STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215088	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammonds Lane Center	613 Hammonds Lane Brooklyn Park, MD 21225

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to 1) maintain a sanitary and comfortable environment, as evidenced by persistent odors of urine and unsanitary conditions throughout multiple resident care units and common areas. This deficient practice was observed on six separate dates during the survey; and 2) maintain residents' bathing/shower rooms that were operational and in good repair to meet the basic hygiene needs and preferences of the facility's residents. This was evident for 9 out of 12 resident bathing/shower stalls observed during the survey. The findings include:1. On 08/14/2025 at 7:30 AM, upon entry into the facility, the surveyor detected a strong, pungent odor of urine in the main lobby, which was consistently present throughout the hallways of Unit A, Unit C, and the conference room.On 08/14/2025 at 8:30 AM, the surveyor detected a strong urine odor consistently present throughout the hallways of Unit B.On 08/14/2025 at 10:40 AM, during an interview, the Director of Nursing (DON, Staff #2) acknowledged the surveyor's observations and stated, Yes, we have talked about the odor in the building with housekeeping.On 08/14/2025 at 10:46 AM, the Housekeeping Manager (Staff #14) reported that three housekeepers were assigned, one per unit, from 7:00 AM–2:00 PM daily, and confirmed that no housekeeping staff were present in the facility after 2:00 PM.On 08/15/2025 at 7:30 AM, on Unit C, the surveyor observed:A yellow puddle of fluid approximately 10 inches x 4 inches on the hallway floor with a strong odor of urine.A dark brown moist substance approximately 3 inches x 3 inches on the wall near the shower room.After surveyor intervention, housekeeping staff cleaned the area.On 08/19/2025 at 2:55 PM, the surveyor, accompanied by Staff #23 and Staff #24, observed a strong odor of urine and feces in the hallway of Unit C, traced to the soiled utility room. Upon entering, the surveyor noted large trash cans filled and overflowing with multiple bags containing soiled incontinent products.During an interview, Staff #23 stated, The odor is bad in this hallway. The laundry staff are supposed to take out the trash, but after 9:00 PM there is no housekeeping or laundry staff, and there are no cleaning supplies for us to use if a resident has an accident. There is not enough staff to handle all the trash and cleaning.Staff #24 stated, There is always an odor in this place, and if you call laundry after housekeeping leaves at 2:00 PM, they don't know where the cleaning supplies are or what to do.On 08/25/2025 at 11:00 AM, the surveyor again detected a strong odor of urine throughout the hallways of Units A, B, and C. 2. During observation rounds of the facility bathing/shower rooms on 08/18/2025 at 8:50 AM with Nursing Home Administrator and staff #12 there were a total of 12 resident bathing/shower stalls for resident use within the facility. 9 out of the 12-facility bathing/shower stalls were found unusable to bath residents due to the facility using the stalls as storage for boxes, wheelchairs, bedside tables, oxygen concentrators, resident mattresses, and other medical devices. 2 out of the 9 unusable facility bathing/shower stalls did not have a shower head connected to the shower faucet piping. During an interview, while making observation rounds, on 08/18/2025 at 8:50 am the Nursing Home Administrator (NHA) stated and agreed that there were only 3 out of 12 facility bathing/shower stalls (continued on next page)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	able to be used for resident bathing/shower needs and preferences. The NHA also agreed and stated that 9 out of 12 bathing/shower stalls were unusable as well as that there were no resident room bathrooms with bathing/shower stalls within the facility that could be used to bathe/shower residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and staff, it was determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment for the residents. This was evident for 4 resident rooms out of 21 resident rooms observed on the A wing nursing unit and 3 resident rooms out of 11 resident rooms reviewed on the B wing nursing unit during the survey. The findings include: 1.) On 8/14/2025, during a tour of the A wing nursing unit between 8:30AM and 10:20AM, the Surveyor observed the following environmental concerns: 1a. In room [ROOM NUMBER]A, the privacy curtain, which separated the 2 bed spaces, was soiled with scattered white smears and reddish-brown spots. 1b. In room [ROOM NUMBER]A, the privacy curtain, which separated the 2 bed spaces, was soiled with scattered white smears. On 8/15/2025, during a tour of the A wing unit between 8:15AM and 9:40AM, the Surveyor observed the following environmental concerns: 1c. In room [ROOM NUMBER]A, the baseboard under the air conditioning unit was damaged, the phone jack outlet being used on the back wall between the residents' head of the bed was loosely sticking out of the wall and held in place with a black duct tape like product surrounding all four sides. 1d. In room [ROOM NUMBER]A and 8A, the over-the-toilet commode in the shared bathroom had rust build-up and damage on the front of the frame and the legs. On 8/18/2025 between 8:20AM and 8:45AM, the Surveyors conducted an environmental tour of the A wing, B wing, and C wing nursing units and an interview with the Nursing Home Administrator (NHA) and Maintenance Director #12. During a tour of the A wing, this Surveyor made the NHA and Maintenance Director #12 aware of the concerns regarding the observations of the soiled privacy curtains in rooms 08A and 19A on 8/14/2025 and rust build-up on the over-the-toilet commode in the shared bathroom in 6A and 8A on 8/15/2025. The NHA and Maintenance Director #12 stated that they would make sure the concerns were addressed. On 8/20/2025 at 12:35PM, the Surveyor and the Director of Nursing (DON) confirmed the environmental concerns in room [ROOM NUMBER]A. The DON stated she would have Maintenance Director #12 take care of the issue. 2. During observation rounds on 08/14/2025 the following concerns were found: 2a. At 8:35 AM in room [ROOM NUMBER]B-1: Behind the resident's bed was peeling paint with several gouges of plaster missing from the wall. 2b. At 8:40 AM in room [ROOM NUMBER]-B: The cove base was missing on wall behind the door entering the room. 2c. At 9:10 AM in room [ROOM NUMBER]-B: The calking around the resident bathroom sink was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cracked, brownish gray in color and the sink was disconnecting from the wall. The air vent grate on the wall of the bathroom was dented, brown and black in color, with a musty smell. The bathroom cove base was peeling from the walls and there was dry wall missing on wall to the right after entering the bathroom door. The toilet seat lid was found broken and not attached to the toilet. During an interview on 08/14/2025 at 9:08 AM resident #79 stated, The bathroom does not look good and the lid to the toilet is broken. During an interview on 08/14/2025 at approximately 10:00 AM the Director of Nursing (DON) was made aware of the concerns found on observation rounds in residents' rooms. The DON stated, I will let Maintenance know. During observation rounds and interview on 08/18/2025 at 8:50 AM with Nursing Home Administrator staff #1 and staff #12, all concerns were visual shown and reviewed regarding resident rooms. During these rounds staff #12 stated, these items will be fixed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews it was determined the facility failed to store food in accordance with professional standards for food safety during the annual survey.The findings include: An initial tour of the facility kitchen was completed on 08/14/2025 at 08:03 AM with staff (#6) and the following items were found to be missing an expiration date on the product: 1) One 7 lb. can of Banana Pudding 2) One 6.56 lb. can of Ultra-Premium Marinara Sauce 3) Several spice containers of spices 4) Five 5oz packages of Reduced Calorie Vanilla Pudding and Pie Filling mix During the tour interview on 08/14/2025 at 08:03 AM with staff #6 he/she confirmed and stated that the above items did not have an expiration date on them, and staff were supposed to label all food items with an expiration date. During interview on 08/14/2025 at 2:25 PM staff #7 stated that all food items are to be labeled by staff with an expiration date upon being received.