STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215097	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Catonsville	16 Fusting Avenue Catonsville, MD 21228

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled:Number of residents citedBased on observations and interviews with staff, it was determined that the facility failed to: 1) maintain proper labeling, dating, and expiration practices for food items, and 2) properly thaw raw meat in the proper area of the kitchen which had the potential to cross contaminate the food. This was evident during the annual recertification survey. The findings include:On 08/07/2025 at 8:00 AM the initial kitchen tour was conducted with the Dietary Director, Staff # 22.In the walk-in refrigerator, an opened package of hot dogs, a half onion, a half tomato, and an opened package of American cheese were observed without proper labeling, including open and expiration dates. Staff #22 acknowledged these items should be labeled and subsequently labeled and returned them to the refrigerator.In the kitchen area, three white Rubbermaid containers with dry cereal (Corn Flakes, [NAME] Crispi's, and Toasted Oats) were found on a stainless-steel counter without labels indicating the date the cereal was put in the container or expiration dates. Staff #22 confirmed the need for labeling and proceeded to label the containers with the appropriate dates.In the freezer, an unlabeled item appearing to be meatballs lacked identifying information and an expiration date. Staff #22 identified the item as meatballs and added a label.On 08/ 11/ 2025 at 10:12 AM, Staff #23 was observed thawing raw chicken in the triple sinks designated for sanitizing dishes. A blender with blended food and utensils were in an adjacent sink. When questioned, Staff #23 stated they were thawing the chicken to prepare it for baking. The Dietary Director, Staff #22, confirmed that the facility's thawing procedure for raw meat involved either thawing the meat in the refrigerator over three days or under cold water in the food preparation sink, not the sanitizing sinks. Staff #23 was directed to move the raw chicken to the designated food preparation area for thawing.

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observations and interviews it was determined that the facility staff failed to provide a dignified existence to residents as evidenced by storing the residents' clothing in garbage bags, storing the residents' shoes and bed pan in their wheelchairs, and failed to repair furniture in a resident's room. This deficient practice was discovered during the recertification survey.The findings include:On 08/07/25 at 8:04 am the surveyor observed Resident #121 shoes in their wheelchair. At 8:42 am the surveyor observed Resident #78 clothes were in a clear plastic garbage bag. At 8:59 am the surveyor observed Resident #25 & Resident #108 clothes in clear garbage bags. The surveyor observed a bedpan in Resident #108 wheelchair.On 08/11/25 at 1:57 pm while in Resident #108 room the surveyor observed laminate was off the top dresser drawer and the first and second drawer did not have handles. Geriatric Nursing Assistant (GNA) #36 confirmed the surveyor's findings. The surveyor asked GNA #36 why the residents' clothing is in garbage bags are. GNA #36 verbalized the staff needs hangers to hang the residents' clothing in the armoire.On 08/11/25 at 2:05 pm the surveyor reported to the Administrator that multiple residents' clothing was in garbage bags. The Administrator verbalized that some of the residents have hangers. The surveyors reported it was observed that most of the residents who reside on Unit C clothing were in garbage bags.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews it was determined that the facility staff failed to ensure the resident who reside on Unit C had their call bells to notify the staff of their needs. This deficient practice was evidenced in 7 (#4, #18, #29, #38, #40, #78, #92) of 27 residents who resided on Unit C when this deficient practice was discovered during the recertification survey.The findings include:During observation rounds on 08/07/25 beginning at 7:47 am the surveyor observed Resident #4 without their call bell. Registered Nurse (RN) #28 confirmed the resident did not have their call bell. At 8:22 am Resident #18 was unable to find their call bell. At 8:42 am Resident #97 & Resident #78 who share a room, both residents were unable to find their call bells. At 8:56 am while speaking with Resident #40, they were unable to locate their call bell. At 9:21 am the surveyor observed Resident #29 call bell on the floor near the right side of the bed.On 08/12/25 at 9:21 am the surveyor asked Geriatric Nursing Assistant (GNA) #30 when the staff ensure the residents have their call bells. GNA #30 verbalized they ensure the residents have their call bell when they come onto the unit when rounds are done. At 9:23 am GNA #31 was asked the same question. GNA #31 verbalized they make sure the residents have their call bell after assisting the resident.

