and a review of the QAPI documents from 10/30/2025 through 1/29/2026 failed to identify how the facility tracked and trend areas of concerns and implemented corrective action during that time for improvement in those areas and how they evaluated for effectiveness. The Surveyor was informed that the QAPI committee reviews the basic concern areas such as falls, pressure ulcers, pain management, employee retention, and housekeeping; but, has no performance improvement projects that the facility has worked on since they began in May of 2025. The NHA acknowledged that the facility failed to maintain meeting agendas, minutes, attendance records, and QAPI program progress reports for January 2025 through [DATE]. |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with staff, it was determined that the facility failed to provide the residents with respect and dignity by failing to 1.) knock/ask permission to enter prior to entering the residents' rooms, evident for 5 resident rooms (#222, #221, #223, #224, # 227) out of 15 resident rooms observed on the Liberty Hall Unit; 2.) ensure dependent residents were clothed and out of bed to chair, evident for 3 (Resident #23, Resident #124, and Resident #74); 3.) ensure residents clothing was timely laundered, evident for 5 (Resident #61, Resident #87, Resident #53, Resident #2, and Resident #125); and 4.) maintain privacy and appropriate covering during care and transfers, evident for 2 (Resident #13 and Resident #63) out of 57 residents reviewed during the survey. The findings include:<br><br>1. On 2/2/2026 at 8:55AM through 9:13AM, the Surveyor observed Geriatric Nursing Assistant (GNA) #29 as they passed out breakfast trays on the Liberty Hall Unit. The Surveyor observed GNA #29 enter rooms #222, #221, #223, #224, and #227, without knocking or asking permission to enter prior to entering the residents' rooms.<br><br>On 2/2/2026 at 9:22AM, during an interview conducted with GNA #29, the Surveyor expressed the concern that as they passed out breakfast trays to rooms #222, #221, #223, #224, and #227, they did not knock or ask permission to enter before entering the residents' rooms. GNA #29 apologized for their actions.<br><br>During an interview conducted with Unit Manager (UM) #13 on 2/2/2026 at 11:25AM, the Surveyor expressed the concern with multiple observations of GNA #29 entering residents' rooms and failing to knock or request permission to enter prior to entering the residents' rooms. UM #13 acknowledged the Surveyor's concern and informed the Surveyor that staff will be educated on knocking and announcing themselves prior to entering resident rooms.<br><br>On 2/2/2026 at 11:36AM, the Nursing Home Administrator (NHA) was made aware of the Surveyors concerns.<br><br>2. On 2/2/2026 at 8:20AM the Surveyor observed Resident #23 laying in bed with a gown and an adult brief on. The resident stated that he/she used to have a Geri chair and a wheelchair in his/her room, but the staff took them out of the room. The resident stated that he/she was supposed to get out of the bed on Mondays, Wednesdays, and Friday; however, the staff have not gotten him/her out of the bed in over a week. An observation of the resident's closet/cabinet space revealed a couple pairs of unfolded clothes in a bag and random unhung, unfolded clothes scattered at the bottom of the closet/cabinet space with an open pack of adult briefs and other resident belongings. The resident was unsure if the clothing was clean or dirty.<br><br>On 2/2/2026 at 8:42AM, the Surveyor observed Resident #124 awake in bed with a gown on and covered with a blanket. The resident was aphasic (difficulty expressing words) with mild cognitive impairment. An observation of the resident's closet/cabinet space revealed a jacket on a hanger, a dark gray suitcase, and random unhung, unfolded clothing scattered at the bottom of the closet/cabinet space with other resident belongings. It was unclear if the clothing was clean or dirty based on the presentation.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/2/2026 at 8:50AM, the Surveyor observed Resident #74 awake in bed with a gown on and covered with a blanket. The resident was nonverbal with involuntary bodily movements and severe cognitive impairment. An observation of the resident's closet/cabinet space revealed random unhung, unfolded pants and shirts scattered at the bottom of the closet/cabinet space with other resident belongings. It was unclear if the clothing was clean or dirty based on the presentation.<br><br>On 2/3/2026 between 10:50AM and 11:00AM, the Surveyor observed Resident #23, Resident #124, and Resident #74 lying in bed with a gown on.<br><br>On 2/5/2026 between 12:45PM and 1:00PM, the Surveyor observed Resident #23, Resident #124, and Resident #74 lying in bed with a gown on.<br><br>On 2/5/2026 at 1:33PM during a review of Resident #23's electronic medical record, the Surveyor discovered an annual Minimum Data Set (MDS) assessment completed on 9/11/2025. Section F for Preferences and Customary Routine and Activities stated that it was very important for the resident to choose what clothes to wear. Further review revealed the resident was dependent on staff for activities of daily living (ADLs) and transfers.<br><br>On 2/5/2026 at 1:45PM during a review of Resident #74's electronic medical record, the Surveyor discovered an annual Minimum Data Set (MDS) assessment completed on 11/10/2025. Section F for Preferences and Customary Routine and Activities stated that it was very important for the resident to choose what clothes to wear. Further review revealed the resident was dependent on staff for activities of daily living (ADLs) and transfers.<br><br>On 2/5/2026 at 2:00PM, a review of Resident #124's electronic medical record revealed a care plan with a focus, [Resident #124] has an ADL self-care performance deficit [related to] impaired balance and limited mobility, with interventions which state The resident is totally dependent on 1 staff for dressing and The resident is totally dependent on 2 staff for transferring using mechanical lift.<br><br>During an interview conducted with the Director of Nursing (DON) on 2/9/2026 at 3:00PM, the Surveyor made the DON aware that Resident #23, Resident #74, and Resident #124 were observed, on multiple days and times during the survey, in bed with a gown on. The Surveyor informed the DON that Resident #23 stated that they had not been out of bed in over a week and was supposed to get up out of bed to a chair via mechanical lift on Mondays, Wednesdays, and Fridays; however, the staff took his/her chair out of the room and never replaced it. Resident #23 was not observed out of bed on those days. Also, Resident #23, Resident #74, and Resident #124 had random unhung, unfolded clothing in their closet/cabinet space and it was unclear if the clothing was clean or dirty based on its' presentation. The Surveyor expressed the concerns facility failed to ensure residents who are dependent on staff for ADLs and transfers get dressed for the day and get out of bed to chair. The DON informed the Surveyor that they would review the resident's medical record to determine a plan of care.<br><br>3. On 2/2/2026 between 8:20AM and 9:30AM, during a tour of the Liberty Hall unit, the Surveyor observed:<br><br>room [ROOM NUMBER], Resident #61 had a tall laundry basket full of dirty clothes. Resident #87 had a tall laundry basket full of dirty clothes with additional dirty clothes piled on top leaning against the wall.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #87 could not recall the last time his/her clothes had been washed.<br><br>room [ROOM NUMBER], Resident #53 had a large tote full of dirty clothes. Resident #2 had a tall laundry basket, next to the nightstand, full of dirty clothes.<br><br>On 2/3/2026 at 8:00AM, the Surveyor observed room [ROOM NUMBER], Resident #125 had a tall laundry basket full of dirty clothes with additional dirty clothes piled on top.<br><br>On 2/5/2026 at 12:50PM, during an interview with Resident #61, the Surveyor was informed that the washing machine had been broken for weeks and he/she just had his/her clothes washed. Any longer, and the resident would have to wear dirty clothes.<br><br>On 2/5/2026 at 12:53PM during an interview with Resident #53 and Resident #2, Resident #53 informed the Surveyor that the washing machine was broken for a while, but he/she had his/her clothes washed on 2/4/2025. Resident #53 stated that the facility usually washed his/her clothes on Tuesdays but came a day later this week. Resident #2 still had a full basket of dirty clothes. Resident #2 stated he/she would like to get dressed but did not have any clean clothes. During the interview, Geriatric Nursing Assistant (GNA) #29 came to the doorway. The Surveyor asked if they knew about the resident's laundry schedule because Resident #2 needed his/her clothes washed. GNA #29 was unsure and stated they would find out for the resident.<br><br>On 2/6/2026 at 11:30AM, during an interview with Environmental Service and Laundry Manager (EVSM) #23, the Surveyor was informed that a washing machine was down for the day on 1/27/2026. The washing machine was serviced that day and up and running by the evening. The Surveyor expressed the concern that multiple residents had laundry baskets full and even overfull of dirty laundry, leaving some without clean clothes to wear. EVSM #23 acknowledged the Surveyor's concern and stated that because of the broken washing machine on 1/27/2026, the laundry department had been playing catch up with washing the resident's dirty laundry. Each resident had a specific day, Monday-Friday, and shift, morning and evening, when the laundry aide goes to their rooms to collect the dirty laundry. Dirty laundry is bagged, washed, dried, and folded. Clean laundry is bagged and returned to the resident. Friday through Sunday, laundry is done by request only. According to the Personal Laundry Collection Schedule, Resident #61's, Resident #87's, Resident #53's, and Resident #2's collection day was Tuesday evenings, and Resident #125 was Tuesday morning. EVSM #23 stated that the department was working on getting back to the regular collection schedule and would ensure to provide staff education on collecting, washing, and returning resident's laundry timely.<br><br>4a. On 02/02/2026 at approximately 8:15 a.m., during observation rounds, Resident #63 was observed lying in bed in room [ROOM NUMBER] with his/her hospital gown positioned in a manner that exposed his/her adult brief (pull-up). The resident was not covered with a top sheet or blanket, and no top sheet was present on the bed at the time of observation. The resident's room door was open, and the resident was visible from the hallway, making it possible for staff and visitors walking past the room to view the resident in this exposed condition.<br><br>The surveyor proceeded down the hallway to locate the nurse or Geriatric Nursing Assistant (GNA) assigned to Resident #63. Upon reaching the nurses' station, GNA Staff #17 stated that the assigned nurse had just walked down the hall toward room [ROOM NUMBER].<br><br>The surveyor then spoke with Nurse #16, who stated he had just placed linen in the resident's room. The surveyor accompanied Nurse #16 back to room [ROOM NUMBER]. Upon entering the room,<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #63 remained in the same exposed condition, visible from the hallway, and still without a top sheet or covering. Clean linen had been placed on a chair inside the room; however, the resident had not been covered. After surveyor intervention, a top sheet was applied to cover Resident #63.<br><br>4b. On 02/09/2026 at approximately 2:00 p.m., Resident #13 was observed on Unit 1 being transferred from a Hoyer lift to the bed by two licensed nurses, LPN Staff #14 and RN Staff #15. During the transfer, the resident's room door was open to the hallway. The resident was positioned in the Hoyer lift with his/her brief exposed and visible to staff and visitors passing in the hallway. Both nurses were observed standing on the same side of the bed while raising and lowering the bed to adjust the mechanical lift. During the transfer, the resident repeatedly yelled, Please don't let me fall, and continued crying out throughout the transfer process.<br><br>On 02/09/2026 at approximately 2:30 p.m., the Director of Nursing (DON) confirmed that both staff observed were licensed nurses. The DON acknowledged that the resident's room door should have been closed during the transfer to maintain privacy and dignity and stated that education would be provided to both nurses regarding resident dignity.<br><br>On 02/09/2026 at approximately 2:45 p.m., Staff #14 and Staff #15 were interviewed and acknowledged that the residents' door should have been closed during the transfer to provide privacy and dignity. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>Based on observations and interviews with residents and facility staff it was determined the facility failed to accommodate residents by allowing residents to smoke at the designated facility times. This was found to be evident for all residents who smoked including 2 Residents (# 4 and # 121) of 25 residents reviewed for smoking during the facility's survey. The Findings include: A recertification survey was conducted at the facility between 2/2/2026 and 2/9/2026. During the survey resident interviews were conducted and resident observations were made as follows:1. Resident # 4 was interviewed on 2/2/26 at approximately 12:22 PM. The resident was asked the question regarding smoking, are you able to smoke when you want to and the resident replied, no. I have not been allowed to go outside to smoke for approximately two weeks. The resident went on to say that the facility has designated times in which they can go outside and smoke, but were being told that the temperature outside has been less than 32 degrees each day, which was a facility restriction, preventing residents from going outside during this time. The resident further stated that there was another time around Christmas Eve in which the elevator that goes down to the ground level was not working and residents on that level were not allowed to go outside and smoke for approximately one week. The resident expressed feelings like being trapped inside of the building.2. Resident # 121 was interviewed on 2/2/26 at approximately 3:25 PM and was asked the question, are you able to make choices regarding your care and/or interests while at the facility? The resident replied, I have not been allowed to go outside to smoke for a long time. The resident stated that the facility has a sign posted on the window next to the designated courtyard where the residents go out to smoke that states if the temperature is a certain degree the smoke breaks will be cancelled. The resident stated, I don't mind going outside to smoke when it is cold outside because I have a heavy coat and a hat, and besides, I have enough sense to come back in afterwards. Observations were made by the survey team on day 1 of the survey on 2/2/26, and on day 2 of the survey on 2/3/26 at each of the facility designated smoke times of: 9:00AM, 12:00PM and 3:00PM no residents were observed smoking outside in the designated area.During a follow-up interview with resident # 4 on the same date at approximately 3:30PM, the resident again expressed concerns about not being allowed to go outside and smoke. The resident told the two surveyors that it does not matter what the temperature is outside, s/he wants to be able to go outside to smoke. The resident stated that this is a violation of his/her right to be able to smoke when they want to.An interview was conducted with the Nursing Home Administrator (NHA) on 2/2/26 at approximately 3:40PM and he was asked to explain to the survey team why residents were not allowed to smoke. The NHA stated that it is the facility's policy to implement restrictions when the temperature is at a certain degree of 32 degrees or less. When asked by the survey team if residents have a right to make the decision to go outside and smoke at the facility designated times, he stated that the facility will continue to follow the facility's policy and not allow residents to smoke at the facility designated times. He stated that the Medical Director (MD) provided input into the smoking restriction policy.The policy was reviewed by the survey team and was as follows:Smoke Break and Cigarette Policy. Winter Smoke Break policy 1/8/26 posted:9:00AM smoke break will occur as scheduled unless otherwise cancelled.For 12:00PM, 3:00PM, and 6:00PM, smoke breaks, an activities team member will check the temperature 15 minutes prior.If the temperature is 32 degrees or below, the smoke break will be cancelled due to extreme cold. A phone interview was conducted with the facility's Medical Director (MD # 7) on 2/4/26 at 2:06 PM and he was asked if he provided input into the facility's smoking restrictions that were implemented by the facility due to cold weather. The MD #7 stated that he has no recollection of any input regarding restrictions. He went on to say that if a resident is alert and oriented and has appropriate attire, the resident can go outside and smoke. It is the resident right to do so. He went on to say that if a resident does not have appropriate attire to wear outside to smoke, a care plan should<br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | be created.During follow-up visits with Resident #4 and Resident #121, on 2/4/26 and 2/5/26 they both stated that they were not allowed to smoke at the designated smoke time of 6:00PM on 2/2/26, and 2/3/26. They both confirmed that the facility provided inconsistent smoking times to residents beginning on 2/4/26 and they were not consistent at the facility designated smoke times.All concerns were discussed with the Administration team at the exit conference on 2/9/26. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review it was determined the facility failed to ensure the monitoring and oversight of food temperatures in accordance with professional standards for food service safety, failed to ensure sanitary practices were followed in accordance with professional standards for food service safety, failed to ensure food and food equipment was stored in accordance with professional standards for food service safety, failed to ensure thorough environmental cleaning and a sanitary environment of the kitchen, failed to ensure monitoring and oversight of kitchen equipment and environment, and failed to ensure kitchen wall paint was in good repair to prevent potential for contamination of food and food contact surfaces. This was evident during surveyor review of the kitchen task during the facility's recertification survey. The findings include:During the surveyor's initial tour of the facility's kitchen on 2/2/26 at 8:13AM the surveyor conducted an interview with Certified Dietary Manager #11 who confirmed that the dishwasher was used and was used in hot water mode. At this time the surveyor requested for CDM #11 to perform a dual observation of the kitchen. On 2/2/26 at 8:14AM the surveyor observed dishwashing area with multiple areas of pooling water present on the floor.On 2/2/26 at 8:14AM the surveyor observed a lower portion of the wall located behind the dishwasher with a thick black coating of debris present and an area of flooring near to this with a brown appearance.On 2/2/26 at 8:14AM the surveyor observed a layer of black and brown debris present on the wall above and below the dirty side of the dishwashing area extending several feet in width. On 2/2/26 at 8:14AM the surveyor observed black speckled areas of debris present along the corners where the ceiling met the walls. On 2/2/26 at 8:15AM the surveyor observed the side of the dishwashing conveyor where clean dishes exit the conveyor. On this side of the dishwashing area, dish racks were observed sitting directly on the floor's surface which was observed to be dirty in appearance with dark areas of debris present with one dish rack observed to be chipped and extensively worn in appearance. Several black dish buckets were observed sitting below the conveyor area observed to have a white film present on them sitting next to a disposable plastic lid. On 2/2/26 at 8:15AM the surveyor observed an area of pooling water present underneath and directly in front of the conveyor dishwasher on the floor with a brown and yellow film present with debris.On 2/2/26 at 8:15AM the surveyor observed a disposable glove sitting on top of an area of white debris located on top of the the facility's dishwasher.On 2/2/26 at 8:15AM the surveyor observed a layer of grey debris with a fuzzy appearance sitting on the lines which extended from the top of the dishwasher over to the area above where clean dishes exited the conveyor dishwasher.On 2/2/26 at 8:16AM the surveyor observed a cooking pot with a severely worn appearance with a dark area present on the inside of the pot.On 2/2/26 at 8:17AM the surveyor observed the hand washing sink area in the dish room which contained a broom, dustpans, a trash container lid, and a mobile cleaning bucket with a mop sitting in front of it which was extensively dirty with dark grey debris present on it. The flooring surrounding the hand washing sink area in the dish room was observed to have an extensive layer of dark debris present. The handwashing sink was observed to have a pooling of dark liquid within it and the sink surfaces were observed to have brown, black, and white debris present. On 2/2/26 at 8:20AM the surveyor observed an electric fan present in the dish room with an extensive layer of grey matter present on and within it. On 2/2/26 at 8:20AM the surveyor observed a cloth rag which was wrapped around a wall fixture in the kitchen which appeared to have wiring present extending from it.On 2/2/26 at 8:21AM the surveyor observed an extensive layer of dark debris present around and behind the floor drain and on the wall behind the three compartment sink. On 2/2/26 at 8:22AM the surveyor observed various cookware, serving ware, and food storage ware including a coffee pot drink and food storage containers and container lids with various crumbs and debris present on the surfaces. An area on the wall directly behind the rack which held the wares was observed to have various crumbs and debris present on the surface. On 2/2/26 at<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8:23AM the surveyor observed a cart located near to the food serving and cook line which held food plates and pellets which had a broken plastic clipboard sticking out from in between a stack of pellets on top of it and food plates beneath it. The food plates, clipboard surface, and cart surface in which the plates and items were sitting on were observed to have various debris present. A sleeve of unopened condiment containers and a stack of uncovered condiment containers were observed to have speckled debris present on their surfaces. After surveyor intervention, the surveyor observed CDM #11 obtain a rolling cart and they began removing the unclean items and placed them onto the cart to be cleaned. On 2/2/26 at 8:29AM the surveyor observed a damaged and missing area of plastic wall in refrigerator curtain.On 2/2/26 at 8:30AM the surveyor observed a food slicing prep table with a lower level shelf observed with an unclean appearance with food crumbs present. On 2/2/26 at 8:30AM the surveyor observed the walk in freezer floor surface located approximately 2 inches beneath packaged hot dog rolls and other packaged bread items. Various pieces of beverage ice was present on the floor's surface and various dark matter and debris was observed to be present with a bottle of water and two small containers of frozen dessert on the floor. On 2/2/26 at 8:31AM the surveyor observed the kitchen trash can with no lid which was nearly full of trash sitting directly next to the bread rack which was holding packaged bread. The corner wall adjacent to both the rack holding packaged bread, and the trash can was observed to have various splattering and food debris present on the wall's surface. Peeling paint was observed on the corner wall's surface. On 2/2/26 at 8:33AM the surveyor observed the microwave located within the kitchen with instructions of how to use it posted on it, which upon further inspection, was noted to not be a commercial grade microwave. At this time the surveyor conducted an interview and inquired to CDM #11 as to if the microwave was a commercial grade, at which time CDM #11 was observed turning the microwave around to observe the labeling on it and confirmed with the surveyor that the microwave was not commercial grade. CDM #11 confirmed with the surveyor that the microwave was used for re-heating of Resident food. All concerns were shared with CDM #11 who acknowledged understanding of the concerns. On 2/2/26 at 8:52AM the surveyor observed the ice cooler cart located on the Liberty Unit dining area with one ice scooper in which the handle was sitting in a pool of water within the ice scoop holder container. On 2/2/26 at12:27PM after surveyor intervention, CDM #11 approached the survey team and stated: We cleaned up and got all dusty areas and ran everything through the dish machine, the dish room is in better shape, you can come take a look. On 2/6/26 at 12:35PM the surveyor entered the facility's kitchen and observed [NAME] #32 on the tray line plating food with no hair net on and Dietary Aide #31 assembling food trays with no hair net on. CDM #11 was observed to be present and assisting with the food service line and at this time, the surveyor informed CDM #11 of the concerns at which time they acknowledged the concerns and stated: I will re-educate and in-service, and the tray line was observed by the surveyor to continue. This surveyor then further inquired as to what actions they planned to take to ensure food service safety at this time, to which CDM #11 responded, I'll have her put it on. After surveyor intervention, [NAME] #32 and Dietary Aide #31 obtained and put on a hair net. On 2/6/26 at 12:39PM after surveyor intervention, CDM #11 informed the surveyor that the cloth had been removed from the horn, extensive cleaning had taken place in the dish room, and they had plumbers coming to replace the plumbing to the dishwasher, however, they had to wait on a plumbing part. On 2/6/26 at approximately 12:47PM the surveyor observed a stack of dishes being used to plate food was out of the heat warmer equipment and was sitting on the tray line food area and utilized for Resident meal trays. Additionally, the surveyor observed milk and other beverages on a cart near the food line in a deep clear plastic container in which there was a low level of ice within it. On 2/6/26 at 1:01PM the surveyor observed the last food cart leaving the kitchen to be distributed to Residents on the Ground floor for the lunch meal service. At this time, CDM #11 confirmed with the surveyor that this was the last food cart for lunch service.On 2/6/26 at 1:14PM the surveyor observed the plastic lid covers to the Resident meals within the food cart to be loose fitting and sliding off. On 2/6/26 at 1:27PM the surveyor confirmed with nursing staff that all Residents had been (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | provided their meals, at which time a Resident refused their meal and their meal tray was immediately tested for temperature with CDM #11. Breaded fish patty was found to have a temperature of 123F and an assorted vegetable medley was found to have a temperature of 119F. On 2/6/26 at 1:33PM the surveyor conducted temperature testing of a carton of milk which was on the tray line in the kitchen with CDM #11 which was found to have a temperature of 53F. Subsequently, the surveyor tested an additional carton of milk from within the walk in refrigerator with CDM #11, at which time the temperature was found to be 42F. At this time the surveyor conducted an interview of CDM #11 who stated the following information: Milk should be 40F or below, food should be 135-140F leaving the food line, and about 135F the Residents should receive it.On 2/6/26 at 2:02PM the surveyor conducted an interview and shared concerns with the facility's Administrator who stated to the survey team: I'm embarrassed because we did so much education with staff. The facility Administrator further reported during the interview that they took this surveyor's concerns seriously and ordered the parts for the dishwasher plumbing, however, they would not arrive soon. At this time the surveyor offered an opportunity for all documentation they wished to provide to be provided for surveyor review.On 2/9/26 at 8:27AM the facility Administrator provided documentation of education performed beginning on 2/7/26 with dietary staff regarding sanitation, cleanliness, and food temperatures in response to the previously shared surveyor concerns. On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure: 1. & 2 .) medical record documentation from outside consult providers was present within the medical record. This was evident for: 1.) 