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident and staff, it was determined that the facility failed to maintain accurate medical records in accordance with accepted professional standard and practices. This was evident for 11 (Resident #11, #23, #33, #34, #41, #13, #27, #72, #84, #5, and #97) residents out of 68 residents reviewed 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. 1. On [DATE] at 11:18AM, during an interview with Resident #11, the Surveyor observed the resident lying in bed with the head of the bed at about 30 degrees. There were quarter size bed rails raised on both sides at the top of the bed. The resident stated that the bed rails assist them with bed mobility. On [DATE] at 12:25PM, during rounds on the A wing nursing unit, the Surveyor observed Resident #11 lying in bed with the head of the bed at about 30 degrees. The quarter size bed rails were raised on both sides at the top of the bed. On [DATE] at 11:35AM, a review of Resident #11’s electronic medical record revealed a Bed Safety Evaluation dated [DATE] and a Bed Safety Evaluation Follow-up dated [DATE], with quarter size bed rails recommended on both sides of the bed for mobility. The final action for bed rail use was to obtain consent and obtain a physician’s order. Further review failed to reveal resident or resident representative consent nor a physician’s order for bed rail use. 2. On [DATE] at 11:34AM, the Surveyor observed Resident #34 sitting on the right side of their bed with their feet touching the ground. The resident was using the right quarter bed rail to hold themselves upright with the left hand. On [DATE] at 8:30AM, during an interview with Resident #34, the Surveyor observed the resident lying flat in bed with both quarter bed rails raised at the top of the bed. The resident used the bed rail to adjust themselves in bed. On [DATE] at 11:45AM, a review of Resident #34’s electronic medical record revealed a Bed Safety Evaluation dated [DATE] and a Bed Safety Evaluation Follow-up dated [DATE], with quarter size bed rails recommended on both sides of the bed for mobility. The final action for bed rail use was to obtain consent and obtain a physician’s order. Further review failed to reveal resident or resident representative consent nor a physician’s order for bed rail use. During an interview with the Director of Nursing (DON) on [DATE] at 12:20PM, the Surveyor was informed that Resident #11 and Resident #34 use the quarter bed rails for mobility. The facility only uses the quarter bed rails at the top of the bed. Any resident who uses bed rails should have a Bed Safety Evaluation and Bed Safety Evaluation Follow-up (if recommended to use bed rails) completed on admission or whenever initiating the use of bed rails. Resident or resident representative consent (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a physician’s order is obtained prior to use. The Surveyor expressed the concern that Resident #11 nor Resident #34 had an order for the use of side rails and resident or resident representative consent in their electronic medical record and requested that documentation. On [DATE] at 2:30PM, the DON and Surveyor confirmed that Resident #11and Resident #34 had signed consent, however failed to have a physician orders for the use of quarter bed rails. The DON conducted a house-wide audit, and new orders for Resident #11 and Resident #34 were received. 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. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone’s breathing or heartbeat has stopped. Do Not Resuscitate (DNR) is an order placed in a person’s medical record by a doctor informs the medical staff that CPR should not be attempted. 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. 3. On [DATE] at 11:49AM, the Surveyor reviewed a MOLST form. 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. There is option A-1, allowing intubation and option A-2, Do Not Intubate (DNI). A review of Resident #23’s current MOLST form dated [DATE], indicated that the resident requests No CPR option A-1, which states that comprehensive efforts may include intubation and artificial ventilation. On [DATE] at 10:45AM, a review of Resident #23’s electronic medical record revealed a physician’s order for DNR. Additional review of the resident’s electronic medical record revealed a Social Services Assessment and Documentation form completed on [DATE]. Within Section 5g., Resident Rights/Healthcare Decision Making/Advanced Directives, it is noted that “per resident request the following orders are in place: DNR/DNI. On [DATE] at 12:05PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #23’s MOLST indicated that the resident was No CPR (DNR) Option A-1 allowing intubation and the Social Services Assessment Documentation indicated the resident was DNR/DNI, not allowing intubation. The DON stated she would review the concern with Social Service Director #3. On [DATE] at 1:30PM, during an interview with the Social Service Director #3, the Surveyor was informed that Resident #23 is No CPR (DNR) Option A-1, allowing intubation. Social Services Director #3 stated that the information in the Social Services Assessment and Documentation form, Section 5g., completed on [DATE], was incorrect and will provide education to the staff member who completed the document. The document was updated to reflect the resident’s current code status. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preadmission Screening and Resident Review (PASRR) is a federal program that screens individuals applying to or reside in Medicaid-certified nursing facilities for serious mental illness (SMI) or intellectual disability (ID). The purpose is to ensure these individuals receive the most appropriate and least restrictive care setting and services. 4. On [DATE] at 9:30AM, during a review of Resident #11’s electronic medical record, the Surveyor discovered that the resident had diagnoses of, but not limited to, schizoaffective disorder, bipolar type, major depressive disorder, and vascular dementia without behavioral, psychotic, or mood disturbance, and anxiety. On [DATE] at 11:23AM, during a review of Resident #11’s PASRR dated [DATE], the Surveyor noted that Section C1: Diagnosis. Does the individual have a major mental disorder? “No” was checked off. On [DATE] at 12:00PM, during an interview with Social Services Director #3, the Surveyor was informed that examples of diagnoses that would indicate major mental disorder would include schizophrenia, bipolar disorder, major depression, and anxiety disorder. The Surveyor expressed the concern that Resident #11’s current PASRR did not reflect his/her current mental health diagnoses. According to the resident’s diagnosis information, in their electronic medical record, the resident was diagnosed with major depressive disorder [DATE], depression [DATE], and schizoaffective disorder, bipolar type [DATE]. Social Service Director #3 stated that at the time the initial PASRR was completed, Resident #11 was not diagnosed with a major mental disorder. The Surveyor and the Social Services Director #3 confirmed the resident’s current diagnosis, and determined that the resident should have had a new PASRR completed to reflect the resident’s current mental health status to ensure he/she receives the appropriate care. Social Services Director #3 stated that she would review Resident #11’s medical record to see if he/she has a updated PASRR. On [DATE] at 1:30PM, Social Services Director #3 informed the Surveyor that she was unable to locate an updated PASRR which included current diagnoses of major depression and schizoaffective disorder, bipolar type. Social Services Director #3 stated that she would complete a new PASRR for Resident #11. On [DATE] at 3:39PM, Social Services Director #3 provided the Surveyor with a updated copy of Resident #11’s PASRR. 