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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, record review, and interview with the staff, it was determined that the facility failed to: 1) provide clean and sanitary carpets in resident care areas, and 2) maintain a clean and comfortable homelike environment. This was evident for all carpeted areas on the first floor, 4 of 4 rooms on Unit C, and 2 (Resident #47 and #91) of 2 residents observed during the annual survey. The findings include: 1) On 08/07/25 at 8:00 AM, the surveyors observed numerous stains on the carpets at both the front and side entrance areas of the facility. The hallway leading down the A-wing showed multiple stains and dark patches on the carpeted floors. On 08/18/25 at 8:30 AM, the surveyors observed that multiple stains persisted on the carpeted areas throughout the first floor. At 9:00 AM, the Administrator reassured the surveyors that the floors on the first floor were scheduled for renovation. A copy of the renovation contract agreement was requested. Review of the contract revealed that a renovation agreement was signed and dated in May 2025. On 8/18/25 at 10:55 AM, an interview with the Environmental Service Director confirmed that the numerous dark stains on the A-wing carpet flooring resulted from the renovation process. However, the stains in high traffic areas are attributed to normal wear and tears, and large stains in various locations cannot be effectively cleaned with chemicals over a long period of time. Therefore, the EVS staff are permitted to use only hot water for cleaning the carpets on the first floor. 2) On 08/07/25 at 8:00 am the surveyor observed the commode in room [ROOM NUMBER] was clogged. At 9:18 am the surveyor observed Resident #91's foot-board damaged and a significant amount of trash was on the floor under the bed. At 9:21 am the surveyor observed Resident #47 overbed tray table was heavily rusted. At 9:23 am the surveyor observed the commode lid did not fit properly in the shared bathroom between Rooms 215 -216. At 9:24 am the surveyor observed damaged drywall and tile on the floor near the entrance of the bathroom in room [ROOM NUMBER]. On 08/10/25 at 2:10 pm while walking past room [ROOM NUMBER] the surveyor observed the paper towel dispenser was not secure on the wall and was leaning to the side. On 08/10/25 at 4:22 pm during an interview with the Director of Nursing concerning the maintenance issues on Unit C, the surveyor asked how the staff communicates with the maintenance department to report maintenance concerns. The Director of Nursing verbalized the facility used a computer program named TELS which is linked to PointClickCare (PCC) where the staff enters the room number and the problem.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews it was determined that the facility staff failed to practice according to professional nursing standards as evidenced of a nurse failing to clarify a medication order prior to preparing/administering the medication to resident's, a nurse documented medications were given but there was no documentation to verify the resident received the medication, and a nurse documented a medical test was done that was not. This deficient practice was evidenced in 3 (#14, #18, #50) of 3 medication administration observations and 1 (#6) of 1 resident record reviewed for a change in condition during the recertification survey. The findings include: On 08/15/25 at 7:48 AM the surveyor observed Licensed Practical Nurse (LPN) #33 prepare a medication for Resident #18. The resident was ordered Polyethylene Glycol 3350 Powder Give 17 gram by mouth one time a day. The surveyor observed the nurse pour the powder into the cap; the contents were added into an 8 oz plastic cup. About six ounces of water was added to the contents of the cup which was 2/3 full. The nurse did not read the manufacturer's instructions prior to adding the water to the powder and the nurse did not clarify the order with the Pharmacist to verify how much water should have been added to the powder. On 08/15/25 at 8:05 AM the surveyor observed LPN #33 prepare medications for Resident #14. The order read Miralax Oral Packet 17 GM (Polyethylene Glycol 3350) Give 1 packet by mouth one time a day for bowel regimen. The surveyor observed the nurse pour the powder into the cap and add the powder to an 8 oz plastic cup. Water was added to the contents of the cup which was 2/3 full. The nurse did not read the manufacturer's instructions prior to adding the water to the powder and failed to clarify the order with the Pharmacist. On 08/15/25 at 8:31AM the surveyor observed LPN #33 check Resident #50 gastrostomy tube for residual gastric contents in preparation for medication administration. LPN #33 administered medications through the gastrostomy tube and failed to check the placement of the gastrostomy tube before administering the medications. On 08/15/25 at 10:24 AM during an interview with the Regional Director of Nursing he/she verbalized LPN #33 should have clarified the order before giving the medication to the residents and the placement of the gastrostomy tube should have been checked prior to medication administration. On 08/18/2025 at 9:00 AM a review of Resident #6 electronic health record (HER) revealed LPN # 35 documented the resident C/O gas pain while in dialysis on 08/08/25 but he/she told the surveyor the dialysis nurse called the unit and told him/her the resident was having chest pain. LPN #35 documented Tylenol and Mylanta was given to Resident #6 but there was no documentation to verify the resident received the medications. Also, LPN #35 documented that the resident had a electrocardiogram (EKG) and he/she did not have the medical test.On 08/18/25 at 12:02 PM during an interview with the Director of Nursing he/she verbalized speaking with LPN #35 they verbalized they probably forgot to sign off the medications were given. LPN #35 realized the next day after the resident was hospitalized on [DATE].

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews and record, review, it was determined that the facility staff failed to: 1) update staffing boards on Unit's A, C and D during various shifts, and 2) include all the required components on the posted nurse staffing information sheet. This deficient practice occurred on 3 of 4 units during the review of sufficient and competent nurse staffing. The findings include: 1) On 8/10/25 at 2:03 PM the surveyor went to Unit C to assess if there were enough staff to meet the needs of the residents. The surveyor observed that the assignment board was not updated to reflect the current date, shift, and staff who worked. The date on the assignment board was 08/09/25. The shift read 11 PM – 7 AM shift, and the staff listed was from the previous shift. The surveyor asked Registered Nurse #39 why the assignment board was not updated to reflect the current date, time and staff who are presently working. The surveyor did not receive a response. On 8/10/25 at 2:06 PM the surveyor checked the assignment board on Unit D to assess for accuracy. The assignment board read 08/09/25 shift 11 PM- 7 AM shift. The surveyor asked Registered Nurse (RN) #37, who is responsible for updating the assignment board. RN #37 verbalized the nurses are responsible for updating the assignment board. On 8/10/25 at 4:27 pm the surveyor reported to the Director of Nursing the assignment boards were not updated to reflect the current date, shift, and staff on Unit C and the current date & shift on Unit D. The DON verbalized the nurses are supposed to update the staffing boards on the units. The nursing supervisor is supposed to ensure the staffing boards are updated every shift. On 8/10/25 at 4:44 PM during an interview with Licensed Practical Nurse Supervisor (LPN) #29 the surveyor asked why they did not ensure that the assignment boards on the units were updated. LPN Supervisor #29 verbalized they overlooked the boards because they were busy with a resident safety issue. The shift was 8 hours and the surveyor observed the assignment boards were not updated past the seventh hour of the shift. On 8/15/25 at 7:38 AM while on Unit A the surveyor observed the staffing board was not updated to reflect the current date, shift, and staff. The staffing board read 08/14/25. The shift was recorded 11 PM – 7 AM shift, and the staff documented on the board was not the staff who were working. 