1 out of 1 Resident (#55) reviewed for urinary catheter and 2.) 1 out of 1 Resident reviewed for Neglect (#134) and during the surveyor's review of Complaint #2694340 during the facility's recertification survey.The findings include: Based on observation, interview and record review and review of Complaint #2694340 it was determined the facility failed to: 1) maintain medical records in accordance with accepted professional standards and practices. This was evident for 7 (Resident #5, #23, #7, #99, #115, #61, and #125) out of 57 residents reviewed; 2) ensure that a hospital transfer form document contained current and accurate documentation. This was found to be evident for 1 (Resident # 11) of 3 residents reviewed for hospitalizations; 3) ensure medical record documentation from outside consult providers was present within the medical record. This was evident for 1 out of 1 Resident (#55) reviewed for urinary catheter and 1 out of 1 Resident reviewed for Neglect (#134) during the facility's annual survey.<br><br>The findings include:<br><br>1. On [DATE] at 2:00PM, a review of the facility's Smoker's List as of [DATE] revealed that Residents #99, #115, #61, and #125 were independent smokers. The facility completed Safe Smoker Assessment quarterly and as needed for Resident's who are smokers.<br><br>On [DATE] at 8:10AM, during a review of Resident #99's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] and was a smoker prior to admission. A smoking contract was completed on admission. Further review failed to reveal a Safe Smoker Assessment completed at the time of admission.<br><br>On [DATE] at 8:27AM, during a review of Resident #115's electronic medical record, the Surveyor discovered that the facility failed to complete a quarterly Engage Safe Smoker Assessment between the assessment on [DATE] and [DATE].<br><br>On [DATE] at 9:10AM, during a review of Resident #61's electronic medical record, the Surveyor discovered that the facility failed to complete a quarterly Engage Safe Smoker Assessment between [DATE] and [DATE], and [DATE] and [DATE].<br><br>On [DATE] at 9:35AM, during a review of Resident #125's electronic medical record, the Surveyor discovered that the facility failed to complete quarterly Engage Safe Smoker Assessments between [DATE] and [DATE].<br><br>During an interview conducted with the Director of Nursing on [DATE] at 10:00AM, the Surveyor expressed the concern that Resident #99, #115, #61, and #125 were identified as independent smokers according to the facility's smokers list and had missing quarterly Engage Safe Smoker Assessments. The DON confirmed that Safe Smoking Assessments should be completed quarterly and as needed for residents who smoke.<br><br>2. On [DATE] at 1:31PM, during a review of Resident #5's electronic medical record, the Surveyor discovered the resident had a history of falls. A review of the residents Fall Risk Evaluation<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | completed on [DATE], indicated the resident was a low fall risk with a score of 3; however, the fall assessment was incomplete and failed to include medications used and gait analysis. A review of a Fall Risk Evaluation completed on [DATE], indicated the resident was a low fall risk with a score of 4; however, the fall assessment was incomplete and failed to include all medications used and gait analysis. A review of a Fall Risk Evaluation completed on [DATE], indicated the resident was a low fall risk with a score of 5; however, the fall assessment was incomplete and did not include medications used and gait analysis.<br><br>3. Maryland Medical Orders for Life-Sustaining Treatment (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.<br><br>Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. Full code.<br><br>Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed.<br><br>On [DATE] at 10:20AM, during a review of Resident #5's paper chart, the Surveyor discovered a MOLST form dated [DATE]. According to the MOLST form, within Option A, prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. Option A-2, Do Not Intubate (DNI) was selected. Further review revealed another MOLST form dated [DATE]. According to this MOLST form, attempt CPR was selected.<br><br>On [DATE] at 11:00AM, a review of Resident #5's electronic medical record revealed an active physician's order for full code and an uploaded copy of the MOLST dated [DATE] which stated to attempt CPR.<br><br>On [DATE] at 11:50PM, during an interview conducted with Unit Manager (UM)#13, the Surveyor confirmed that Resident #5 had a MOLST form dated [DATE] indicating DNI and a MOLST form dated [DATE] indicating attempt CPR within the resident's paper chart. During a review of Resident #5's electronic medical record, UM #13 and the Surveyor confirmed that the resident had a physician's order for full code and an uploaded copy of the MOLST form dated [DATE] indicating full code. The Surveyor asked the UM #13 to confirm the resident's code status. UM #13 stated they would review the resident's medical record and the physician for clarification.<br><br>On [DATE] at 12:49PM, the Surveyor informed the Director of Nursing (DON) and the Regional Director of Clinical Operations of their findings in Resident #5's paper and electronic medical record. The DON stated that the resident was a DNI code status and that Full code was documented in the resident medical record in error. The Surveyor asked the DON to verify the code status with the resident/resident representative and the physician to ensure the correct code status was placed in the medical record.<br><br>On [DATE] at 3:00PM, a review of Resident #5's electronic medical record revealed a new physician order for DNI. The DON confirmed the resident code status with the physician who completed the MOLST dated [DATE] indicating DNI code status.<br><br>On [DATE] at 2:50PM, the DON provided the Surveyor with a copy of the Medical Provider Visit note<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | where the resident's code status was reviewed with the resident and the resident representative.<br><br>On [DATE] at 11:00AM, during a review of Resident #5's electronic medical record, the Surveyor reviewed the Engage Care Conference Meeting dated [DATE] which documented the resident as a Full Code. A review of the Dialysis Services Communication Forms reviewed from [DATE] through [DATE] revealed that the nursing staff did not complete, in full, the Pre-Treatment Report/SNF Nurse section on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review of [Dialysis Company] SNF Dialysis Service Communication Forms, the Pre-Treatment Report/SNF Nurse section to be completed by nursing staff, on [DATE],[DATE], and [DATE] the code status checked was Full Code and on [DATE], [DATE], and on [DATE] the code status was DNI.<br><br>On [DATE] at 9:00AM, during an interview conducted with the DON, the Surveyor expressed the concern that due to inaccurate documentation of Resident #5's code status in the medical record, the Resident's code status was inaccurately documented on a care conference meeting note on [DATE] and in the Pre-Treatment Report/SNF Nurse section of the Dialysis Services Communication Forms from [DATE] through [DATE]. The Surveyor also expressed the concern that the Dialysis Services Communication Forms were not completed in full by nursing staff. The DON stated that they would review the resident's medical record and provide staff education for completing the Pre-Treatment Report/SNF Nurse section of the Dialysis Services Communication Form prior to the resident going to dialysis.<br><br>4. Physician certification of incapacity requires written documentation. Personal examination-based evaluation determines a resident's decision-making capacity due to physical or mental health issues and requires 2 qualified professionals, often the attending physician and a second physician.<br><br>On [DATE] at 10:30AM, during paper chart review on the Liberty Hall Unit, the Surveyor discovered Resident #23 had Physician Certifications completed on [DATE], [DATE], and [DATE] determining the resident lacks adequate decision-making capacity (including decisions about life sustaining treatments) with only one physician signature.<br><br>During continued paper chart review, the Surveyor discovered Resident #7 had a Physician Certification completed on [DATE] determining the resident lacks adequate decision-making capacity (including decisions about life sustaining treatments) with only one physician signature.<br><br>On [DATE] at 1:00PM, during an interview with the DON on the Liberty Hall Unit, the Surveyor expressed the concern that Resident #23 had Physician Certifications completed on [DATE], [DATE], and [DATE] with only one physician signature and Resident #7 had a Physician Certification completed on [DATE] with only one physician signature. The DON and the Surveyor reviewed the documentation, and the DON confirmed the Surveyor's findings. The DON stated that the facility will ensure the physicians address the residents' Physician Certifications and the staff will be completing audits for Physician Certification.<br><br>5. On [DATE] at 12:42PM, during an interview with Resident #23, the resident informed the Surveyor people are taking my belongings. The resident stated that he/she had some long sleeve shirts and pants that were missing. The resident could not give further description of the missing clothing.<br><br>On [DATE] at 8:40AM, a review of Resident #23's electronic medical record failed to reveal documentation of personal property.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 10:30AM, a paper chart review failed to reveal documentation of personal property.<br><br>On [DATE] at 1:34PM, during an interview with the DON, the Surveyor was informed that resident belongings should be documented on a personal belongings form during admission and updated when the resident gets new belongings. The form should be filed in the resident's medical record. The Surveyor expressed the concern that Resident #23 stated that people were taking their belongings and a review of the resident's medical record failed to reveal documentation of personal property to determine what he/she could be missing. The DON stated that they would review the resident's medical record and ensure that the resident has a completed personal belongings form.<br><br>6. On [DATE] at 8:55AM the surveyor conducted a review of Resident #55's electronic medical record at which time no urology specialist provider documentation could be found.<br><br>On [DATE] at 9:15AM the surveyor conducted a review of Resident #55's hard chart medical record at which time no urology specialist provider documentation could be found.<br><br>On [DATE] at 9:16AM the surveyor conducted a dual observation of Resident #55's hard chart and conducted an interview with Unit Manager, LPN #13 who confirmed there was no urology consult documentation present. At this time, the surveyor requested for Unit Manager, LPN #13 to provide urology documentation to the surveyor.<br><br>On [DATE] at 9:35AM the surveyor observed documentation in the medical record by facility staff regarding Resident #55 having attended and also having refused urology visits, however, no urology specialist provider documentation could be found.<br><br>On [DATE] at 10:25AM the surveyor conducted an interview with the facility's Director of Nursing who provided documentation of a urology visit and reported that they had obtained the documentation today from urology, because they could not find any in the medical record.<br><br>On [DATE] at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing.<br><br>7. On [DATE] at 9:21AM the surveyor conducted an interview of the facility's Director of Nursing (DON) who stated the following information when the surveyor inquired as to if Resident #134 had a foley catheter: Oh absolutely, s/he had a long term catheter.<br><br>On [DATE] at 9:46AM the surveyor began requesting documentation relating to Resident #134's medical care from the facility's Administrator.<br><br>On [DATE] at 12:20PM the surveyor conducted an interview with the facility's DON who stated that they were unable to provide a Nurse Practitioner's visit note because they had to reach out to obtain them. This surveyor requested to the DON to observe the complete hard copy of Resident #134's medical record and be provided access to the Resident's complete medical record, at which time access to the paper medical records was not provided by the facility's Director of Nursing who stated they would have to bring them to the surveyor.<br><br>On [DATE] at 1:22PM the surveyor reviewed the medical record of Resident #134 at which time no urology specialist provider documentation could be found.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 1:49PM the surveyor requested to the facility's Director of Nursing to provide Resident #134's urology consult documentation from [DATE] forward.<br><br>On [DATE] at 8:35AM the surveyor conducted an interview of the facility's Director of Nursing at which time they reported they had asked for all of the Resident's urology consults and had requested the Resident's entire medical record from the outside provider and that it would take more than three days to receive it. At this time, the facility's Director of Nursing stated to the survey team: I can't confirm or deny whether the facility has the urology records at this time. At this time, the surveyor additionally noted that the Director of Nursing had not provided the urology documentation previously requested by the surveyor on [DATE]. At this time, the surveyor provided another opportunity for the medical record to be reviewed by the DON and facility staff to provide a clear response to the survey team as to if the urology consult documentation was or was not present within the facility's medical record of the Resident.