5. On [DATE] at 9:05AM, the Director of Nursing (DON) provided the Surveyors with a copy of the facility’s current list of independent smokers. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. On [DATE] at 1:00PM the DON provided the Surveyors with an updated independent smoking list. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. During a review of Resident #33’s electronic medical record on [DATE] at 1:45PM, the Surveyor discovered a current Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and a note that states the “patient attempts to keep [his/her] liter on person.” (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:05PM, the DON provided the Surveyors with an updated independent smoking list. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. On [DATE] at 10:15AM, a review of Resident #33’s electronic medical record revealed the same Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and a note that states the “patient attempts to keep [his/her] liter on person.” During an interview with the DON on [DATE] at 10:45AM, the Surveyor expressed the concern that Resident #33 had a current Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and that the current smoking list provided on [DATE] at 3:05PM, listed the resident as an independent smoker. The DON stated that the resident only smokes when family comes in and takes him/her outside to smoke. The Surveyor asked, “Does this resident need to be supervised while smoking?” The DON stated she would get back to the Surveyor. On [DATE] at 3:00PM, the DON provided the Surveyors with a copy of the updated smoking list. Resident #33 was listed as a supervised smoking resident who only smokes with family. 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. 6. On [DATE] at 11:00AM, a review of Resident #41’s electronic medical record revealed that the resident had diagnoses of, but not limited to, contracture of the left hand, muscle weakness, abnormalities of gait and mobility, functional quadriplegia, and dementia. On [DATE] at 11:21AM, during a review of Resident #41’s electronic medical record, the Surveyor discovered an Annual MDS assessment from [DATE]. Section GG identifies the resident’s functional abilities. According to Section GG, Resident #41 has impairment to one side of the upper extremity, no impairment of the bilateral lower extremity, uses a wheel chair, was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The resident was dependent with roll left and right, sit to lying, lying to sitting on the side of the bed, independent with sit to stand, setup or clean up assistance with chair/bed to chair transfer, and substantial/maximal assistance with toilet transfer. Further review revealed Geriatric Nursing Assistant Point of Care documentation for [DATE] which indicated that the resident was dependent with ADL cares, bathing, personal hygiene, dressing, bed mobility, transfers, locomotion, and required the use of mechanical lift to get out of bed. On [DATE] at 12:20PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Section GG of the Annual MDS assessment completed on [DATE], indicated Resident #41 was independent with sit to stand, setup or clean up assistance with chair/bed to chair transfer, and substantial/maximal assistance with toilet transfer. The DON stated that Resident #41 was total dependent with all ADL care, bed mobility, and transfers. The resident is transferred out of bed using a Hoyer lift (mechanical lift) and he/she cannot stand on their own. The DON stated she would look into the Annual MDS assessment from [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On [DATE] at 10:41 AM, Resident #13's medical record was reviewed. During the medical record review, the resident’s eINTERACT Change in Condition Evaluation - V 5.1, dated [DATE], in section 1. General Background Information, in 1. Is the resident/patient in the facility for:, 3. Other is selected and under 1a3a. If other, specify: it states hospice. On [DATE] at 11:03 AM, the facility's records were reviewed. During the facility record review, the matrix did not indicate that Resident #13 was receiving hospice care. On [DATE] at 11:16 AM, the surveyor interviewed the Director of Nursing staff #2. During the interview, the surveyor asked staff #2 if Resident #13 was on hospice. Staff #2 stated that Resident #13 was on hospice. On [DATE] at 2:36 PM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that according to the matrix, Resident #13 was not listed as being on hospice. Staff #2 stated that she was not sure why Resident #13 was not listed on the matrix as being on hospice. On [DATE] at 8:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that the resident was not listed on the matrix, because she did not click the refresh button when she entered data on the matrix. 8. On [DATE] at 9:05 AM, the facility's records were reviewed. The facility record review revealed that Resident #27 was listed on the facility’s smoker list. On [DATE] at 9:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that all smokers listed on the facility's smoker list can smoke independently. On [DATE] at 1:31 PM, Resident #27’s medical records were reviewed. The medical record review revealed that Resident #27’s Smoking Evaluation (SNF) - V 4, dated [DATE], in 1. Smoking decision under E. Evaluation states that Supervised smoking is required. On [DATE] at 1:36 PM, Resident #27's medical record was reviewed. During the medical record review, the resident’s care plan states Patient may smoke with supervision per smoking evaluation. On [DATE] at 11:47 AM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #27’s Smoking Evaluation (SNF) - V 4 and care plan do not indicate that Resident #27 can smoke independently. Staff #2 stated that she will update the facility’s smoker list. 9. On [DATE] at 9:05 AM, the facility's records were reviewed. The facility record review revealed that Resident #72 was listed on the facility’s smoker list. On [DATE] at 9:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that all smokers listed on the facility's smoker list can smoke independently. On [DATE] at 1:45 PM, Resident #72’s medical records were reviewed. The medical record review revealed that Resident #72 did not have a Smoking Evaluation (SNF) - V 4 documented. On [DATE] at 1:52 PM, Resident #72's medical record was reviewed. The medical record review (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed that Resident #72 was not care planned for smoking. On [DATE] at 11:48 AM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #72 does not have a Smoking Evaluation (SNF) - V 4 documented, and Resident #72 was not care planned for smoking. On [DATE] at 3:06 PM, the surveyor interviewed staff #2. During the interview, staff #2 stated that Resident #72 no longer smokes. Staff #2 also stated that she will update the facility’s smoker list. 9. On [DATE] at 9:05 AM, the facility's records were reviewed. The facility record review revealed that Resident #84 was listed on the facility’s smoker list. On [DATE] at 9:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that all smokers listed on the facility's smoker list can smoke independently. On [DATE] at 1:48 PM, Resident #84’s medical records were reviewed. The medical record review revealed that Resident #84’s Smoking Evaluation (SNF) - V 4, dated [DATE], in 1. Smoking decision under E. Evaluation states that Supervised smoking is required. Also, “1a. Reason/Additional Comments” of E. Evaluation states “to be supervised at all time[s]”. On [DATE] at 1:51 PM, Resident #84's medical record was reviewed. The medical record review revealed that the resident’s care plan stated Patient may not smoke cigarette per smoking evaluation. On [DATE] at 3:16 PM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #84’s Smoking Evaluation (SNF) - V 4 does not indicate that Resident #84 was an independent smoker, and that Resident #84’s care plan stated Patient may not smoke cigarette per smoking evaluation. Staff #2 stated that she will review Resident #84’s care plan. On [DATE] at 9:41 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that she will update Resident #84’s Smoking Evaluation(SNF) - V 4 and care plan to reflect Resident #84 as an independent smoker. 10. Review of Resident #5's medical record on [DATE] at 08:00 AM revealed a Medication Administration Record (MAR) for the month of [DATE] with a physician order dated [DATE]; Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN) every shift for Monitoring. Further review of the MAR revealed that staff documented “No” on [DATE] on evening and night shift. On 08/02, 08/03, 08/04, 08/05, 08/06, 08/07, 08/08, 08/09, 08/10, 08/11, 08/12, 08/13, 08/14, 08/15, 08/16, [DATE] on day, evening and night shift, there were no progress notes (PN) documenting the side effects that were found. During an interview on [DATE] at 10:00 AM the Director of Nursing stated “that the letters (PN) noted on Resident #5's order dated [DATE]; Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN) every shift for Monitoring, means to document side effects in Resident #5's medical record under Progress Notes (PN), there were no progress notes completed for staff members who documented no, staff should have completed a progress note and or (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff are documenting incorrectly”. 11. During observation rounds and interview on [DATE] at approximately 8:10 AM, Resident #97 was found in his/her room holding a green and white in color pack of cigarettes as well as a blue lighter. Resident #97 stated that, “Yes I smoke, and these items belong to me”. On [DATE] at 9:05 AM a list of facility smokers was provided to the survey team by the facility and revealed that Resident #97 was not listed as a smoker. During an interview on [DATE] at 1:00 PM the Director of Nursing staff #2 (DON) brought an updated list of residents that smoke and stated, “Resident #97 should have been on the list of facility smokers because Resident #97 smokes”. Review of updated list of facility smokers at [DATE] at 1:00 PM revealed that resident #97 was added to the list.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, and record review, the facility failed to ensure that residents were provided care in a manner that protected and promoted dignity for 2 of 3 residents reviewed for dignity (Residents #40 and #93).Findings include: 1. On 8/21/25 at approximately 11:10 AM, during a tour of the shower/tub room, Resident #40 was observed in a shower stall without the privacy curtain being pulled. The shower/tub room contained three shower stalls, a bathtub, and a toilet. At the time of the observation, staff were present rendering morning care; however, the privacy curtain remained open, leaving the resident in full view of the room. During an interview at the time of the observation, the GNA (Geriatric Nursing Assistant) staff #22 acknowledged that the curtain should have been pulled to ensure privacy during bathing and confirmed it was not done. In an interview with the Director of Nursing on 8/21/25 at 12pm, she stated she was made aware of the findings and had reeducated the GNA on resident rights, including the importance of maintaining privacy during personal care. 2. On 8/21/25 at 11:23 AM, during observation rounds, Resident #93 was observed lying in bed with a urinary catheter drainage bag hanging on the side of the bed. The drainage bag was not covered with a privacy bag and was visible from the hallway to anyone walking by. During an interview conducted on 8/21/25 at 11:28 AM, Registered Nurse (RN) Staff #11 confirmed that catheter drainage bags should be covered with a privacy bag or positioned to ensure they are not visible to others, to protect the residents' dignity. After surveyor intervention, staff #11 placed a privacy bag over Resident #93's urinary catheter drainage bag.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility reported incidents (FRIs) and interview with staff, it was determined that the facility failed to report allegations of abuse within 2 hours to the Office of Health Care Quality (OHCQ). This was evident for 3 (#356914, #356923, and #356927) FRI's out of 15 FRI's reviewed during the annual and complaint survey.The findings include: 1. On 08/25/25 at 01:46 PM, the Facility Reported Incident #356917 was reviewed. The Facility Reported Incidents revealed that on 7/31/24 at 1:00 PM, the facility was made aware by the resident's representative that during the 11:00 PM – 7:00 AM shift on 7/29/24, the resident's representative alleged that he/she heard two staff members verbally abusing Resident #112. The facility interviewed the resident and the resident stated that he/she heard Geriatric Nursing Assistant staff #20 and Licensed Practical Nurse staff #21 speaking negatively about him/her and his/her representative. The Facility Reported Incidents also revealed that the facility submitted the initial Facility Reported Incident to the Office of Health Care Quality (OHCQ) on 8/1/24 at 11:57 AM. On 08/25/25 at 3:03 PM, the surveyor interviewed the Nursing Home Administrator staff #1. During the interview, the surveyor made staff #1 aware that according to the facility's initial Facility Reported Incident, the facility became aware of the verbal abuse allegations on 7/31/24 at 1:00 PM, and they submitted the initial Facility Reported Incident to OHCQ on 8/1/24 at 11:57 AM. Staff #1 stated that he believes that he made an error on the submission date and time listed on the initial Facility Reported Incident and will follow-up with the surveyor after he checks his files. On 08/25/25 at 4:03 PM, the surveyor interviewed staff #1. During the interview, staff #1stated that he tried to submit the initial Facility Reported Incident to OHCQ on 7/31/24 while he was home; however, when he arrived at the facility, he realized that the initial Facility Reported Incident did not submit to OHCQ. Staff #1 agreed with the surveyor that the initial Facility Reported Incident, regarding abuse allegations, was not submitted to OHCQ within the required two-hour window. 2. On 8/21/2025 at 3:00PM, during a review of the investigative file for facility reported incident #356923, the Surveyor discovered that Resident #34 reported an allegation of abuse on 9/30/2024 at 5AM to a registered nurse. The Nursing Home Administrator (NHA) was informed about the incident at 5:30AM. Further review of the investigative file revealed that the facility initiated an investigation and the Nursing Home Administrator (NHA) submitted the initial report to OHCQ on 9/30/2024 at 11AM, not within the 2-hour time frame for an allegation of abuse. On 8/25/2025 at 4:00PM, the Surveyor and the NHA confirmed that the facility failed to report FRI #356923 within 2 hours, as required for an allegation of abuse. 