2) Nursing facilities are required to post daily nurse staffing information, including the facility name, current date, Resident census, and the total number and actual hours worked per shift for licensed and unlicensed nursing staff responsible for Resident care. This includes Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nurse Aides (CNA), Geriatric Nurse Aides (GNA) and Certified Medication Aides (CMA). The information should be easily accessible and clearly displayed for Residents and visitors. Facilities should also retain nurse staffing data for review by the surveyors for a minimum of 18 months. On 8/18/2025 at 7:45 AM the surveyor observed the posted nurse staffing information sheet on the wall in the hallway by the receptionist desk adjacent to the employee time clock. The posted nurse staffing information sheet displayed a date of 8/18/2025, employee names, position/title and hours worked by each employee. The posted nurse staffing information sheet did not include the facility name and the Resident census; however, the Resident census was displayed on a white bulletin board (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at the nurse's station on Nursing Unit A-Wing. The surveyor interviewed the Licensed Nursing Home Administrator (LNHA) at 9:30 AM on 8/18/2025 and conveyed that the posted nurse staffing information sheet did not include the facility's name, and that this was one of the components that was required to be included on the posted nurse staffing information sheet. The LNHA reviewed the posted nurse staffing information sheet for 8/18/2025, acknowledged the surveyor's concern and stated that he would check on this. The surveyor conducted a record review on 8/18/2025 at 10:15 AM of July 2025 and August 2025 posted nurse staffing information sheets which were provided by the facility's Staffing Coordinator. The posted nurse staffing information sheets for July 2025 and August 2025 did not display the facility's name and the Resident census. At 11:00 AM on 8/18/2025 in a follow up interview with the Licensed Nursing Home Administrator (LNHA) he stated that the facility's name was not on the posted nurse staffing information sheet that was observed posted in the lobby. Additionally, the LNHA stated that going forward the facility's name would be handwritten on the posted nurse staffing information sheet until the IT/Computer Department corrected the nurse staffing sheet. At the time of survey exit no additional information was provided by the facility related to posted nurse staffing information.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and interviews it was determined that the facility staff failed to dispose of garbage and refuse properly as evidenced of waste bags on the ground behind the facility's dumpster, COVID 19 test kits on the ground behind the dumpster, empty bottles of water, the dumpster lid, and waste on the ground in front, back and sides of the dumpster. This deficient practice was discovered during the recertification survey. The findings are:On 08/10/25 at 1:55 PM as the surveyor pulled into the back parking lot of the facility they noticed Maintenance Director # 14 and another male throwing items into the dumpster. The Administrator was standing near the dumpster on the left. The surveyor noticed the dumpster was full and the lid was open.On 08/10/25 at 2:57 PM the surveyor went to assess the facility's dumpster. The surveyor observed waste on the ground in the front, sides, and back of the dumpster. There was a large clear plastic garbage bag, a large black garbage bag, a small clear white bag, and a large board on the ground in the back of the dumpster. There were several empty water bottles and COVID 19 tests on the ground close to the dumpster. The surveyor observed 4-5 boxes on the top of the refuge in the open dumpster. Part of the lid of the dumpster was on the ground.On 08/10/25 at 3:53 PM the surveyor reported the issues observed concerning the dumpster to Maintenance Director #14. Maintenance Director #14 verbalized the maintenance of the dumpster is a joint effort between Environmental Services and the kitchen. The dumpster was scheduled to be emptied on Monday, Tuesday, and Friday every week. Everyone who throws waste in the dumpster is responsible for keeping it clean. The staff should not throw waste over the dumpster and it is a joint effort to keep the area clean. The surveyor reported the dumpster lid should be closed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with the facility staff, it was determined that the facility failed to: 1) provide alcohol-based sanitizer and cold running water necessary for hand hygiene procedures, and 2) maintain infection control precautions with residents use of a urinal. This was evident for 2 (Residents #33 and #42) out of 2 residents' rooms and 1 of 1 observation of urinal storage in a resident's room during the recertification survey.The findings include: 1) On 08/07/25 at 8:10 AM, the surveyors observed a two-handle faucet in room [ROOM NUMBER] and turned on the water to assess the temperatures. The hot water was operational, but the cold water did not dispense any running water. The surveyors then turned to the alcohol-based sanitizer dispenser to sanitize their hands before leaving the room. However, the dispenser was empty. At 8:15 AM, an interview with the unit manager indicated that the staff utilized the hand sanitizer bottle located on the medication cart after exiting each resident's room. At 9:40 AM, the surveyors informed the Administrator about the absence of cold running water and the lack of alcohol-based hand sanitizer in the dispenser in room [ROOM NUMBER]. He confirmed that the wall-mounted alcohol-based sanitizer dispensers were in the process of being replaced, and/or a sanitizer bottle would be placed in front of each resident's room. At 10:00 AM, the surveyors confirmed that a bottle of hand sanitizer had been placed on top of a two-tiered plastic drawer in front of the resident's room. On 08/08/25 at 3:30 PM, the surveyors returned to the room to check the cold running water at the handwashing sink in room [ROOM NUMBER]. At 3:40 PM, the Maintenance Director verified that he needed to shut off the water line on the same side of the hall on the A-wing rooms to repair all the valves. At 3:45 PM, the Administrator was interviewed to find out where he would relocate the residents during the shutdown of the water line in the A-wing for the hand sink repairs. He stated that there were several unoccupied rooms available in the facility to accommodate the residents during the repair process. On 08/10/25 at 2:05 PM, the surveyors confirmed that room [ROOM NUMBER], which lacked cold running water, was unoccupied. On 08/18/25 at 10:45 AM, the Director of Nursing (DON) was interviewed and confirmed the procedures that were implemented while the water supply was temporarily cut off during the renovation process. She indicated that temporary water jugs and soap were provided in the rooms of residents who lacked water. However, the surveyors were unable to validate these claims at the time of the survey. 