<br><br>On [DATE] at 10:11AM the facility's Director of Nursing provided one urology consult provider note with a date of encounter on [DATE] which was dated with the following information at the top: 02-05-2026 11:22AM along with fax information.<br><br>On [DATE] at 11:16AM approximately six more urology consult notes were provided to the surveyor which were dated Feb. 6 2026 along with fax information.<br><br>On [DATE] at 8:41AM the surveyor conducted an interview with the facility's DON who reported to the survey team that they were not aware that the urology consult information was not on the Resident's chart, and confirmed that the surveyor was correct that the documentation was not present in the Resident's medical record and confirmed with the surveyor that after surveyor intervention, they then requested the Resident's medical documentation. During the interview, both the DON and Regional Clinical Director of Operations acknowledged and confirmed that the urology consults were not present within the Resident's medical record.<br><br>On [DATE] at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing.<br><br>8. A medical record review was conducted on [DATE] at 1:21 PM for Resident # 11. The review revealed that on [DATE] the resident made a 911 call indicating that s/he wanted to go to the hospital. The resident went to the hospital.<br><br>Further review reveals the resident was evaluated on [DATE] for concerns of difficulty breathing. The resident was sent to the hospital for further evaluation. The survey team requested documentation of the resident hospital transfer forms.<br><br>The DON stated that the resident did not have a transfer form for [DATE] because the resident dialed 911. At this time the DON provided the survey team with a hospital transfer form and upon review, it revealed the following varying documentation. The date of the transfer to hospital was [DATE] 02:02. The date the specified hospital was notified was [DATE] 03:20. The other side of the hospital transfer form had clinical information such as vital signs with dates of [DATE]. The DON was asked to explain why the hospital transfer form had a transfer date of [DATE] and clinical information dated [DATE] and she was unable to explain the varying documentation. When asked how she ensures that accurate information is provided on the transfer form she confirmed that the information should have been reviewed to ensure that it is accurate and reflects the resident's status.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | All concerns were discussed with the Administration team at the exit conference. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on record review and interview with staff, it was determined that the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) meetings had the required committee members in attendance and conducted meeting at least quarterly. This was found to be evident for 1 out of 2 quarterly committee attendance sheets reviewed during the survey and due to no documentation made available for 3 out of 4 quarterly meetings in 2025. The findings include: During a review of the QAPI attendance sheets conducted on 2/9/2026 at 4:30PM, the Surveyor discovered that the facility had documented QAPI meetings on 10/30/2025 (quarterly), 11/21/2025, 12/26/2025, and 1/29/2026 (quarterly). A review of the quarterly committee attendance sheet for January 29,2026 revealed that the Medical Director or his/her designee did not attend the meeting. Further review failed to reveal documentation of QAPI meetings held from January 2025 through September 2025. During an interview conducted with the Nursing Home Administrator (NHA) on 2/9/2026 at 4:40PM, the Surveyor was informed that the NHA oversaw the QAPI program. The Surveyor expressed the concern that the facility failed to provide documentation that the QAPI committee meets at least quarterly and the Medical Director did not attend the last quarterly meeting on January 29, 2026. The NHA informed the Surveyor that the goal for the facility is to meet on a monthly basis and facilitate quarterly meetings which include a representative from all disciplines and departments within the facility, which includes, but not limited to, the Medical Director, Infection Preventionist, Director of Nursing, and the NHA. Going forward, the NHA would ensure the required QAPI committee members attend quarterly meetings. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff it was determined the facility failed to ensure the facility environment was kept safe, clean, comfortable, and homelike. This was found to be evident of 4 (Resident # 4, # 41, 31 and # 121) of 40 residents observed and 2 out of 2 ceiling vents observed during the facility's survey.<br><br>The findings include:<br><br>During observation rounds conducted during the survey, the following concerns were identified:<br><br>1. Resident # 4's room was observed on 2/2/26 at approximately 8:35 AM and a pile of clothes and personal belongings were piled in the corner and extending along the wall and walk space near the resident bed.<br><br>2. Resident #41's room was observed on 2/2/26 at approximately 8:40AM and there was an oversized TV on top of the dresser leaning back against the wall. There were no legs observed underneath the TV to stabilize the TV to keep it from falling.<br><br>3. Resident # 31's room was observed on 2/2/26 at approximately 8:45AM and inside of the bathroom there was an open area and bubbling noted on the ceiling tile that needed repair.<br><br>4. Resident #121's room was observed on 2/4/26 with clothes on top of another bed in his/her room. The resident stated that s/he would like to have a place to put all personal belongings.<br><br>During an interview with the NHA on 2/4/26 stated to the survey team that an audit would be conducted of the residents' rooms and plastic bins would be provided for the residents. The NHA provided the survey team with a copy of the audit results.<br><br>A tour was conducted with the maintenance Director on 2/6/26 at approximately 11:55AM and he was shown the concerns regarding Resident # 4's TV and stated that he would fix the TV to prevent any hazards and stated that repairs were made to Resident # 31's room ceiling tile.<br><br>All concerns were discussed with the Administration team at the exit conference on 2/9/26.<br><br>5a. On 2/6/26 at 1:10PM during the food tray pass, the surveyor observed a ceiling vent located on the ground floor hallway outside of room [ROOM NUMBER] with oscillating components that when observed in the open position, had copious amounts of dark matter present within, and grey matter was observed on the outer vent cover and also within and beyond the vent's cover.<br><br>On 2/6/26 at 1:11PM the surveyor conducted a dual observation of the concern with Certified Dietary Manager (CDM) #11 who observed and acknowledged the surveyor's concern and regarding the grey matter within the vent cover, CDM #11 additionally stated: That's probably a filter that needs changed.<br><br>5b. On 2/6/26 at 1:13PM during the food tray pass, the surveyor observed a ceiling vent located on the ground floor hallway near room [ROOM NUMBER] with oscillating components that when (continued on next page) |

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| | 215084 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Patapsco Healthcare | 9109 Liberty Road<br>Randallstown, MD 21133 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | observed in the open position, had dark matter present within, and grey matter was observed on the outer vent cover and also within and beyond the vent's cover. During the surveyor's observation, CDM #11 observed and acknowledged the surveyor's concern.<br><br>On 2/6/26 at 2:02PM the surveyor shared the concern with the facility's Administrator.<br><br>On 2/6/26 at 3:30PM the surveyor shared concerns with the facility's Regional Director of Clinical Operations #3 who stated to the survey team: Okay I'll let maintenance know.<br><br>On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on review of record review, interview, it was determined the facility failed to ensure facility Residents were free from abuse. This was evident for 1 out of 1 facility reported incident (#2728128) reviewed by the surveyor during the facility's recertification survey.The findings include:On 2/4/26 at 9:30AM in response to the surveyor's request to the facility Administrator to provide the complete investigative file and all documentation relating to Facility Reported Incident #2728128, the surveyor was provided with the complete investigative file. At this time, the surveyor conducted an interview with the facility Administrator who confirmed with the survey team that the file being provided was the facility's complete investigative file. On 2/4/26 at 9:42AM the surveyor reviewed the facility's complete investigative file for Facility Reported Incident #2728128 which revealed an initial self report made to the Office of Health Care Quality by the facility's Administrator dated 1/27/26 in which the allegation type was documented as sexual and additionally documented under the suspected crime section: allegation of physical abuse. Further review of the initial self report revealed that Resident #86 was documented as an alleged victim and Resident #69 was documented as an alleged perpetrator. Continued review of the facility's initial self report form revealed the following documented allegation details: On 1/27/26 at approximately 5:15PM, the evening shift supervisor informed the DON (Director of Nursing) that Resident (#69) was observed touching male employees and Resident (#86) inappropriately. During the surveyor's review of the initial self report form, the following information was noted which was documented by the facility on the form under the section outlining all steps taken immediately to ensure resident(s) are protected: Psychiatric Nurse Practitioner was notified of new onset of inappropriate touching behaviors . Review of the documentation in the facility's initial self report also revealed that Resident #69 was placed on direct 1:1 staff supervision, and that law enforcement was not contacted, and other agencies were not notified. On 2/4/26 at 10:09AM the surveyor conducted an interview of the facility's Administrator at which time they stated during the interview: This was on the memory care unit, when I initially got it, we reported it as if it was an allegation of abuse because of the inappropriate touching. On 2/4/26 at 10:29AM the surveyor conducted a review of the facility's final self report made to the Office of Health Care Quality by the facility's Administrator dated 1/31/26 which revealed the following information was included regarding Resident #69: 1.) On 1/28/26 wandering behaviors present, continued to attempt to touch other Residents and staff but was redirected with each episode, 2.) On 1/29/26 patient continued to show unsafe behaviors involving ambulating into other Resident rooms, maintained on 1:1 supervision by female staff, attempting to grope other Residents but was frequently redirected, refused AM medication and was subsequently EP'd [emergency petitioned] at 1456 to Northwest Hospital.Further review of the facility's final self report revealed the following documentation under the conclusion section of the form under the verified section: The facility investigation confirmed Resident #69 did inappropriately touch Resident #86 and male staff. Resident #86 did not have any injury, mental distress, or behavior change because of the incident. Further review of the facility's self report revealed the following information was also documented under the section of the form which directs the facility to provide as a result of a finding of abuse, such as physical, sexual, or mental abuse, identify counseling or other interventions planned and implemented to assist the Resident: Resident (#86) did not suffer any physical or emotional distress because of the incident. The surveyor noted that on the facility's final self report, the facility's Director of Nursing was documented as being the facility's individual with primary responsibility for conducting the investigation.On 2/4/26 at 10:29AM the surveyor reviewed the facility's complete investigative file which revealed the following documented statement from Geriatric Nursing Assistant (GNA) #33 dated 1/27/26 at 5:23PM: When dinner trays came up, (Resident #69) was walking around in the hallway, I observed him/her reach and touch another male Resident's buttocks, outside of his pants, Like<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [s/he] smacked him lightly on the butt as [s/he] was walking by. The documented statement by GNA #33 further identified the other Resident was Resident #86.Further review of the complete investigative file revealed the following documented statement from Activities Assistant #34: Earlier in the afternoon (Resident #69) tried to touch my butt while I was on the unit initiating activities for the Residents, I was able to redirect him/her and give him/her an activity to do, I told the nurse about this. Continued review of the complete investigative file revealed the following documented statement by GNA #35: I witness (Resident #69) slap (Resident #39) on his/her buttocks as s/he walked by him/her during dinner time. Review of the documentation on a form titled petition for emergency evaluation, which was dated 1/29/26 regarding Resident #69 documented the following information: The evaluee is demonstrating the following behavior that leads me to conclude that they currently have a mental disorder: sexually and physically assaulting residents and staff, wandering in and out of Resident's rooms, difficult to redirect, requires a one to one supervision, The evaluee presents a danger to the life or safety of the evaluee or others because: physically assaulting, Residents and staff, s/he is not allowing care to be provided, inappropriate sexual touching of staff and Residents.Review of Resident #69's medical record by the surveyor on 2/4/26 at 10:29AM revealed a nursing progress note dated 1/29/26 at 1:52PM which documented the following regarding Resident #69 by Licensed Practical Nurse #36: Resident alert and