3. On 08/21/25 at 3:24 PM during Record Review of FRI #356927 regarding Resident #120 the initial report revealed that staff became aware of an alleged physical incident on 12/22/24 at 3:30 AM and reported it to Nursing Home Administrator Staff #1 (NHA) on 12/22/24 at 3:45 AM. However, the FRI was submitted to OHCQ at 10:48 AM. This reflects over 7hrs later, not within the regulation timeframe of 2 hours. On 08/25/25 at 10:5 AM during an interview with Nursing Home Administrator Staff #1 (NHA) we (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed the time delay. NHA Staff #1 states that the reporting was delayed because I did not have access to a computer at the time of being made aware. When asked what the facility normal reporting procedures are when the NHA is unable to submit a timely report, NHA Staff #1 stated the DON or other designated staff member could submit the report to OHCQ as well. NHA Staff #1 further stated, this did not occur.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview with staff, it was determined that the facility failed to 1.) provide written notification of transfer to the resident representative and provide written notification of the facilities bed hold policy upon transfer to the hospital (Resident #41); 2.) ensure the local ombudsman was notified of a facility-initiated transfer to the hospital (Resident #37and #41); and 3.) ensure a resident received accurate written information regarding the bed-hold policy (Resident #109). This was evident for 3 out of 6 residents reviewed for hospitalization during the survey.The findings include: Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. 1. On 8/15/2025 at 2:08PM, a review of Resident #41's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on 4/19/2025, 5/15/2025, and 6/9/2025. Further review failed to reveal documentation to verify Resident #41's resident representative had been notified in writing of the transfer and the facilities bed hold policy for the transfers to the hospital on 4/19/2025, 5/15/2025, and 6/9/2025. During an interview conducted with Business Office Manager #13 on 8/18/2025 at 12:23PM, the Surveyor was informed that when a resident is transferred to the hospital, a Bed Hold Policy & Authorization form and a letter for Notice of Hospital Transfer is completed. Both documents are sent to the resident representative via mail, unless they are present at the facility at the time of transfer. A copy of the documents should be maintained in the resident's medical record. On 8/19/2025 at 1:00PM, Business Office Manager #13 was able to provide a copy of the Bed Hold Notice of Policy & Authorization and letter of Notice of Hospital Transfer for Resident #41's transfer to the hospital on 4/19/2025. The Business Office Manager #13 failed to provide bed hold documentation (Bed Hold Notice of Policy & Authorization) and transfer notification (letter of Notice of Hospital Transfer) for the hospital transfers on 5/15/2025 and 6/9/2025. 2. On 8/18/2025 at 12:20PM, a review of Resident #37's medical record revealed that the resident was transferred to the hospital on 8/7/2025 and 8/9/2025. An interview with Business Office Manager #13 on 8/18/2025 at 12:23PM revealed that once the Bed Hold Notice of Policy & Authorization and letter of Notice of Hospital Transfer are completed, a copy is placed in the resident's medical record, a copy is mailed to the resident representative (if they haven't received it in person), and a copy is mailed to the Ombudsman's office. Business Office Manager #13 makes a copy of the envelope with paperwork that she sends to the Ombudsman and keeps a copy of the envelope in the resident's medical record. Business Office Manager #13 was able to provide the Surveyor with a copy of the Bed Hold Notice of Policy and Authorization and the letter of Notice of Hospital Transfer on 8/7/2025 and 8/9/2025. She was able to provide a copy of the envelope mailed for notification to the Ombudsman's office for the hospital transfer on 8/7/2025 but failed to provide a copy of the envelope mailed to the Ombudsman's office for hospital transfer on 8/9/2025. During an interview with Business Office Manager #13 on 8/20/2025 at 1:15PM, the Surveyor (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expressed the concerns that the Ombudsman was not notified of Resident #37's transfer to the hospital on 8/9/2025 and Resident #41's transfer to the hospital on 5/15/2025 and 6/9/2025. Business Office Manager #13 and the Surveyor confirmed that she could not provide documentation to verify the Ombudsman was notified of Resident #37's transfer to hospital on 8/9/2025 and Resident #41's transfer to the hospital 5/15/2025 and 6/9/2025. 3. On 5/19/25, Resident #109 was provided with a copy of the facility's bed-hold policy upon transfer to the hospital. Review of the policy showed that the information stated, Medicaid will pay to hold the bed for 15 days, which is not consistent with the state-approved bed-hold duration of no Medicaid bed-hold coverage. During an interview on 8/18/25 at 12:30pm, Staff #13 (Business office Manager) confirmed that this version of the bed-hold policy was the one currently being distributed to residents and acknowledged the information was not correct. Inaccurate information provided to residents regarding bed-hold rights has the potential to mislead residents/representatives about their rights to return to the facility following hospitalization.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview with staff, it was determined that the facility failed to develop and implement a person-centered care plan for residents. This was evident 3 out of 13 residents (Resident #13, #41, #97) investigated for smoking during the survey.The findings include: 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. 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. 1. On 08/20/25 at 10:41 AM, Resident #13's medical record was reviewed. During the medical record review, the resident's eINTERACT Change in Condition Evaluation - V 5.1, dated 6/27/25, in section 1. General Background Information, under 1. Is the resident/patient in the facility for:, 3. Other is selected and under 1a3a. If other, specify: it states hospice. On 08/20/25 at 10:53 AM, Resident #13's medical record was reviewed. During the medical record review, the resident's care plan stated Hospice start date 6/25/23 Hospice care due to end stage diagnosis of _____. In the resident's care plan, the surveyor could not locate interventions for hospice care. The record review revealed that the resident was admitted to the facility on [DATE]. On 08/20/25 at 11:16 AM, the surveyor interviewed the Director of Nursing staff #2. During the interview, the surveyor asked staff #2 if Resident #13 was receiving hospice care. Staff #2 stated that Resident #13 was on hospice. On 08/20/25 at 2:36 PM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #13's care plan for hospice did not list any interventions. Staff #2 stated she was not certain why the care plan did not list any interventions for hospice care. 2. On 8/15/2025 at 9:18AM, the Surveyor observed Resident #41 lying in bed awake with the head of the bed raised to 30 degrees. The Surveyor introduced themselves to the resident. The resident moved his/her head back and forth and finally stared towards the wall. The resident did not acknowledge the Surveyor's presence. On 8/18/2025 at 10:30AM, a review of Resident #41's electronic medical record revealed that the resident