2) On 08/07/25 at 8:18 AM, during observation rounds the surveyor observed two unlabeled used urinals in room [ROOM NUMBER] where two residents reside. At 8:27 AM while in the shared bathroom in room [ROOM NUMBER], the surveyor observed brown matter on the commode. At 8:48 AM the surveyor observed two unlabeled urinals in the shared bathroom and a brown substance was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the commode. At 8:59 AM while speaking with Resident # 108 the surveyor observed 4 urinals hanging over the wastebasket. Urine was in three of the four urinals. At 9:12 AM the surveyor observed a trash bag with clothing on the floor in Resident #122 room. On 08/10/25 at 3:32 PM, the surveyor asked EVS Director #12 what the responsibilities of the department are in relation to the residents. EVS Director #12 verbalized the department is responsible for cleaning the residents' room and emptying the trash. On 08/11/25 at 1:48 PM, during an interview with Geriatric Nursing Assistant (GNA) #36 the surveyor asked how the staff determines what urinal belongs to a resident. GNA #36 verbalized the urinals are supposed to be labeled. On 08/15/25 at 8:42 AM, the surveyor observed Unit Manager #5 place the stock bottle of Docusate Sodium Oral Liquid on Resident #50 bedside table. LPN #33 administered the medication though the resident's gastrostomy tube. The resident was on Enhanced Barrier Precautions, and the stock medication was brought into the resident's room. At 8:50 am the surveyor observed the nurse put the medication back on the medication cart without sanitizing the bottle. On 08/15/25 at 10:24 AM, the surveyor reported to the Regional Director of Nursing a stock bottle of medication was used in a resident's room. The Regional DON verbalized the stock medication should not have been taken into the resident's room but since it was the bottle should have been sanitized afterwards.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations interviews it was determined that the facility staff failed to maintain equipment in safe operating condition. This deficient practice was discovered during the recertification survey. The findings include:On 08/07/25 at 8:25 AM the surveyor observed a black wire hanging from a hole in the wall next to Resident #50 bed. At 8:28 AM the surveyor observed the charging cord to the standing scale in the hallway next to room [ROOM NUMBER] hanging from the wall in two pieces. To the left above the electrical outlet was a hole in the wall with electrical wires exposed. At 8:33 AM while in room [ROOM NUMBER] the surveyor attempted to turn the light on the in the shared bathroom, but the light did not turn on. Resident #14 verbalized I needed to go to the room next door to turn on the light. The surveyor went to room [ROOM NUMBER] to turn on the bathroom light; the light came on. At 8:48 AM the surveyor attempted to turn the light on in the shared bathrooms for Rooms 209 7 room [ROOM NUMBER]. The light did not come on. On 08/08/25 at 2:08 PM while speaking with Resident #6 the surveyor heard the resident's bed alarm every few minutes; the bed control read low pressure.On 08/11/25 at 10:55 AM while on Unit A the surveyor observed a hole in the wall with exposed wires next to the clean utility room on Unit A near the nurse's station. At 10:59 AM the surveyor asked the Administrator why were the wires exposed. The Administrator verbalized the issue would be rectified right away. On 08/11/25 at 1:37 PM the surveyor toured the facility with Maintenance Director #14 to report the maintenance concerns visualized during the surveyor rounds. Maintenance Director #14 verbalized the staff is supposed to put maintenance concerns in TELS so the issues can be addressed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observations, and interviews with the residents and facility staff, it was determined the facility failed to ensure: 1) there was an accessible call bell within reach for Resident #52, 2) call bell lights were operable and visible above the residents' doors for room [ROOM NUMBER] and #106, and 3) a functioning call bell system was installed in the Physical Therapy bathroom for resident use. This was evident for 4 of 4 resident call bells observed during the annual survey.The findings include:On 08/07/25 at 10:45 AM, an interview with the Resident #52 indicated that he/she was unable to reach the call bell to request assistance in getting back to bed. The surveyors noted that the resident was seated in a wheelchair, with the call bell positioned on the opposite side of the bed.At 11:15 AM, the surveyors activated the call bell. Around 11:19 AM, GNA #11 rushed into the room to deactivate the call bell and explained that she was attending to another resident in the shower room. At 11:24 AM, the surveyors informed the Director of Nursing (DON) and the Administrator that Resident #52 required help returning to bed and raised concerns about the call bell's placement.On 08/12/25 at 9:22 AM, the surveyors conducted spot checks in the A-wing to assess the call bell system and discovered that the corridor light cover was missing above the room [ROOM NUMBER] door. The surveyors pressed the call bells in Rooms #105 and #106, but the corridor lights above the doors did not illuminate, indicating that the call bells had been activated in both rooms.At 9:35 AM, the Administrator and the Regional DON inspected the A-wing to demonstrate that the call bell system was operational at the nurse's station. However, they confirmed that the corridor lightbulbs above the doors in Rooms #105 and #106 were burned-out. At 10:10 AM, the Maintenance Director informed the surveyors that the burned-out call bell lightbulbs above the residents' doors in the B-wing have been replaced.On 08/18/25 at 10:45 AM, the surveyors interviewed Staff #25 and the Director of Rehabilitation regarding how residents utilized the bathroom at the rehabilitation center. They explained that staff would assist residents to use the bathroom based on their level of independence, with one staff member standing outside the door. Both confirmed that the call bell system was missing from the rehab center bathroom. At 11:00 AM, the surveyors alerted the Administrator about the missing call bell system in the rehab center bathroom. The Administrator acknowledged that an order had been placed for the repair and/or replacement of the call bell system and the lightbulbs.