responsive, continues to require 1:1 supervision due to inappropriate sexual behaviors and physical aggression when redirection is attempted, Writer was able to administer morning medication after encouragement, The Resident continues to wander the memory unit in and out of Resident's rooms, Unit staff must frequently redirect Resident out of occupied rooms throughout the shift despite supervision and redirection the Resident continues to attempt to touch both male and resident staff in a sexually inappropriate manner, this continues to create an unsafe environment, The Resident remains a high elopement risk and continues to require supervision with a 1:1 sitter at all times, Due to elopement risk, the Resident has a wander guard placed on R wrist, Will continue to monitor the Resident for additional behaviors and offer redirection. On 2/9/26 at 10:30AM the surveyor reviewed the medical record of Resident #69 which revealed documentation present of them having been previously emergency petitioned on 1/22/26 for issues which included agitation, aggressive behavior and assaulting of individuals resulting in hospitalization prior to being discharged to this facility. Recommendations on discharge to the facility were observed to be documented which included the necessity of a structured and supervised care environment, continuous monitoring for behavioral disturbances, and ensuring his/her safety and the safety of others. On 2/9/26 at 11:29AM the surveyor conducted an interview of the facility's Director of Nursing who confirmed during the interview with the survey team present, that they did not have any knowledge of Resident #69's documented recent prior medical history of assault of individuals and prior emergency petition. On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on record review and interview it was determined the facility failed to ensure an allegation of abuse was timely reported and failed to ensure all applicable agencies were notified. This was evident for 1 out of 1 facility reported incident (#2728128) reviewed during the facility's recertification survey.The findings include:On 2/4/26 at 9:42AM the surveyor reviewed the facility's complete investigative file for Facility Reported Incident #2728128 which revealed an initial self report made to the Office of Health Care Quality by the facility's Administrator dated 1/27/26 at 7:45PM in which the allegation type was documented as sexual and additionally documented under the suspected crime section: allegation of physical abuse. Further review of the initial self report revealed that Resident #86 was documented as an alleged victim and Resident #69 was documented as an alleged perpetrator. Continued review of the facility's initial self report form revealed the following documented allegation details: On 1/27/26 at approximately 5:15PM, the evening shift supervisor informed the DON (Director of Nursing) that Resident (#69) was observed touching male employees and Resident (#86) inappropriately. During the surveyor's review of the initial self report form, the following information was noted which was documented by the facility on the form under the section outlining all steps taken immediately to ensure resident(s) are protected: Psychiatric Nurse Practitioner was notified of new onset of inappropriate touching behaviors . Review of the documentation in the facility's initial self report also revealed that Resident #69 was placed on direct 1:1 staff supervision, and that law enforcement was not contacted, and other agencies were not notified. Review by the surveyor of the email confirmation of submission form for the initial self report made to the Office of Health Care Quality revealed it was dated and timed with the following: Tue 1/27/2026 7:46PM. Further review of the complete investigative file revealed there was no evidence present that any other agencies besides the Office of Health Care Quality were notified.On 2/4/26 at 10:09AM the surveyor conducted an interview of the facility's Administrator at which time they stated during the interview: This was on the memory care unit, when I initially got it, we reported it as if it was an allegation of abuse because of the inappropriate touching. During the interview the surveyor inquired as to if the Administrator had reported the incident to law enforcement and the ombudsman, at which time the Administrator confirmed in the presence of the survey team that they did not report the incident to law enforcement and had called the Ombudsman but did not hear back from them and also confirmed they did not leave the details of the incident in a message for the Ombudsman. When the surveyor asked if the Administrator had any documentation showing contact was made, they stated: I do not. At this time the surveyor shared the concerns and the Administrator acknowledged the concerns and stated: Okay. After surveyor intervention, the Administrator stated: We have a consistent record with the police, I'll look into that. Continued review of the facility's complete investigative file on 2/4/26 at 10:29AM revealed the facility's follow up self report made to the Office of Health Care Quality which documented the following information: If the allegation was reported to law enforcement or another state agency, where applicable and if available, what is the status or provide conclusions of their investigation: N/A. Review by the surveyor of the facility's follow up self report revealed there was no evidence of other agencies having been contacted.Further review of the facility's final self report revealed the following documentation under the conclusion section of the form under the verified section: The facility investigation confirmed Resident #69 did inappropriately touch Resident #86 and male staff, Resident #86 did not have any injury, mental distress, or behavior change because of the incident. Further review of the facility's self report revealed the following information was also documented under the section of the form which directs the facility to provide as a result of a finding of abuse, such as physical, sexual, or mental abuse, identify counseling or other interventions planned and implemented to assist the Resident: Resident (#86) did not suffer any physical or emotional distress because of the incident. Continued review of the complete<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | investigative file revealed the following documented statement by GNA #35: I witness (Resident #69) slap (Resident #39) on his/her buttocks as s/he walked by him/her during dinner time. The surveyor noted that no further investigation into the concern by the facility regarding Resident #39 was present within the complete investigative file, and they were not mentioned or documented as an alleged victim on the facility's self report forms. On 2/5/26 at10:25AM the surveyor conducted an interview with a facility Ombudsman who stated that they received no notification from the facility regarding facility reported incident #2728128 and additionally stated: This incident, nobody called me.On 2/6/26 at 10:13AM the surveyor conducted another interview of the facility Ombudsman who reported having further confirmed with their office that the incident was never reported by the facility to the Ombudsman. On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on review of Facility Reported Incident #2728128, interview, and record review it was determined the facility failed to ensure a thorough investigation. This was evident for 1 out of 1 facility reported incident (#2728128) reviewed by the surveyor during the facility's recertification survey.The findings include:On 2/4/26 at 9:30AM in response to the surveyor's request to the facility Administrator to provide the complete investigative file and all documentation relating to Facility Reported Incident #2728128, the surveyor was provided with the complete investigative file. At this time, the surveyor conducted an interview with the facility Administrator who confirmed with the survey team that the file being provided was the facility's complete investigative file. On 2/4/26 at 9:42AM the surveyor reviewed the facility's complete investigative file for Facility Reported Incident #2728128 which revealed an initial self report made to the Office of Health Care Quality by the facility's Administrator dated 1/27/26 in which the allegation type was documented as sexual and additionally documented under the suspected crime section: allegation of physical abuse. Further review of the initial self report revealed that Resident #86 was documented as an alleged victim and Resident #69 was documented as an alleged perpetrator. Continued review of the facility's initial self report form revealed the following documented allegation details: On 1/27/26 at approximately 5:15PM, the evening shift supervisor informed the DON (Director of Nursing) that Resident (#69) was observed touching male employees and Resident (#86) inappropriately.During the surveyor's review of the initial self report form, the following information was noted which was documented by the facility on the form under the section outlining all steps taken immediately to ensure resident(s) are protected: Psychiatric Nurse Practitioner was notified of new onset of inappropriate touching behaviors . Review of the documentation in the facility's initial self-report also revealed that Resident #69 was placed on direct 1:1 staff supervision, and that law enforcement was not contacted, and other agencies were not notified. Further review of the complete investigative file revealed there was no evidence present that any other agencies besides the Office of Health Care Quality were notified.On 2/4/26 at 10:09AM the surveyor conducted an interview of the facility's Administrator at which time they stated during the interview: This was on the memory care unit, when I initially got it, we reported it as if it was an allegation of abuse because of the inappropriate touching. During the interview the surveyor inquired as to if the Administrator had reported the incident to law enforcement and the ombudsman, at which time the Administrator confirmed in the presence of the survey team that they did not report the incident to law enforcement and had called the Ombudsman but did not hear back from them and also confirmed they did not leave the details of the incident in a message for the Ombudsman. When the surveyor asked if the Administrator had any documentation showing contact was made, they stated: I do not. At this time the surveyor shared the concerns and the Administrator acknowledged the concerns and stated: Okay. After surveyor intervention, the Administrator stated: We have a consistent record with the police, I'll look into that. On 2/4/26 at 10:29AM the surveyor conducted a review of the facility's final self-report made to the Office of Health Care Quality by the facility's Administrator dated 1/31/26 which revealed the following information was included regarding Resident #69: 1.) On 1/28/26 wandering behaviors present, continued to attempt to touch other Residents and staff but was redirected with each episode, 2.) On 1/29/26 patient continued to show unsafe behaviors involving ambulating into other Resident rooms, maintained on 1:1 supervision by female staff, attempting to grope other Residents but was frequently redirected, refused AM medication and was subsequently EP'd (emergency petitioned) at 1456 to Northwest Hospital.Further review of the facility's final self report revealed the following documentation under the conclusion section of the form under the verified section: The facility investigation confirmed Resident #69 did inappropriately touch Resident #86 and male staff, Resident #86 did not have any injury, mental distress, or behavior change because of the incident. Further review of the facility's self report revealed the following information was also documented under the<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | section of the form which directs the facility to provide as a result of a finding of abuse, such as physical, sexual, or mental abuse, identify counseling or other interventions planned and implemented to assist the Resident: Resident (#86) did not suffer any physical or emotional distress because of the incident. The surveyor noted that on the facility's final self-report, the facility's Director of Nursing was documented as being the facility's individual with primary responsibility for conducting the investigation.On 2/4/26 at 10:29AM the surveyor reviewed the facility's complete investigative file which revealed the following documented statement from Geriatric Nursing Assistant (GNA) #33 dated 1/27/26 at 5:23PM: When dinner trays came up, (Resident #69) was walking around in the hallway, I observed him/her reach and touch another male Resident's buttocks, outside of his pants, Like s/he smacked him lightly on the butt as s/he was walking by. The documented statement by GNA #33 further identified the other Resident as Resident #86.Further review of the complete investigative file revealed the following documented statement from Activities Assistant #34: Earlier in the afternoon (Resident #69) tried to touch my butt while I was on the unit initiating activities for the Residents, I was able to redirect him/her and give him/her an activity to do, I told the nurse about this. Continued review of the complete investigative file revealed the following documented statement by GNA #35: I witness (Resident #69) slap (Resident #39) on his/her buttocks as s/he walked by him/her during dinner time.Continued review of the facility's complete investigative file on 2/4/26 at 10:29AM revealed the facility's follow up self-report made to the Office of Health Care Quality which documented the following information: If the allegation was reported to law enforcement or another state agency, where applicable and if available, what is the status or provide conclusions of their investigation: N/A. Review by the surveyor of the facility's follow up self report revealed there was no evidence of other agencies having been contacted.The surveyor noted that no further investigation into the concern by the facility regarding Resident #39 was present within the complete investigative file, and they were not mentioned or documented as an