had a diagnosis of, but not limited to, dysphagia, dementia, and aphasia. Further review revealed an annual MDS assessment dated [DATE]. Section B: indicated the resident had adequate hearing and vision, unclear speech and rarely makes self understood; Section C indicated the resident had severe cognitive impairment; and Section I indicated the resident had a diagnosis of aphasia. On 8/18/2025 at 11:10AM, an additional review of Resident #41's electronic medical record failed to reveal a care plan for impaired communication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/2025 at 1:01PM, during an interview conducted with Licensed Practical Nurse (LPN) #26, the Surveyor was informed that the Resident #41 would express themselves verbally to certain people. The resident could understand and follow some commands. The resident used hand gestures and shakes his/her head yes or no to communicate his/her needs with staff. LPN #26 had no concerns with the resident communicating their needs indicating not all staff are familiar with the resident or know that he/she can at times communicate verbally because he/she does not express himself to everyone. On 8/19/2025 at 12:00PM, during an interview with the Director of Nursing (DON), the Surveyor was informed that the DON was unaware that Resident #41 was verbal. The Surveyor expressed the concern that the resident failed to have a care plan for impaired communication and interventions on ways to communicate with the resident. On 8/19/2025 at 1:00PM, the DON provided the Surveyor with a copy of a care plan for impaired communication developed on 8/19/2025 by A wing Unit Manager (UM) #5. 3. Review of Resident #97's medical record on 08/14/2025 at 12:00 PM revealed a Care Plan dated 07/31/2025 with a focus area that patient may smoke independently per smoking evaluation but contained no interventions. During an interview on 08/14/2025 at approximately 12:05 PM the Director of Nursing (DON) agreed there were no interventions listed and stated that the Care Plan for Resident #97 should have interventions listed on it. On 08/14/2025 at 1:00 PM after surveyor intervention, the Director of Nursing gave surveyor an updated care plan for Resident #97 with interventions regarding smoking.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interviews, resident interviews, observations, and facility record reviews, it was determined that the facility failed to provide residents with adequate supervision as evidenced by residents having cigarettes and a lighter stored in their room. This was evident for 2 (Resident #24 and #97) out of 13 residents reviewed for smoking during an annual recertification survey.The findings include: 1. On 08/14/25 at 10:46 AM, the surveyor interviewed the Director of Nursing staff #2. During the interview, staff #2 indicated that residents who are smokers must have their cigarettes and lighters stored in a locked box that is secured at the Receptionist staff #8's desk. Staff #2 also stated that when a resident wants to smoke, they can retrieve their cigarettes (maximum of 2 at a time) and lighter from staff #8, and once the resident is finished smoking the resident must return the lighter to staff #8. On 08/14/25 at 2:16 PM, the surveyor interviewed staff #8. During the interview, the surveyor asked staff #8 if there were cigarettes and a lighter stored at the receptionist area for Resident #24. Staff #8 stated that Resident #24 does not have cigarettes and a lighter stored at the receptionist area. On 08/14/25 at 2:47 PM, the surveyor interviewed Resident #24. During the interview, the surveyor asked Resident #24 if he/she smoked today, and if he/she has cigarettes and a lighter in his/her possession. Resident #24 indicated that he/she smoked today and has his/her cigarettes and lighter in his/her possession. The surveyor also asked Resident #24 if he/she would show the surveyor the cigarettes and lighter. Resident #24 indicated that he/she would show the surveyor the cigarettes and lighter. On 08/14/25 at 2:48 PM, the surveyor observed Resident #24 take his/her cigarettes from his/her dresser located on the right side of the bed. The surveyor observed a green and white pack of cigarettes, labeled Cheyenne, and a gray cigarette lighter. On 08/14/25 at 3:45 PM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #24 has cigarettes and a lighter in his/her room. Staff #2 stated that she would have Unit C Manager staff #9 remove the cigarettes and the lighter from Resident #24's room. On 08/19/2025 at 8:47 AM, the facility's records were reviewed. The facility record review revealed that the facility's OPS137 Smoking policy, under 2.6.1 in 2. For Centers that allow smoking: states that if the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment. Also, the facility's OPS137 Smoking policy, under 2.6.2 in 2. For Centers that allow smoking: states that patients will not be allowed to maintain their own lighter, lighter fluid, or matches. On 08/19/25 at 9:31 AM, the surveyor interviewed the Nursing Home Administrator staff #1 and staff #2. During the interview, staff #1 and staff #2 indicated that although the smoking policy says that if the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment, the facility stores residents' cigarettes and lighters in a secured box located in the receptionist area. (continued on next page)

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	215088	A. Building B. Wing	08/25/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During observation rounds and interview on 08/14/2025 at approximately 8:10 AM, Resident #97 was found in his/her room holding a green and white in color pack of cigarettes as well as a blue lighter. Resident #97 stated that, Yes I smoke, and these items belong to me. During an interview on 8/14/2025 at approximately 10:30 AM, the Director of Nursing staff #2 (DON) was made aware that Resident #97 had cigarettes and a lighter in their possession. The (DON) stated that, Resident #97 should not have those items in [his/her] room and staff would go and remove them right away and that any resident that smokes should not have any cigarettes or lighters in their room at any time. During an interview on 8/14/2025 at approximately 12:35 PM staff member #5 stated, I have removed smoking items from [Resident #97] and placed them at the front desk. During an interview on 8/19/2025 at 9:26 AM with the Nursing Home Administrator and Director of Nursing both stated, that any residents that smoke should not have cigarettes, lighters or any smoking items in their rooms and all smoking items should be kept at the front desk even though the facility smoking policy states; if the patient is cognitively and physical able to secure all smoking materials, the Center may allow him/her to maintain his/her tobacco or electronic cigarette products in a locked compartment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, facility record reviews, and staff interviews, it was determined that the facility failed to: 1) maintain proper temperature controls for stored drugs and biologicals; 2) ensure the removal of expired emergency medication from the medication storage room; 3) ensure that residents' medication is stored in the medication carts; and 4) ensure the removal of expired medication from the medication cart. This was evident for 2 of 2 medication storage rooms and 1 of 4 medication carts reviewed during an annual recertification survey.The findings include:1. On [DATE] at 10:25 AM, a medication storage observation was conducted. During the medication storage observation, the surveyor observed a buildup of ice in Unit C's medication storage room freezer.On [DATE] at 10:26 AM, the facility's records were reviewed. The facility record review revealed