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interviews and review of contractor records, it was determined that the facility failed to keep a sanitary environment. This was found evident in the conference room, ice machine room, kitchen, laundry room and rehabilitation room during the survey. The findings include: On 8/13/25 at 5:43 AM, the surveyor observed vermin dropping located in the first floor conference room. On 8/14/25 at 6:10 AM, the surveyor reviewed the pest management company treatment documents. The surveyor noted that several recommendations were repeated throughout the treatment reports. The pest management company wrote they observed voids (holes) in the kitchen on 2/24/25, 7/16/25 and 7/25/25. On 7/25/25 the comment stated, one of the voids in the kitchen still needs to be sealed. It also stated broken tiles were found that were holding dirty water in breakage under the floor. The company also commented that this attracts roaches to the area. Additionally the company recommended improving sanitation procedures. This was recommended on 5/29/25, 7/16/25 and 7/24/25. On 7/24/25 the comments stated, poor sanitation throughout the kitchen and dish room area were observed. Due to sanitation conditions, this can create and attract roaches; better cleaning procedures are needed for staff to follow. On 8/14/25 at 7 AM, two surveyors took a tour of the facility. In the first-floor ice room a void in the wall where a plumbing pipe was entering the room was stuffed with steel wool. Additionally, what appeared to be a wet dirty towel was noted under the ice machine. On the back wall behind the machine there was debris, a few cup lids and a facemask on the floor. On 8/14/25 at 7:05 AM, the surveyors observed the kitchen. Several cracked tiles were noted on the floor in the hallway just outside the chemical room. On 8/14/25 at 7:07 AM, the surveyors observed the area under the dishwasher. A lid to a pitcher, a bowel, a piece of wrapper and debris were noted. On further observation vermin droppings were noted. Next the surveyor observed a French fry, wrappers and debris under the sink next to the drain. No French fries were being prepared during this observation On the back wall under the stainless steel preparation table, located next to the oven, there was noted vermin droppings. The surveyor next observed the stainless steel preparation tables in the center of the kitchen. Both tables had water accumulation under them. The farther table had a piece of cut banana under it. No bananas were being prepped during the observations. On 8/14/25 at 7:14 AM, the surveyors observed the laundry area in the basement. Multiple corners of the walls had rusted broken metal trim with what appeared to be holes in them. Multiple sections of tile were broken. On 8/14/25 at 7:16 AM, the surveyors observed a bucket collecting drips from a leaking sink. Tiles were broken under the sink. On 8/14/25 at 7:19 AM, the surveyors observed the clean laundry room. A chain of lint was noted alongside the side wall. Behind a linen cart was a dried spill of brown substance, a bottle cap, a wrapper, and a shoe. On 8/14/25 at 7:23 AM, the surveyors observed the rehabilitation department. Along the entrance wall vermin droppings were noted. Further up the wall a pistachio nut was noted. Debris, plastic cap and a ball were noted under the Air Condition (AC) unit. On 8/14/25 at 11:58 AM, the surveyor reviewed the observations and concerns that the facility had accumulated debris, vermin droppings in multiple areas throughout the facility with poor sanitation practices. Cross Reference F925

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, pest control management record reviews, facility staff interviews, and an investigation into a complaint, it was determined that the facility failed to have an effective pest control program. This was found evident in 3 out of 3 recurrent recommendations given to the facility by the pest management company, and also evident for Complaint #292313. The findings include: 1) On [DATE] at 5:43 AM, the surveyor observed vermin dropping located in the first floor conference room. On [DATE] at 8:41 AM, the surveyor made the Regional Director of Nursing (RDON) aware of the observations and requested any pest management documentation. The RDON stated she would pass the request on to the Nursing Home Administrator. On [DATE] at 10:36 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor asked how the facility handles pest control. The NHA stated that a pest management company comes and treats the facility weekly. He further stated that each unit has a pest log for documenting any concerns and the pest management company checks these books each time they come. The NHA stated that any recommendation the pest management company has is communicated verbally to someone at the facility. On [DATE] at 10:48 AM, the surveyor reviewed the pest log from the A wing nursing unit. Staff did not report any concerns [DATE] through April of 2025, two in May, and two in June. All reports were for bugs (ants, beetles, roaches) and each time the pest management company responded with treatments. On [DATE] at 6:10 AM, the surveyor reviewed the pest management company treatment documents. The surveyor noted that several recommendations were repeated throughout the treatment reports. On [DATE] and [DATE], [DATE] and [DATE] it was recommended the facility utilize the unit log books. Specifically on [DATE] it was written; spoke with nursing that moving forward sightings need to be documented in pest control log books, however, after this it was recommended again on [DATE]. Additionally, the pest management company observed voids (holes) in the kitchen on [DATE], [DATE] and [DATE]. On [DATE] the comment stated, one of the voids in the kitchen still needs to be sealed. It also stated broken tiles found that were holding dirty water in breakage under the floor. Also commented this attracts roaches to the area. The third recommendation was to improve sanitation procedures. This was recommended on [DATE], [DATE] and [DATE]. On [DATE] the comments stated poor sanitation throughout the kitchen and dish room area were observed. Due to sanitation conditions, this can create and attract roaches; better cleaning procedures are needed for staff to follow. On [DATE] at 7 AM, two surveyors took a tour of the facility. In the first floor ice room a void in the wall where a plumbing pipe was entering the room was stuffed with steel wool. Additionally, what appeared to be a wet dirty towel was noted under the ice machine. On the back wall behind the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	machine there was debris, a few cup lids and a facemask on the floor. On [DATE] at 7:05 AM, the surveyors observed the kitchen. Several cracked tiles were noted on the floor in the hallway just outside the chemical room. On [DATE] at 7:07 AM, the surveyors observed the area under the dishwasher. A lid to a pitcher, a bowel, a piece of wrapper and debris were noted. On further observation, vermin droppings were noted. Next the surveyor observed a French fry, wrappers and debris under the sink next to the drain. No French fries were being prepared during this observation On the back wall under the stainless steel preparation table, that was located next to the oven, was noted vermin droppings. The surveyor next observed the stainless steel preparation tables in the center of the kitchen. Water accumulation was noted under both tables. The farther table had a piece of cut banana under it. No bananas were being prepped during the observations. On [DATE] at 7:14 AM, the surveyors observed the laundry area in the basement. Multiple corners of the walls had rusted broken metal trim with what appeared to be holes in them. Multiple sections of tile were broken. On [DATE] at 7:16 AM, the surveyors observed a bucket collecting drips from a leaking sink. Tiles were broken under the sink. On [DATE] at 7:19 AM, the surveyors observed the clean laundry room. A chain of lint was noted alongside the side wall. Behind a linen cart was a dried spill of brown substance, a bottle cap, a wrapper, and a shoe. On [DATE] at 7:23 AM, the surveyors observed the rehabilitation department. Along the entrance wall vermin droppings were noted. Further up the wall a pistachio nut was noted. Debris, plastic cap and a ball were noted under the Air Condition unit. On [DATE] at 11:58 AM, the surveyor reviewed the observations and concerns that the facility was not following the recommendations of the pest management company and that the facility had an ineffective pest control program. Cross Reference F921 2) The Office of Healthcare Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland’s health care facilities and community-based programs. The surveyor investigated Complaint #292313 on [DATE] at 7:15 AM that was filed with the Office of Healthcare Quality (OHCQ) on [DATE] at 10:36 AM by Resident #143’s family. The complainant reported that the facility staff left a mouse on the trap for 10 hours in the Resident’s room before removing it after a request for it to be removed from the Resident’s room. Resident #143 was admitted to the facility for short term rehabilitation on [DATE] and discharged home on [DATE]. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:00 AM on [DATE], the survey team observed mouse droppings behind the credenza in the conference room. The Licensed Nursing Home Administrator (LNHA) was notified at 12:00 PM; observed these mouse droppings; acknowledged the surveyors and stated that the contracted pest control company services the facility on a weekly basis. The surveyor conducted a record review on [DATE] at 2:15 PM of the All State Pest Management Service Inspection Reports for the months of [DATE] and [DATE]. All State Pest Management was the contracted company that serviced the facility for pest control. On the [DATE] visit, the technician “inspected and treated all 4 nurses’ stations for occasional invaders; inspected and treated activity room for prior mice activity; deceased mouse was found under the refrigerator during the visit”. On the [DATE] service visit, the technician “inspected and treated all 4 nurses’ stations, kitchen area and dishwasher room, rehab gym and nourishment rooms for occasional invaders”. On the [DATE] service visit, the technician “inspected and treated kitchen area and dishwasher room, all 4 nurses’ stations, and rehab gym for occasional invaders; inspected and treated the country inn for prior mice activity; replenished RTUs (mouse bait stations) as needed”. On the [DATE] service visit, the technician “inspected and treated all 4 nurses’ stations and dining room for occasional invaders; inspected and treated the country inn office for prior mice activity”. On the [DATE] service visit, the technician “checked logbooks; mice activity reported in room [ROOM NUMBER]; inspected and treated kitchen area and dishwasher room, and all 4 nurses’ stations for occasional invaders; inspected and treated room [ROOM NUMBER] for mice activity”. On [DATE] at 6:35 AM the survey team observed additional mouse droppings in the conference room behind boxes of copy paper. The Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Nurse were notified of the mouse droppings and acknowledged the surveyors. In an interview with the Licensed Nursing Home Administrator (LNHA) at 7:10 AM on [DATE], the surveyor conveyed to the LNHA that there was a complaint submitted to the Office of Healthcare Quality (OHCQ) from a Resident’s family regarding a rodent in the facility. Additionally, the surveyor conveyed that the All State Pest Management Service company found occasional invaders, mice, and evidence of mice activity during their weekly visits in various locations of the facility, including Resident rooms. This concern with pests and rodents was indicated on the pest management service inspection reports that were reviewed by the surveyor from the company’s service visits on [DATE] through [DATE]. The LNHA acknowledged the surveyor’s concerns regarding pests and rodents in the facility. At the time of the survey exit no additional information was provided by the facility related to maintaining an effective pest control program.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Number of residents sampled: Number of residents cited: Based on observations and interviews it was determined that the facility staff failed to provide accommodation for a married couple who resided in the facility to live together. This deficient practice was evidenced in 2 (#56, #57) of 2 residents who are married who were residing separately in the facility. This deficient practice was discovered during the recertification survey. The findings include:On 08/07/25 at 1:17 pm while interviewing Resident #56 they verbalized their wife resides in the facility, but they sleep in separate rooms. Resident #56 verbalized they would like to share a room. On 08/13/25 at 8:41 am during an interview with Social Services Director #1 the surveyor asked were they aware Resident #56 & Resident #57 are married and want to share a room. They verbalized when Resident #57 was admitted they talked about sharing a room. Resident #56 was admitted in January 2024, and Resident #57 was admitted in August 2024. She had to check what the specifics are. At 8:44 am the surveyor spoke with the Administrator about the married resident's sharing a room, he/she verbalized it was not brought to their attention and will see if they have a policy and they would assess the room availability to move the resident's around. On 08/14/25 at 9:22 am the surveyor asked what the status of Resident #56 & Resident #57 sharing a room. The Administrator verbalized he/she was not aware they wanted to share a room. The surveyor reported the residents had been in the facility for a year and that was ample time to assess if the residents wanted to share a room.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Number of residents sampled: Number of residents cited: Based on observations, staff interviews and record review, it was determined that the facility failed to provide documentation for the use of a physical restraint. This was evident for (Resident #39) reviewed during the annual recertification survey. The findings include: On 8/7/2025 at 8:00 AM and 12:00 PM, Resident #39's bed was observed positioned against the wall with a floor mat on the left side of the bed. Resident #39 was in bed during both observations. In contrast, B bed was in the middle of the room and C bed was by the window, both B and C beds were facing forward and not against a wall. On 8/11/2025 at 10:30 AM, the bed was again observed against the wall, though the resident was not in bed at this time. On 8 /12/ 2025, at 9:24 AM, Resident #39 was observed in bed with the bed against the wall, and a fall mat was in place on the left side of the bed. When interviewed, Staff #8 Geriatric Nursing Assistant, (GNA) and Staff #10 Licensed Practical Nurse, (LPN) stated that Resident #39 rolls from side to side and out of bed, which is why a fall mat was used and the bed is against the wall , as Resident #39 used to fall frequently. On 8 /13/ 2025, at 8:40 AM, Resident #39 was in bed, and the bed was observed against the wall. On 8/13/2024 at 8:49 AM on the same day, the Regional Director of Nursing (DON) was asked why Resident #39's bed was against the wall. The Regional DON responded, I am not sure why the bed is against the wall; we do not do restraints here. I will need to look in the room. On 8/ 13/ 2025 at11:18 AM, Resident #39's bed was observed and was no longer against the wall. On 8 /18/2025, at 8:20 AM, the Director of Nursing (DON) was interviewed about Resident #39's bed positioned against the wall. The DON explained that Resident #39, previously resided on the second floor, had frequent falls, sometimes tripping over a roommate's belongings. To provide more room, Resident #39 was moved to the first floor, and the bed was placed against the wall. The DON was then asked to provide documentation for this rationale and proof of consent from Resident #39's responsible party for the bed to be against the wall, but no documentation was provided.