alleged victim on the facility's self report forms. One of five paper documented staff statements was observed to be handwritten and signed with the corresponding staff name, the remaining four statements were documented by the facility's Director of Nursing (DON) as verbal statements signed by the DON. Two staff statements were observed dated as documented by the DON on 1/27/26 at 5:23PM, one statement was observed dated as documented by the DON on 1/27/26 at 5:24PM, one statement had no time of documentation and was dated 1/27/26, and another statement was dated as documented by the DON on 1/27/26 at 5:26PM, and there was no documented evidence of interview questions asked. There was no further documentation found in the complete investigative file of further investigation and assessment in response to the written statement regarding Resident #39 in which documented observation of Resident #69 slapping Resident #39 on his/her buttocks. On 2/4/26 at 11:25AM the surveyor shared concerns with the facility's Administrator which included that there was no evidence within the facility's complete investigative file of any assessments or interviews of other facility Residents residing on the memory care unit. On 2/4/26 at 11:40AM after surveyor intervention, the facility provided a witness statement form which was not part of the complete investigative file in which the DON documented they had attempted to interview other Residents and no Residents were identified that were capable of interview on 1/27/26 at 5:44PM. The surveyor noted that there were no documented assessments of Residents deemed incapable of interview on the unit included within the complete investigative file. On 2/5/26 at10:25AM the surveyor conducted an interview with a facility Ombudsman who stated that they received no notification from the facility regarding facility reported incident #2728128 and additionally stated: This incident, nobody called me.On 2/6/26 at 10:13AM the surveyor conducted another interview of the facility Ombudsman who reported having further confirmed with their office that the incident was never reported by the facility to the Ombudsman's. On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on record review and interview with staff, it was determined that the facility failed to provide the resident representative with written notification of transfers to the hospital and written notification of the facility's bed hold policy upon transfer to the hospital. This was found to be evident for 2 (Resident #11 and Resident #2) out of 3 residents reviewed for hospitalizations during the annual survey.<br><br>The findings include:<br><br>A Resident Representative is a person authorized to act on behalf of the resident.<br><br>Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.<br><br>1. A medical record review was conducted on 2/4/26 at 1:21 PM for Resident # 11. The review revealed that on 12/18/25 the resident made a 911 call indicating that s/he wanted to go to the hospital. The resident went to the hospital.<br><br>Further review revealed the resident was assessed on 1/31/26 for concerns of difficulty breathing. The resident was sent to the hospital for further evaluation.<br><br>During a meeting with the DON and on 2/4/26 at 4:02 PM she was asked to provide the survey team with documentation of the transfer forms that were given to the resident and/or resident responsible party (RP). The facility provided documentation of a hospital transfer form for Resident # 11 titled transfer form with a date of transfer for 12/18/25. The DON confirmed that the facility does not have a transfer form for the resident transfer to the hospital on 1/31/26.<br><br>The DON and Nursing Home Administrator (NHA) confirmed that a hospital transfer form is to be provided to the resident and/or responsible party upon transfer. She stated that education will be provided for staff.<br><br>2. On 2/4/2026 at 1:50PM, during a review of Resident #2's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on 8/14/2025, 9/17/2025, 9/30/2025, 11/7/2025, and 11/25/2025. There was no transfer form completed for the transfer to the hospital on 9/17/2025.<br><br>On 2/4/2026 at 2:00PM, during a review of the resident's electronic medical record, the Surveyor discovered that the resident's family member was his/her resident representative. Further review failed to reveal documentation to verify that the resident representative was provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 8/14/2025, 9/17/2025, 9/30/2025, 11/7/2025, and 11/25/2025.<br><br>During an interview conducted with the Director of Nursing (DON) on 2/4/2026 at 3:20PM, the Surveyor was informed that the facility provides verbal communication to the resident representative regarding a resident transfer to the hospital and the facility's bed hold policy upon transfer to the hospital. A copy of the eInteract Transfer Form and Bed Hold Policy form can be given to the resident representative if they are present at the time the resident is being sent to the hospital. The Surveyor (continued on next page) |

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| | 215084 | A. Building<br>B. Wing | 02/09/2026 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | expressed the concern that there was no documentation in Resident #2's medical record to verify their resident representative was notified in writing of the resident's transfer and the facility's bed hold policy upon transfer on 8/14/2025, 9/17/2025, 9/30/2025, 11/7/2025, and 11/25/2025. The DON was unable to provide the Surveyor with documentation to verify Resident #2's resident representative was provided with written notification of the transfer and the facility's bed hold policy for their hospitalization. The DON was unsure if any other facility department notified the resident representative in writing via mail or email, but the nursing department does not.<br><br>On 2/9/2026 at 9:05AM, the Surveyor confirmed that the Business Office and the Admissions Office do not send written notification of hospital transfers to resident representatives. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with residents and staff, it was determined that the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect the resident's status. This was evident for 3 (Resident #2, #99, and #125) out of 25 residents reviewed for smoking during the annual survey.The findings include:The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A comprehensive MDS assessment is completed at admission, annually, quarterly, and with significant change.On 2/3/2026 at 2:00PM, a review of the facility's Smoker's List as of 2/2/2026 revealed that Resident #2, #99, and #125 were independent smokers.On 2/5/2026 at 8:10AM, a review of Resident #99's electronic medical record revealed the resident was admitted to the facility on [DATE] and was a smoker prior to admission. A Smoking Contract was completed upon admission. During review of the admission MDS assessment completed on 9/30/2025, Section J1300 revealed No to tobacco use.On 2/5/2026 at 9:00AM, a review of Resident #2's electronic medical record revealed the resident was admitted to the facility on [DATE]. An Engage Safe Smoker Assessment was completed on 8/9/2025 and identified the resident as an independent smoker with a smoking apron indicated. During review of the admission MDS assessment completed on 8/15/2025, Section J1300 revealed No to tobacco use.On 2/5/2026 at 9:35AM, a review of Resident #125's electronic medical record revealed an Engage Safe Smoker Assessment completed on 1/26/2025 and identified the resident as an independent smoker with a smoking apron indicated. During a review of the Annual MDS assessment completed on 2/1/2025, Section J1300 revealed No to tobacco use.On 2/5/2026 at 12:15PM, during an interview with Resident #125, the Surveyor was informed that the resident was a current smoker.On 2/5/2026 at 12:42PM, during an interview with Resident #2, the Surveyor was informed that the resident was a current smoker.On 2/5/2026 at 12:45PM, during an interview with Resident #99, the Surveyor was informed that the resident was a current smoker.During an interview conducted with MDS Coordinator (MDSC) #30 on 2/6/2026 at 11:10AM in the presence of Regional Director of Clinical Operations (RDCO), the Surveyor was informed that Section J1300 Tobacco Use is assessed during admission, annual, and significant change MDS assessments. The Surveyor expressed the concern that the facility did not accurately assess tobacco use on residents MDS assessments. Resident #125 was identified as an independent smoker on 1/26/2025 and his/her annual assessment completed on 2/1/2025, Section J1300, failed to indicate yes for tobacco use; Resident #2 was identified as an independent smoker on 8/8/2025 and his/her admission MDS assessment completed on 8/15/2025, Section J1300, failed to indicate yes for tobacco use; Resident #99 was identified as a smoker on 9/24/2025 and the admission MDS completed on 9/30/2025, Section J1300, failed to indicate yes for tobacco use. MDSC #30 stated there is no UDA [User Defined Assessment] for tobacco use and that was why Section J1300 was coded No for tobacco use. The residents medical record can be reviewed for supporting documentation to code J1300; however, MDSC #30 does not conduct interviews with the residents to determine if they smoked at the time of the MDS assessment.During an interview conducted with RDCO on 2/6/2026 at 11:20AM in the presence or MDSC #30, the Surveyor was informed that a UDA will be created to assess tobacco use on the admission, annual, and significant change MDS assessments and the UDA will also include resident interview for current tobacco use. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff, it was determined that the facility failed to ensure comprehensive person-centered care plans were developed and implemented for residents which reflect resident's goals, measurable objectives, and interventions to meet the specific goal for the resident. This was evident for 1 resident (Resident #84) out of 5 residents reviewed for choices, 2 residents (Resident #55 and Resident #53) out 25 residents reviewed for smoking, and 1 resident (Resident #5) reviewed for communication-sensory during the annual survey.The findings include:<br><br>A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility.<br><br>1.) On 2/3/26 at 12:27PM the surveyor conducted an interview of Resident #84 who expressed that they wanted to go out to the court yard to get fresh air, and the only time they were currently allowed out is when smokers go out, if their not out there for smoking, I can't go out. Resident #84 further reported during the interview that if the outside temperature was 32 degrees or less, Residents who smoke couldn't go outside.<br><br>On 2/6/26 at 11:43AM the surveyor reviewed the medical record of Resident #84 which revealed there was no activities assessment documented for the Resident to capture the types of activities the Resident enjoys.<br><br>On 2/6/26 at 11:43AM the surveyor reviewed the medical record of Resident #84 which revealed that activities was not in the care plan in place for Resident #84.<br><br>On 2/6/26 at 12:02PM the surveyor conducted an interview of Social Services Assistant (SSA) #6 who confirmed with surveyors that Resident #84 should have activities care planned for them and also reported that Residents receive an activity assessment interview specifically for activities. SSA #6 further reported to surveyors that they did not know why Resident #84 did not have the activity assessment interview and they did not know that Resident #84 wanted to go outside other than smoke break times and confirmed that Resident #84 should be able to do so. At this time, the surveyor clearly shared the Resident's request to go outside.<br><br>On 2/6/26 at 3:18PM the surveyor conducted another interview of SSA #6 who stated: No I haven't had a chance to discuss with (the Administrator) as to if we are gonna let them out in the weather, I don't know what the game plan is yet, s/he has not been let outside today, not today yet, no ma'am.<br><br>On 2/6/26 at 3:26PM the surveyor conducted an interview of SSA #6 who stated regarding the activities assessment: Yes, every Resident is expected to have one, and no it has not been put in yet. SSA #6 further reported to surveyors that they did not know how the care plan for activities for Resident #84 was not there.<br><br>2.) On 2/5/26 at 11:24AM the surveyor reviewed the medical record of Resident #55 which revealed they were a smoker with smoking assessments completed, however, smoking was not included as (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | part of the Resident's care plan.<br><br>On 2/5/26 at 11:27AM the surveyor conducted an interview with the facility's Director of Nursing who informed surveyors that the Social Worker initiates all smoking care plans and confirmed that Residents who are smokers are to have a care plan in place with a focus listed as smoking and interventions listed. Resident #55's current care plan was requested by the surveyor to be provided.<br><br>On 2/6/26 at 8:25AM the facility's Director of Nursing provided a copy of Resident #55's care plan to the surveyor at which time the surveyor shared the concern and conducted an interview of the Director of Nursing who was asked to review the care plan of Resident #55 and show where smoking was addressed on it, at which time they were unable to find evidence of smoking addressed on the care plan of Resident #55. After surveyor intervention, the Director of Nursing reported to surveyors that they would make sure smoking was added to the Resident's care plan.<br><br>After surveyor intervention, the Director of Nursing and Regional Director of Clinical Operations #3 informed surveyors on 2/6/26 at 9:03AM that the smoking care plan had been added for Resident #55 and additionally reported that all care plans of Residents of the facility who smoke were now being audited.<br><br>3. On 2/3/2026 at 2:00PM, a review of the facility's Smoker's List as of 2/2/2026 revealed that Resident #53 was an independent smoker.<br><br>On 2/5/2026 at 8:45AM, a review of Resident #53's electronic medical record failed to reveal a care plan developed and implemented for smoking. A review of the facility's Resident Smoking policy revealed that All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking.<br><br>On 2/5/2026 at 12:53PM, during an interview with Resident #53, the Surveyor confirmed that the resident was a current independent smoker.<br><br>During an interview conducted with the Director of Nursing on 2/6/2026 at 10:00AM, the Surveyor expressed the concern that Resident #53 was an independent smoker and failed to have a care plan developed and implemented for smoking. The DON confirmed that residents who smoke should have a care plan developed and implemented for smoking. The Surveyor was later provided a copy of Resident #53' smoking care plan initiated on 2/6/2026.<br><br>4. On 2/3/2026 at 12:20PM, during an interview with Resident #5, the Surveyor discovered that the resident did not speak English; however, spoke Spanish.<br><br>On 2/4/2026 at 1:30PM, during a review of Resident #5's electronic medical record, the Surveyor discovered that the resident was admitted on [DATE]. Further review of Resident #5's electronic medical record revealed a quarterly Minimum Data Set assessment completed on 1/14/2026, Section A listed Spanish as the resident's preferred language and answered yes to needing or wanting an interpreter to communicate with a doctor or health care staff. A care plan, last reviewed on 1/22/2026, noted a focus which stated, The resident has a communication problem r/t (related to) Language barrier, a goal which stated, The resident will be able to make basic needs known on a daily basis through review date, and interventions which included, Communication: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Monitor effectiveness of communication strategies and assistive devices. The care plan failed to identify the language barrier (as the resident was a non-English speaking and spoke Spanish) and initiate resident specific interventions.<br><br>On 2/5/2026 at 1:48PM, during an interview conducted with the Director of Nursing (DON) and the Regional Director of Clinical Operations (RDCO), the Surveyor expressed the concern that Resident #5 was a non-English speaking resident who spoke Spanish; however, a review of the resident's care plan failed to identify the resident's specific language barrier and resident specific interventions. The Surveyor questioned how nursing staff communicate with residents who do not speak or understand the English language and should this be a part of the resident's care plan. The Regional Director of Clinical Operations informed the Surveyor that the facility utilizes a Language Line App that can be downloaded onto an iPhone, Android, or Laptop to connect with a Spanish interpreter at any time. The DON confirmed that the care plan should identify the resident's preferred language, the use of the specific translation services, the use of any communication aids, the staff should be educated, and the effectiveness should be evaluated in order to provide resident centered care. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on observations, record review, and interview with staff, it was determined that the facility failed to ensure the use of a functional communication system for a non-English speaking resident. This was evident for 1 resident (Resident #5) reviewed for communication-sensory during the annual survey. The findings include:On 2/2/2026 at 8:51AM, the Surveyor observed Resident #5 laying in bed sleeping. Geriatric Nursing Assistant (GNA) #29 entered the resident's room to bring his/her breakfast tray. The GNA called to the resident in English to inform him/her that breakfast was here. The resident remained asleep. GNA #29 did not use any language interpretation device while communicating with the resident.On 2/3/2026 at 12:20PM, during an interview with Resident #5, the Surveyor discovered that the resident did not speak English; however, spoke Spanish. No observations of nursing staff using a language interpretation device while communicating with the resident. On 2/4/2026 at 1:30PM, a review of Resident #5's electronic medical record revealed a quarterly Minimum Data Set assessment completed on 1/14/2026, Section A listed Spanish as the resident's preferred language and answered yes to needing or wanting an interpreter to communicate with a doctor or health care staff. Further review revealed a care plan last reviewed on 1/22/2026 with a focus which stated, The resident has a communication problem r/t (related to) Language barrier.On 2/5/2026 at 1:48PM, during an interview conducted with the Director of Nursing (DON) and the Regional Director of Clinical Operations (RDCO), the Surveyor questioned how nursing staff communicate with residents who do not speak or understand the English language. For instance, Resident #5 only spoke Spanish and barely understood English. The Regional Director of Clinical Operations informed the Surveyor that the facility utilizes a Language Line App that can be downloaded onto an iPhone, Android, or Laptop to connect with a Spanish interpreter at any time. The Surveyor expressed the concern that during rounds on the Liberty Unit on 2/2/2026 and 2/3/2026 the Surveyor did not observe nursing staff using a language interpretation app while interacting with the resident. The Surveyor reviewed a nursing note from 7/2/2025 which stated the resident had an unwitnessed fall and was unable to express his/her pain due to a language barrier; later, the [spouse] arrived and was able to ask the resident where he/she was hurting and then the physician was notified of the complaint. This was an example that the nursing staff did not utilize a language interpretation device/service to provide care and services to assess the resident's description of pain in real time and waited for the spouse to arrive to translate for the resident. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, record review, and interview, the facility failed to ensure adequate one-to-one supervision for Resident #69 as ordered by the physician. This occurred for 1 of 1 resident reviewed for supervision during the annual survey.The Findings include:During observation rounds on 02/06/26 at approximately 6:30 a.m., Resident #69 was observed on the unit without one-to-one supervision in place. At that time, staffing on the unit consisted of one Geriatric Nursing Assistant (GNA) staff #17 and one licensed nurse staff #12. No staff member was assigned to provide continuous one-to-one supervision for Resident #69.Review of the medical record on 02/06/26 at 6:45 a.m. revealed a physician's order for one-to-one supervision every shift (24 hours per day, 7 days per week) due to inappropriate sexual behavior toward staff and other residents.During an interview on 02/06/26 at 7:00 a.m., Nurse Staff #12 and GNA Staff #17 stated that a scheduled GNA had called out and there were no available staff to replace her.During an interview on 02/06/26 at 7:30 a.m., Staff Nurse #22 stated that Resident #69 needs to be supervised closely and constantly needs to be redirected due to his/her inappropriate behaviors toward staff and other residents.During an interview on 02/06/26 at 8:00 a.m., the Director of Nursing (DON) confirmed that Resident #69 has an order for one-to-one supervision every shift, 24 hours per day, due to behaviors; however, staffing shortages prevented adherence. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure a Resident's environment was free from accident hazards. This was evident during 1 out of 1 initial observation made of Resident #105 during the facility's recertification survey. The findings include:During the surveyor's initial tour of the facility on 2/2/26 the surveyor observed Resident #105 at 9:03AM from the hallway sleeping in their bed with a fall mat which was situated flat on the floor against the wall located next to the doorway to the room and was situated several feet away from the Resident's bed with hard flooring tiles located in between the mat and the Resident's bed. On 2/2/26 at 9:05AM the surveyor conducted an interview and inquired to Licensed Practical Nurse (LPN) #12 as to if and why Resident #105 had a fall mat in place. LPN #12 stated to the surveyor during the interview: Yes s/he has a fall mat in place because sometimes s/he rolls out of bed. At this time, the surveyor requested and conducted a dual observation and shared the concern with Licensed Practical Nurse (LPN) #12 who observed the concern. The surveyor inquired to LPN #12 during the observation as to if the fall mat situated that far away from the Resident was helpful for the problem they just described to the surveyor, at which time they stated: No, it is not. After surveyor intervention, at this time, the surveyor observed LPN #12 move the Resident's fall mat closer to their bed to cover the hard tile surface area that was between the mat and the bed. On 2/2/26 at 9:31AM the surveyor shared the concern with Unit Manager #13 who acknowledged understanding of the surveyor's concern. On 2/9/26 at 11:45AM the surveyor reviewed the medical record of Resident #105 which revealed a care plan with the following care focus last revised on 10/27/25 and interventions documented: Focus: (Resident #105) has a history of falls and remains at risk for falls, Interventions: Follow facility fall protocol, low bed with bilateral floor mats when resident in bed. At this time, the surveyor reviewed all concerns with the facility's Administrator and Director of Nursing. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure oxygen therapy was administered as ordered by the physician. This was evident for 1 resident (Resident #5) out of 3 residents reviewed for respiratory care during the annual survey. The findings include:A nasal cannula is a device that delivers oxygen directly to a person's nares via a flexible plastic tube.On 2/2/2026 at 8:53AM, the Surveyor observed Resident #5 wearing a nasal cannula connected directly to the oxygen concentrator without a humidifier bottle. The resident was receiving oxygen via nasal cannula at a rate of 3 Liters per minute (L/min).On 2/3/2026 at 12:20PM, the Surveyor observed the resident wearing a nasal cannula connected to the oxygen concentrator with a humidifier bottle. The oxygen tubing and humidifier bottle was labeled 2/3/2026. The resident was receiving oxygen via nasal cannula at a rate of 3.5L/min.On 2/4/2026 at 9:41AM, during a review of Resident #5's electronic medical record, the Surveyor discovered that the resident had diagnoses of but not limited to acute and chronic respiratory failure with hypoxia (insufficient oxygen reaching body tissues), kidney failure on dialysis, liver failure, and heart failure. The resident recently developed increased shortness of breath. Further review revealed a physician's order, dated 1/28/2026, for oxygen at 2L/minute via nasal cannula, every shift for shortness of breath.During an interview conducted with Unit Manager #13 on 2/6/2026 at 3:28PM, the Surveyor expressed the concern that Resident #5's oxygen administration order was for 2L/min due to shortness of breath; however, during resident observation on 2/2/2026 the oxygen was at 3L/min and on 2/3/2026 the oxygen was at 3.5Lmin and not provided as ordered by the physician. |

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| | 215084 | A. Building<br>B. Wing | 02/09/2026 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>Based on observations, record review, and interview with residents and staff, it was determined that the facility failed to ensure residents were properly assessed for the safe use of bedrails, obtain consent from the resident or resident representative prior to use of bedrails, and obtain a physician's order for the use of bedrails. This was evident for 4 (Resident #23, #74, #87, and #124) out of 7 residents reviewed for accidents during the annual survey.The findings include:Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident's Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails.On 2/2/2026 between 8:20AM and 9:30AM, during a tour of the Liberty Hall unit, the Surveyor observed:Resident #23, awake and oriented x3, in bed with the head of the bed raised to about 45 degrees with black quarter size bed rails raised on both sides at the head of the bed. The resident's left arm was contracted. During an interview, the resident stated that they use the bed rails to assist with repositioning themselves in the bed.Resident #74, awake, nonverbal with no acknowledgment of Surveyor presence noted with involuntary body movements, in bed with the head of the bed at about 30 degrees with black quarter size bed rails raised on both sides at the head of the bed.Resident #87, awake and oriented to person and place, in bed with the head of the bed raised to about 75 degrees with black quarter size bed rails raised on both sides at the head of the bed. During an interview, the resident was unable to verbalize if they used the bed rails for bed mobility.Resident #124, awake and alert to person with aphasia (a language disorder that impairs speaking), with the head of the bed raised at about 30 degrees with cream colored bed rails raised on both sides at the head of the bed. The resident's upper extremities were contracted bilaterally. The resident was unable to communicate with the Surveyor if they were able to use the bed rails.On 2/3/2026 between 7:45AM and 8:00AM, during a tour of the Liberty Hall unit, the Surveyor observed Resident #74 sleeping in bed with both bed rails raised at the head of the bed and Resident #124 sleeping in bed with both bed rails raised at the head of the bed.On 2/5/2026 between 12:45PM and 1:00PM, the Surveyor observed Resident #23, Resident #74, and Resident #124 with both bed rails raised at the head of the bed.The facility's Safe Use of Bed Rails Policy, reviewed on 2/5/2026 at 1:15PM, determined that Bed rails may only be used in order to assist in mobility and transfer of residents. Documentation for a resident to utilize bed rails includes: a physician's order (required), completion of the Bed Safety Evaluation (for appropriate use), education provided to the resident and/or if applicable, the resident representative on the risk vs benefits of bed rails, signed informed consent obtained for bed rail use, and a care plan for the use/need for bed rails.On 2/5/2026 at 1:30PM, during a review of Resident #23's electronic medical record, the Surveyor discovered a Peak Side Rail Evaluation completed 7/28/2025. Further review failed to reveal quarterly documentation of bed rail assessments, signed consent obtained, a physician's order, or a care plan developed and implemented for the use of bed rails.On 2/5/2026 at 1:40PM, a review of Resident #74's electronic medical record failed to reveal quarterly bed rail assessments, signed consent obtained, a physician's order, or a care plan developed and implemented for the use of bed rails.On 2/5/2026 at 1:50PM, during a review of Resident #87's electronic medical record the Surveyor discovered a Side Rail Evaluation completed on 3/28/2025. Further review failed to reveal quarterly documentation of bed rail assessments, signed consent obtained, a physician's order, or a care plan developed and implemented for the use of bed rails.On 2/5/2026 at 2:00PM, a review of Resident #124's electronic medical record failed to reveal quarterly bed rail assessments, signed consent obtained, a physician's (continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | order, or a care plan developed and implemented for the use of bed rails.During an interview conducted with Unit Manager #13 on 2/6/2026 at 3:28PM, the Surveyor made them aware that Resident #23, Resident #74, Resident #87, and Resident #124 were observed with bed rails raised on both sides at the head of the bed on 2/2/20206, 2/3/2026, and 2/5/2026. The Surveyor and UM #13 observed bed rails in use for Resident #74 and Resident #124 during the interview. The Surveyor asked UM #13 the procedure for a resident to utilize bed rails and was informed that they would have to refer to the facility's bed rail policy. The Surveyor expressed the concern that Resident #23, Resident #74, Resident #87, and Resident #124 failed to have quarterly bed rails evaluations completed (which includes education), signed consent obtained, a physician's order, or a care plan developed and implemented for the use of bed rails. UM #13 stated they would review the residents' electronic medical record. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on record review, observation, and interviews, the facility failed to ensure sufficient nursing staff to meet the needs of residents to provide one-to-one supervision for Resident #69 as ordered by the physician.The Findings include:On 2/6/26 at approximately 6:30 AM, observation revealed that Resident #69, who had a physician's order for 1:1 supervision due to behavioral problems, was not being supervised as ordered. At that time, one GNA (Staff #17) and one nurse (Staff #12) were assigned to the unit, and no staff provided continuous 1:1 supervision.Staff #12 and GNA #17 stated that the GNA called out and no replacement staff were assigned. The Director of Nursing (DON) confirmed that Resident #69 has a 24/7 1:1 supervision order and acknowledged that staffing shortages prevented adherence to the order. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and interview with staff, it was determined that the facility failed to assure that medications were secure in a locked medication cart under the direct observation of authorized staff in an area where residents could not access it. This was evident for 1 treatment cart observed on the 2nd floor Liberty Hall nursing unit.The findings include:On 2/2/2026 at 8:13AM, during a tour conducted on the 2nd floor Liberty Hall nursing unit, the Surveyor observed an unattended, unlocked treatment cart labeled LIBERTY TX CART located across from the unattended nurses' station.During an interview conducted with Licensed Practical Nurse (LPN) #28 on 2/2/2026 at 8:16AM, the Surveyor was informed that they were one of the nurses on duty for Liberty Hall. LPN #28 confirmed that the treatment cart was unattended and unlocked and stated that the cart should've been locked when authorized staff finished using it. LPN #28 locked the treatment cart.On 2/2/2026 at 11:25AM, during an interview with Unit Manager (UM) #13, the Surveyor expressed the concern that the Liberty treatment cart was left unattended, unlocked, and potentially available to other staff and residents during Surveyor rounds this morning. UM #13 was aware and provided education to staff.On 2/2/2026 at 11:36AM, the Surveyor informed the Director of Nursing (DON) of the unattended and unlocked treatment cart on Liberty Hall nursing unit. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview with the resident and staff, it was determined that the facility failed to obtain routine dental care for the resident. This was evident for 1 resident (Resident #23) reviewed for dental services during the annual survey.The findings include:On 2/2/2026 at 8:30AM, during an interview conducted with Resident #23, the Surveyor observed poor dentition, missing teeth, poor oral care, and a tooth with internal black/grey discoloration. The Surveyor was informed that the resident had not been seen by a dentist since he/she was admitted to the facility and would like to see the dentist.On 2/3/2026 at 11:33AM, a review of Resident #23's electronic and paper medical record revealed that the resident was admitted to the facility on [DATE]. Further review failed to reveal documentation of any routine or emergent dental visits.On 2/6/2026 at 2:35PM, during an interview conducted with Licensed Practical Nurse (LPN) #28, the Surveyor was informed that they do not recall the last time Resident #23 was seen by the dentist. LPN #28 stated that residents can be added to the list for [Dental Company] to see the resident when they come into the facility.During an interview conducted with the Director of Nursing (DON) on 2/9/2026 at 9:00AM, the Surveyor was informed that every resident is seen routinely by dental services, and for emergency dental services if needed. The Surveyor requested documentation from the last dental service visit for Resident #23.On 2/9/2026 at 4:25PM, after numerous requests, the DON was unable to provide documentation of any dental service provided to Resident #23. The Surveyor expressed the concern that the facility failed to ensure a resident with poor dentition received routine dental services. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and interview it was determined the facility failed to ensure food provided was palatable and at safe and appetizing temperature. This was evident for 1 food test tray provided by the facility during the surveyor's review of the kitchen task during the facility's recertification survey.The findings include:On 2/3/26 the surveyor conducted an interview of a facility Resident who requested to remain anonymous with regard to their concern. During the interview the Resident stated: The food is disgusting, it's sometimes cold, most of it is not that good.On 2/6/26 at 1:44PM the surveyor performed palatability testing of a meal tray provided by the facility at which time the mixed vegetables was tasted and found to be difficult to chew with hard pieces present, at which time the food was not swallowed due to the consistency present. Breaded fish was tasted and found to be too cool in temperature. The bread roll was served cold and was not appetizing due to the temperature. On 2/6/26 at 2:02PM the surveyor conducted an interview and shared concerns with the facility's Administrator who stated to the survey team: I'm embarrassed because we did so much education with staff. The facility Administrator further reported during the interview that they took this surveyor's concerns seriously.On 2/9/26 at 8:27AM the facility Administrator provided documentation of education performed beginning on 2/7/26 with dietary staff which included food temperature education, in response to the previously shared surveyor concerns. On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. Reference to F812 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation and interview, the facility failed to ensure oxygen equipment was properly dated and labeled in accordance with infection control standards (Resident #136) failed to store clean linen appropriately in accordance with infection control and prevention guidelines to prevent cross contamination. This was evident during observations during the annual survey.The Findings include:<br>1. During observation rounds on 2/2/2026 at 9:33 AM, Resident # 136 was observed receiving oxygen at 2 liters per minute via nasal cannula. The oxygen humidifier bottle was observed without a date indicating when it was initiated or last changed. The oxygen tubing was also observed without labeling to identify initiation date or change date.<br><br>On 2/3/2026 at 10:00 AM, during follow-up observation and interview, the humidifier bottle was observed dated 1/28/2026. At that time, the oxygen was not running.<br><br>During interview on 2/3/26 at 10:15AM nurse staff #13 stated he did not know who labeled the bottle and was not aware of who was responsible for labeling the resident's oxygen humidifier bottle.<br><br>On 2/3/2026 at 1:00 PM, during additional observation rounds, the humidifier bottle had been changed and was dated 2/3/2026. However, the oxygen tubing remained unlabeled.<br><br>The facility failed to ensure oxygen humidifier bottles and tubing were consistently dated and labeled to prevent potential infection control concerns and ensure adherence to the facility's infection prevention and control policies.<br><br>2. A tour of the laundry room was conducted on 2/6/26 at 11:40AM with several surveyors and the Environmental Services (EVS) Director (Staff # 23) present. While observing the clean linen area, there were three linen carts lined against the wall in front of the washing machine room. The door that leads into the washing machine room was wide open with a taped sign on the door that read, This Door Must Remain Closed at all times. The three linen carts were uncovered with folded linen exposed. The first of the three linen carts had folded clothes sitting on the top of the cart. The EVS Director stated that the door to the washing machine room is to be always closed and the linen carts are to be always covered.<br><br>All concerns were discussed with the Administration team at the exit conference on 2/9/26. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>Based on observation and interview it was determined the facility failed to ensure the maintenance of the facility's dishwasher plumbing. This was evident upon the surveyor's initial tour and during subsequent observation of the facility's kitchen during review of the kitchen task during the facility's recertification survey. The findings include:During the surveyor's initial tour of the facility's kitchen on 2/2/26 at 8:13AM the surveyor conducted an interview with Certified Dietary Manager #11 who confirmed that the dishwasher was used and was used in hot water mode. At this time the surveyor requested for CDM #11 to perform a dual observation of the kitchen. On 2/2/26 at 8:14AM the surveyor observed the dishwashing area with multiple areas of pooling water present on the floor.On 2/2/26 at 8:15AM the surveyor observed the plumbing connecting to the facility's commercial conveyer dishwasher to be in severely eroded condition with white and brown flaky areas and powdery appearing areas. A layer of white and brown debris was observed on the top surface of the facility's dishwasher located beneath the area of eroded plumbing. CDM #11 observed and acknowledged the surveyor's concerns.On 2/6/26 at 12:39PM after surveyor intervention, CDM #11 informed the surveyor that they had plumbers coming to replace the plumbing to the dishwasher, however, they had to wait on a plumbing part. On 2/6/26 at 12:49PM the surveyor observed the dishwasher plumbing with an area of pooling water beneath it.On 2/6/26 at 2:02PM the surveyor conducted an interview and shared concerns with the facility's Administrator who stated to the survey team: I'm embarrassed because we did so much education with staff. The facility Administrator further reported during the interview that they took this surveyor's concerns seriously and ordered the parts for the dishwasher plumbing, however, they would not arrive soon. At this time the surveyor offered an opportunity for all documentation they wished to provide to be provided for surveyor review.On 2/9/26 at approximately 11:45AM the surveyor shared all concerns with the facility Administrator and Director of Nursing. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, sanitary, and homelike environment in good repair. This deficient practice was observed on 2 of 2 units reviewed (Promenade and Liberty Units) and in the laundry room during the annual recertification survey.The Findings include:1. Promenade UnitDuring observation rounds on 2/2/26 at 8:30 a.m., the following was observed:room [ROOM NUMBER]: The floor contained dried food and debris. The trash can was overflowing with spilled contents noted on the floor. A resident clothing bin was full. The room had a noticeable urine odor.room [ROOM NUMBER]: The floor contained multiple dried food particles and appeared sticky with a dried substance.Large chips of paint and wood were missing from resident doors on Unit 1.Shower Room: Several wet used washcloths were observed lying on the floor.Staff #16 accompanied the surveyor during the observations on the Promenade Unit and stated he would contact housekeeping and maintenance to address the identified concerns.2. Liberty UnitDuring observation rounds on 2/2/26 at 9:00 a.m., the following was observed:Large dark stains were noted inside the shower room on Unit 2.room [ROOM NUMBER]: A fall mat located on the left side of the bed had a large liquid substance present on top of the mat.Several resident rooms were noted with large piles of unclean laundry emitting a urine odor.Staff #13 was made aware of the findings and stated he would notify housekeeping.The Director of Nursing (DON) and the Administrator were informed of the above findings during the entrance conference.3. Laundry RoomOn 2/6/26 at 10:00 a.m., during observation of the laundry room, a large buildup of gray-colored lint was observed on the ceiling area above three dryers.During interview, the Laundry Aide stated someone had cleaned the area but must have missed that section. The Maintenance Director was present during this observation. |