that the facility's Temperature Log for Refrigerator and Freezer did not have documentation of the temperature of Unit C's medication storage room freezer.On [DATE] at 10:30 AM, the surveyor interviewed the Unit C Manager staff #9. During the interview, the surveyor made staff #9 aware of the buildup of ice in Unit C's medication storage room freezer, and the lack of documentation of Unit C's medication storage room freezer temperature on the facility's Temperature Log for Refrigerator and Freezer. Staff #9 agreed that there were thick layers of ice in Unit C's medication storage room freezer. Staff #9 stated that she was not aware that she needed to document the temperature of Unit C's medication storage room freezer.2. On [DATE] at 10:28 AM, a medication storage observation was conducted. During the medication storage observation, the surveyor observed an expired emergency medication kit (Genesis ANA Kit) with an expiration date of February 2025 in Unit C's medication storage room. The emergency medication kit (Genesis ANA Kit) contained: 2 expired Epinephrine (Adrenaline) 1:1,000 auto-jectors with a [DATE] expiration date; 2 Haldol IM 5 mg/5ml (Haloperidol) with an expiration date of [DATE]; 4 Mephyton 5 mg tablets (Phytonadione) with an expiration date of [DATE]; and 2 Phenergan Injection 50mg/ml (Promethazine) with an expiration date of February 2025.On [DATE] at 10:30 AM, the surveyor interviewed staff #9. During the interview, the surveyor made staff #9 aware of the expired emergency medication kit (Genesis ANA Kit) in Unit C's medication storage room. Staff #9 agreed that the emergency medication kit (Genesis ANA Kit) was expired.On [DATE] at 1:09 PM, the surveyor interviewed the Director of Nursing staff #2. During the interview, the surveyor asked staff #2 explain the process for keeping the emergency medication kit (Genesis ANA Kit) up-to-date. Staff #2 stated PharMerica, the pharmacy the facility uses, comes to the facility to update the emergency medication kit (Genesis ANA Kit) by exchanging the kits for newer ones. Staff #2 also stated that she is not certain why emergency medication kit (Genesis ANA Kit)) in Unit C's medication storage room was not exchanged for a newer kit.3. On [DATE] at 10:49 AM, a medication storage observation was conducted. During the medication storage observation, the surveyor observed 2 blister packs of Isosorbide Mononitrate 120 mg Extended Release for Resident #69 and Albuterol Sulfate Inhalation Solution, 0.083% 2.5 mg/3 ml for Resident #99 stored in a drawer in Unit B's medication storage room.On [DATE] at 10:50 AM, the surveyor interviewed the Unit B Manager staff #10. During the interview, the surveyor made staff #10 aware of the 2 blister packs of Isosorbide Mononitrate 120 mg Extended Release for Resident #69, and the Albuterol Sulfate Inhalation Solution, 0.083% 2.5 mg/3 ml for Resident #99 stored in a drawer in Unit B's medication storage room. Staff #10 mentioned that she was not certain why residents' medication was stored in a drawer in the medication storage room. Staff #10 also mentioned that Resident #69 was discharged .On [DATE] at 1:11 PM, the surveyor interviewed staff #2. During the interview, the surveyor asked staff #2 why Resident #69's and Resident #99's medication was stored in a drawer in Unit B's medication storage room. Staff #2 stated that Resident #69 should have received the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Isosorbide Mononitrate 120 mg Extended Release blister packs when he/she was discharged since he/she was still on the medication at the time of discharge. Staff #2 also stated that she is not certain why Resident #99's Albuterol Sulfate Inhalation Solution, 0.083% 2.5 mg/3 ml was stored in a drawer in Unit B's medication storage room and not the medication cart, and will ensure that staff #10 places Resident #99's medication in the medication cart.4. On [DATE] at 11:13 AM, a medication cart observation was conducted. During the medication cart observation, the surveyor observed expired Olopatadine Hydrochloride 0.1% eye drops in Unit B's, middle medication cart for Resident #17.On [DATE] at 10:50 AM, the surveyor interviewed staff #10 and Registered Nurse staff #11. During the interview, the surveyor made staff #10 and staff #11 aware of the expired Olopatadine Hydrochloride 0.1% eye drops in Unit B's, middle medication cart for Resident #17. Staff #10 and #11 stated that they would remove Resident #17's expired Olopatadine Hydrochloride 0.1% eye drops from Unit B's, middle medication cart.On [DATE] at 1:13 PM, the surveyor interviewed staff #2. During the interview, the surveyor asked staff #2 why there was expired Olopatadine Hydrochloride 0.1% eye drops for Resident #17 in Unit B's, middle medication cart. Staff #2 stated that she was not certain why there was expired Olopatadine Hydrochloride 0.1% eye drops for Resident #17 in Unit B's, middle medication cart, because Unit B's medication carts were recently checked for expired medication.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **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 a resident who requires dental services on a routine or emergent basis receives necessary or recommended dental services in a timely manner. This was evident for 1(Resident #41) reviewed for dental services.The findings include: On 8/18/2025 at 11:10AM, during a review of Resident #41's electronic medical record, the Surveyor discovered the resident's last dental examination was 9/26/2024. Further review revealed a dental note dated 9/26/2024 which stated Not a candidate for surgical extractions or xrays in the facility and remaining teeth have poor prognosis due to periodontal disease, caries, and retained roots. Action required by nursing home staff: Monitor teeth for signs/symptoms of problems; Patient would benefit [from] referral for panoramic xray and extraction with nitrous/IV sedation. Patient at risk for dental infection. Provider continue peridex swabs 2x a day for periodontal disease.On 8/18/2025 at 12:55PM an interview was conducted with A wing Unit Manager (UM) #5. The Surveyor was informed that nursing staff should put orders from consultations into the resident's medical record for the physician to review and sign. Recommendations for further consultation should be reviewed by nursing and appointments should be made accordingly. The Surveyor expressed the concern that Resident #41's last dental visit was 9/26/2024 and reviewed the [Dental Group] note. According to the exam, the resident had poor, general breakdown, heavy soft plaque/food debris buildup, heavy hard calculus deposits, severe [NAME].inflam./swollen bleeding gums, poor periodontal condition, and high risk for caries. The resident's remaining teeth had a poor prognosis due to periodontal disease, caries, and retained roots. Resident #41, at that time, was noted to be non-verbal, have difficulty swallowing, and at risk for dental infection. The Surveyor requested documentation that the resident had a follow up appointment for the dental services required from the last dental exam on 9/26/2024. UM #5 informed the Surveyor that the [Dental Group] will no longer see the resident and has removed the resident from their services. UM#5 and the Surveyor confirmed the resident had not been seen by another dental service provider since 9/26/2024. The Surveyor expressed the concern that Resident #41 was removed from the facility's [Dental group] service and confirmed with UM #5 that the facility made no attempt to schedule an appointment with an outside dental service to meet the dental concerns for the resident. On 8/19/2025 at 12:00PM, the Director of Nursing (DON) provided the Surveyor with a copy of an email from the [Dental Group] which