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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, interview and medical record review, it was determined that the facility failed to implementing the comprehensive person-centered care plans' interventions that includes timelines to meet residents on-going needs i.e. toileting/ oxygen supply needs. This was evident for 1 (Resident #59) of 2 residents reviewed for care plans during the annual survey. The findings include: During a floor rounding, on 08/07/2025 at 08:33 AM, Resident #59 reported that a night shift staff after 11:30pm last night refused to empty a full urinal. The staff replied- it will get emptied in the morning then just left. The resident was up-set being out of breath it happened repeatedly, that his/her couldn't hold bladder until morning or taking a fall risk to walk to the bathroom to empty it, additionally the urinal smells was bothersome; not being cleaned after emptying each time. Observation, on 08/08/2025 at 01:21 PM and on 08//11/2025 at 8:10 AM, found that Resident #59's urinal was full at bedside. Interview, on 08/11/2025 at 01:35 PM, Nurse Staff #9 stated that she did notice in the morning this resident could be in high anxiety level for some care left by the night shift staff i.e. urinal was full. Observation, on 08/14/2025 at 8:27 AM, found that Resident #59 was yelling out in reference his oxygen tank was getting empty/ not getting enough oxygen. After 10 minutes later and no staff responded (the resident somehow did not use the call light), the surveyor altered one of the staff for this resident's oxygen inquiry. Finally a staff went in checked the tank's gauge was almost empty and got a replacement full oxygen tank. During a bedside interview, on 08/14/2025 at 9:47 AM, Unit Manager Staff #15 was at Resident #59's bedside assessed the situations of the full urinal hanging at bed rail, night shift refused to empty it/wash it and oxygen tank was nearly empty. The resident told the manager Staff #15 that the discerption of the night GNA who multiple times not emptying full urinal and washing it. Staff #15 replied that all staff should be making regular rounds, to empty/clean the full urinal immediately when known ,to check oxygen tanks' gauge per shift and to provide urinal hygiene care. Record review, on 8/14/2025 at 12:51 PM, revealed that Resident #59 was admitted on [DATE] to this facility with medical diagnoses of chronic obstructive pulmonary disease -oxygen dependent, Type 2 diabetes, anxiety disorder, morbid obesity and emphysema. Medical orders for oxygen supply was 3 litter nasal cannula continuously and monitoring oxygen, respiratory rate and pulse oximetry every shift. Resident last mobility assessment indicated unstable to ambulate without 2 assistants. One care plan meeting was conducted on 08/12/25 at 11:30 with staff #32, revealed that Resident #59 had some care issues for being anxious causing his breathing to become a problem. Further multiple care plans' interventions review, found that staff was to provide with room check to promote care, to offer/assist with urinal/ commode as needed, to use consistent routines and caregivers for ADLs assistant, to decreased episodes of anxiety cause respiratory distress and to identify stressful time of day and schedule care. Interview, on 08/15/2025 at 10:29 AM, the Unit Manager Staff #15 identified that one particular night shift staff was GNA #21 not assisting Resident #59's requests, (not on scheduled to work). Staff #15 stated he was to address the issue with GNA #21 and to re-educate all staff to implement care plans' interventions and assist residents' immediate needs. Interview, on 08/15/2025 at 1:24 PM, the Administrator was reviewing above findings and was made aware that the facility failed to implementing the care plans' interventions to provide resident's timely toileting/ hygiene and oxygen care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations and interview it was determined that the facility staff failed to consistently provide Activities of Daily Living (ADL) care to a dependent resident as evidenced by mucous on a resident's face/neck and the staff failed to provide incontinence care to a resident who had a strong scent of urine. This deficient practice was evidenced in 1 (#50) of 1 resident observed with unmet ADL needs during the recertification survey. The findings include:On 08/07/25 at 8:28 AM during observation rounds the surveyor observed Resident #50 in bed with copious oral secretion on the right side of their face and neck. On 08/15/25 at 8:41 AM while Licensed Practical Nurse (LPN) #33 provided Resident #50 their medications, the surveyor verbalized to LPN #33 the resident had a strong odor of urine. LPN #33 verbalized they don't have any Geriatric Nursing Assistants at this time, and they are looking for someone to work on Unit C. After LPN #33 finished giving Resident #50 their medications, LPN #33 went back to the medication cart and prepared medications for another resident. LPN #33 did not provide incontinence care to Resident #50 and did not ask for assistance to care for the resident's needs.