noted that the resident was not a good candidate for onsite treatment due to: patient treatment limited due to patient behavior and tolerance, patient would benefit for referral for panoramic xray and extractions with nitrous/IV sedation, [Dental Group] is unable to provide this form of sedation, and provider placed patient on do not treat status. The Surveyor reviewed the email with the DON and asked if [Dental Group] could no longer provide dental services to Resident #41, why didn't the facility retain an outside dental service for the resident after the examination on 9/26/2024? The DON was unable to provide the Surveyor with an answer. The DON informed the Surveyor that Resident #41 had a dental appointment on 11/7/2025 with an outside dental service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview with staff, it was determined that the facility failed to ensure face masks were included Personal Protective Equipment (PPE) inside the PPE carts outside residents' rooms. This was evident for 3 PPE carts on the C wing and 4 PPE carts on the A wing. The findings include: Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. PPE includes, but not limited to, gloves, masks, safety goggles, and gowns. On 8/14/2025 at 8:30AM, during a tour of the C wing nursing unit, the Surveyor observed 3 PPE carts along one side of the hallway. Each cart failed to have face masks inside. On 8/14/2025 at 8:33AM, during a tour of the A wing nursing unit, the Surveyor observed 4 PPE carts along one side of the hallway. Each cart failed to have face masks inside. On 8/14/2025 at 10:19AM, the Surveyor conducted an interview with the Infection Preventionist (IP) #25. The Surveyor was informed that the expectation was for all PPE carts to have gowns, gloves, face shields, and face masks. The Surveyor expressed the concern that 3 PPE carts on the C wing nursing unit and 4 PPE carts on the A wing nursing unit failed to have face masks inside and readily accessible in the resident care area. On 8/14/2025 at 11:30AM, the DON informed the Surveyor that the carts were stocked with masks.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. Based on observations and interviews with staff and residents, the facility failed to ensure residents have an enclosed closet space protected from casual access from others by having a closet door. This was found to be evident for 2 out of 21 resident rooms observed during the annual survey.The findings include: On 8/15/2025 at 8:25AM, during a tour of the A wing nursing unit, the Surveyor observed that Resident #41 and Resident #57 did not have closet doors, and their personal belongings were visible. On 8/15/2025 at 8:30AM, an interview conducted with Resident #57 revealed that the closet door had been taken off the hinges months ago because the door was loose and posed a safety issue. The resident was informed that the door would be replaced, and the resident would get a curtain to cover their exposed belongings in the meantime. The resident stated that it never happened and felt uncomfortable with his/her personal belongings exposed to whoever entered the room. On 8/18/2025 at 8:20AM, the Surveyors conducted an environmental tour of the A wing, B wing, and C wing nursing units and an interview with the Nursing Home Administrator (NHA) and Maintenance Director #12. During a tour of the A wing, this Surveyor called attention to Resident #57's room and confirmed the missing door on the resident's closet. This Surveyor also called attention to Resident #41's room and confirmed the missing door on the resident's closet. During an interview, Maintenance Director #12 informed the Surveyor that the closet doors for multiple residents had to be taken down because they were falling off the hinges and posed a safety issue for the residents. He stated that replacing the doors has been a challenge because the company no longer makes that model to properly fit. During an interview, the NHA stated that they have discussed providing the resident's with curtains to cover their belongings in their closet space. The Surveyor expressed the concern that for months, the residents did not have an enclosed closet space to protect their personal belongings from view and casual access to others. On 8/18/2025 at 10:13AM, during an interview with the NHA, the Surveyor was informed that the facility was in the process of ordering new cabinets to replace the damaged ones in the residents' rooms. As of 7/9/2025, the facility received one cabinet. The NHA stated that the facility decided that this will be a gradual process and not happen all at once. The NHA was unable to determine when the residents with missing closet doors would have them replaced with new cabinets.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews of facility staff it was determined the facility failed to ensure effective pest control as flying gnats and flies were observed throughout the building. This was found to be evident during the survey.The findings include: On 8/14/2025, during a tour of A wing nursing unit between 8:30AM and 10:20AM, the Surveyor observed the following concerns:1.) In room [ROOM NUMBER]A-1 and 2, multiple gnats were noted flying around the room.2.) In room [ROOM NUMBER]A-2, multiple gnats observed on used tissues sitting on Resident #1's bedside table.3.) In room [ROOM NUMBER]A-1 and 2, gnats and flies observed flying around the room. Resident #2 stated that the gnats and flies have been an issue within the facility.On 8/14/2025 at 10:25AM, while walking down C wing hallway towards the conference room, the Surveyor observed gnats flying.On 8/15/2025, during a tour of the A wing nursing unit at 8:15AM through 9:40AM, the Surveyor observed the following concerns:1.) In room [ROOM NUMBER]A-1 and 2, multiple gnats observed flying around the resident's room.2.) In room [ROOM NUMBER]A-1, flies were observed crawling on Resident #41.3.) In room [ROOM NUMBER]A-2, gnats observed on Resident #34's side of the room4.) In room [ROOM NUMBER]A-1 and 2, flies observed flying around room and gnats in bathroom On 8/18/2025 between 8:20AM and 8:45AM, the Surveyors conducted an environmental tour of the A wing, B wing, and C wing nursing units and an interview with the Nursing Home Administrator (NHA) and Maintenance Director #12. During the walk through of B wing and room [ROOM NUMBER]B, Resident #22 appeared upset and informed the Surveyors, NHA, and Maintenance Director #12 that the gnats are an issue in his/her room and they are constantly flying around while eating meals. During a tour of the A wing, this Surveyor made the NHA and Maintenance Director #12 aware of the concerns regarding the observations of gnats and flies within the facility and in rooms 08A, 16A, and 18A on 8/14/2025 and rooms 02A, 3A, 04, and 06A on 8/15/2025.On 8/18/2025 at 9:00AM, an interview with the NHA, the Surveyor expressed the concern that the facility failed to maintain effective pest control. The Surveyor was informed that the facility utilizes [Pest Control Company] and that a representative visits a couple times a month and as needed.On 8/19/2024 at 3:15PM, a representative from [Pest Control Company] and the NHA confirmed visits to the facility 2 to 3 times a month. The representative reviews the pest control log and treats the area's identified in the log since the last time he visited. The [Pest Control Company] representative attributed the residents' own food items to the presence of flies and gnats in some rooms, however, was unable to explain the presence of flies and gnats in rooms that did not have food items. The NHA and the [Pest Control Company] representative stated that they would develop and implement interventions to control the presence of flies and gnats within the facility.