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review, and staff interview, it was determined that the facility failed to ensure that: 1) tube feeding bag was appropriately labeled and 2) the cap on the tube feeding bag was securely closed to prevent potential cross-contamination and the attraction of pests/insects. This was evident for 1 (Resident #116) out of 1 resident reviewed for tube feeding. The findings include:On 08/07/25 at 8:40 AM, the surveyors observed that tube feeding, and normal saline bags were hanging on an IV pole without proper labeling. In addition, the inadequately closed tube feeding bag also drew fruit flies to the resident's surroundings.At 9:30 AM, the surveyors accompanied the Director of Nursing (DON) to the Resident #116's room to show that the tube feeding and normal saline bags were missing labels.On 08/08/25 at 9:30 AM, the surveyors returned to check on the resident's condition and reevaluated the labeling of the tube feeding and normal saline bags. The surveyor observed that both bags had been dated 08/07/25 with a black marker.At 10:45 AM, an examination of the facility's Care and Treatment of Feeding Tubes Policy and Procedures indicated that a licensed nurse should regularly inspect the feeding tube and document when a tube feeding was changed and/or replaced within the facility, including the responsible individual's name.On 08/11/25 at 9:45 AM, the surveyors confirmed that the resident's tube feeding was labeled with a print out sticker containing the information specified in the facility's Feeding Tubes Policy and Procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215097	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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. Based on observation and staff interview, it was determined that the facility failed to properly store and label medications and biologics as evidenced by: 1) failing to ensure that multi-dose medications were properly labeled and dated, also 2) that wasted pills were properly disposed of and 3) resident medication was secured in a locked cart. This was evident in 2 of 4 medication carts observed during the survey. The findings include:While conducting the medication storage and labeling facility task on D-wing on 08/07/2025 at 11:08 AM, it was noted that the ear and eye drops of residents #91, #66 and #2 were not appropriately dated with the month, day and year that the medications were opened. LPN #8 was informed.On 08/07/2025 at 1:07 PM during the medication storage and labeling task, this surveyor observed that RN #3 left medication cart #2 on the A-wing unlocked . This was brought to the attention of the nurse.While reviewing cart 1 on the B-wing on 08/08/2025 at 1:30 PM, a large number of loose pills were found in the back of the cart under the medication bubble packs. LPN #9 was made aware, and it was requested that she dispose of medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews, and interviews, it was determined that the facility failed to: 1) maintain medical records in accordance with acceptable professional standards and practices by keeping complete documentation and 2) file documents in the correct resident's medical record. This was found evident for 2 (Resident #132 and #135) of 60 sampled residents, and for 1 (Resident #6) of 1 resident chart reviewed for change in condition documentation during the recertification survey.The findings include: 1) On 8/11/25 at 12:32 PM, the surveyor reviewed Resident #132’s medical record. The review revealed that Resident #132 had a past medical history that included, but not limited to, acute respiratory failure with hypoxia, sleep apnea, and thrombotic pulmonary embolism. On further review an order was written on 3/27/23 that stated, oxygen at 2 liters per minute via nasal cannula continuously. Next, the surveyor reviewed Resident #132’s vital signs. On 3/26/23, 3/27/23, 3/28/23, 3/29/23, 3/30/23, 3/31/23, 4/1/23, 4/2/23, 4/3/23, 4/4/23, 4/5/23, 4/7/23, 4/11/23, 4/12/23, 4/13/23,4/14//23, 4/15/23, 4/17/23, 4/18/23, 4/19/23 and 4/20/23 a pulse oxygen saturation reading was recorded with a comment indicating that the reading was taken while the resident was on room air, meaning no supplemental oxygen. On 8/11/25 at 1:12 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor relayed the concern that Resident #132 had an order for continuous oxygen and that 21 of the 28 days he/she was at the facility the documentation indicated that he/she was not receiving oxygen while getting his/her vitals taken. The DON stated she believed that the documentation of room air was an error and would follow-up. On 8/11/25 at 1:52 PM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated she spoke to several of the nurses that documented the vital signs. She confirmed that the documentation of room air was an error and the Resident #132 was on oxygen. On 8/11/25 at 1:42 PM, the surveyor reviewed Resident #135’s medical record. The review revealed that Resident #135 was admitted to the facility in late September 2023 as a hospice respite patient. On 8/12/25 9:33 AM, the surveyor conducted an interview with the Director of Nursing DON. During the interview the surveyor asked for the hospice documentation for Resident #135 or any notes related to the hospice visits. The DON stated that all the documents should be part of the closed record and if the hospice staff had come their visit notes would be in the medical record. She further stated that because Resident #135 was a respite hospice resident he/she would have only been at the facility for 5 days and may not have had a visit. The surveyor next reached out to the hospice consult provider and on 8/12/25 at 1:58 PM, the surveyor reviewed the hospice visit notes for Resident #135. The note revealed that the hospice staff made an on-call visit to assess comfort after Resident #135 fell. The note stated that the hospice staff collaborated with the facility nurse and that both Morphine and Lorazepam were administered during her visit. However, this visit was not documented in the Resident’s medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 8/13/25 at 8:57 AM, while reviewing Resident #6 paper medical record on Unit C, the surveyor observed Resident #20 documentation in Resident #6's paper medical record. The documentation consisted of an appointment slip for a Urology appointment, a transportation form, and a consultation note. The surveyor asked Registered Nurse (RN) #35 to make copies of the documents. While putting the documents back in Resident #6 chart, RN #35 realized the documents belonged in Resident #20 chart. On 8/13/25 at 9:29 AM, the surveyor reported to the Regional Director of Nursing Resident #20 medical documentation was in Resident #6 paper chart. The Regional Director of Nursing verbalized the staff filed the documentation in the wrong chart.