STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215109	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossville Rehabilitation and Healthcare Center	6600 Ridge Road Baltimore, MD 21237

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to serve food in a sanitary manner. This was evident during the initial tour of the kitchen during the recertification/complaint survey. The findings include:On 11/17/2025 at 7:31AM, during the initial tour of the kitchen an observation of Staff #1 (Dietary Supervisor) and Staff #2 (Dietary aid) were observed in the tray line serving food on breakfast plates with no hair net. On 11/17/2025 at 7:40AM, during an interview with Staff #1(Dietary supervisor) confirmed that both she and Staff #2 were not wearing hair nets. Staff #1 acknowledged that staff working on the tray line, who handle food, should be wearing hair nets. The Dietary Supervisor was made aware of the concern at this time.On 11/21/2025 at 3:30 PM, the Administrator and Director of Nursing was made aware of the concern.

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews and record reviews, it was determined that the facility failed to ensure governing body oversight of the facility's Quality Assurance and Performance Improvement (QAPI) Program and activities. This was evident during the recertification/complaint survey.The findings includeThe governing body and/or executive leadership are organized groups or individuals who assume full legal authority and responsibility for operation of the facility.On 11/21/25 at 2:00 PM the Director of Nursing (DON), who is also the QAPI contact person was asked in an interview if the QAPI committee have governing bodies, and she responded, Not sure". She was asked who the governing bodies are, and she said: she did not know. She was asked if the facility's governing body and/or executive leadership maintain oversight of their QAPI program and activities per S483.75(f)(1)-6) and she said No.In another interview with the administrator on 11/21/25 at 2:35 PM, he was asked if the facility has a governing body that oversees their QAPI program activities, and he said no, and asked if they were supposed to have one. He was made aware that it is a federal requirement that the facility should have one and that it also says so in their QAPI policy.On 11/21/25 at 2:40 PM the administrator came back to report that their governing body is Atlas, but they do not report their QAPI activities to them. He was made aware that this was a concern.

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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 surveyor observations and interviews with facility staff, it was determined that the facility failed to maintain an effective pest control program. This was found to be evident during the facility's recertification/complaint survey.The findings include:During the survey several observations were made of gnats in the building. On the first day of entry into the facility on [DATE], the surveyor observed multiple flying gnats in the facility's conference room.On 11/20/25 at 2:27 PM as the surveyor entered the laundry area with the Managing Partner and on the tour observed 2 rooms on the dirty side and 2 rooms that were considered clean (one with the dryers and a folding table and one separate room where two laundry staff were folding clothes. Upon entering the dirty side of the laundry area (one smaller room where the laundry chute empties and a larger, rectangular room with 3 washing machines), the surveyor observed gnats flying around in both rooms on the dirty side. There were more observed in the small room where the laundry chute empties into the gray tub. During an interview with Laundry #23 when asked about the fruit flies she stated, Yes, most of the time there are fruit flies. I think it is from the urine (and pointed to the two heaping mounds of dirty laundry in the smaller room). The surveyor shared that it was a concern and Laundry #23 verbalized understanding. An interview was conducted with the Managing Partner on 11/20/25 at 2:34 PM when he entered the dirty side. During the interview, a dual observation of the gnats was made, and he stated the facility had an insect/pest maintenance program with Allstate who comes at least once a month. The surveyor shared the concern of the gnats and the Managing Partner acknowledged understanding. Additionally, he stated I'll make sure they treat the drain here like they do in the kitchen. Throughout the survey conducted from 12/17/25 through 12/21/25, there were several observations made each day of gnats in the conference room from all members of the survey team. On 12/21/25 at 1:25 PM the surveyor shared the concern of the gnats in the conference room with the Nursing Home Administrator (NHA). He stated that he had never seen gnats in the conference room. This surveyor asked the three surveyors who were in the conference room at that time if they had seen gnats throughout the survey and they all verified they had. The surveyor shared this was a concern and the NHA confirmed understanding.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, it was determined that the facility failed to notify the resident's physician and resident representatives of a facility acquired pressure ulcer. This was true for 1 (Resident #9) of 2 residents reviewed for pressure ulcer during the recertification/complaint survey process.Findings included:According to the Center for Medicare and Medicaid services (CMS), a stage 1 wound is describe as, an observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence; may include changes in skin temperature, tissue consistency and/or sensation. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.Change of Condition (CoC) is a standardized tool for health professionals to communicate important details about resident's care to include significant changes in a resident's physical, mental, or psychological status. This tool/form helps ensure early detection and timely intervention, as unaddressed changes can lead to serious complications. This tool will also prompt the writer to indicate who the changes have been communicated to.On 11/17/2025 2:57 PM, a review of Resident #9's wound care consult notes revealed that on 11/14/2025 a new facility acquired Pressure Ulcer, Stage 1 was identified on the left heel. The wound care consult notes described the wound as Epithelial: 100% intact epithelium with evidence of superficial damage (red/pink nonblanchable discoloration). Wound care treatment identified as: Skin Prep; Other Dressings: Leave open to air. On 11/21/2025 12:54 PM, in a Director of Nursing (DON) interview, she was asked to explain the facility's process for a new facility acquired wound. She explained that if a wound of unknown origin was identified on a resident, they would investigate how the wound developed and if they were able to find out the cause, they would educate staff and put interventions in place to prevent further incidents from happening. The nurse would notify the resident's physician to obtain treatment and/or interventions, and the Resident Representative would be notified of the newly identified wound and the treatment plan moving forward. The wound care team would also reach out to the family as well to notify them of the wound care treatment plan. The DON was asked how the facility documents wound notification, and she explained that new skin issues were documented on the e-interact Change of Condition form that would generate a progress note in the electronic medical record (EMR) chart. She was asked the timeframe of when the documentation should be placed in the Resident's chart, and she explained that it should be placed in the EMR the same day the wound was identified. The DON was asked to provide documentation to support that Resident# 9's physician and resident representative were notified of the newly developed left heel pressure ulcer.On 11/21/2025 at 3:00 PM, in a DON interview, the DON stated that there was no documentation to suggest that the facility notified the physician and resident's representatives that the resident developed a new wound in the facility. The DON was asked if the expectation that documentation should have been available and she stated yes. She was informed that it would be a concern, and she acknowledged the concern. The Nursing home administrator was also present for this notification.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews it was determined that the facility failed to notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment. This was evident for 1(Resident #10) of 3 residents reviewed for hospitalization during the recertification/complaint survey.The findings include:On 11/17/2025 at 12:06 PM during the initial tour of the facility, Resident #10 was asked if he has been sent out to the hospital emergently and he said he went sent out recently but was not sure if he was given a bed hold policy at the time.Review of the facility census on 11/19/25 at 1:42 PM revealed that Resident #10 was hospitalized on [DATE] due to abnormal MRI result and came back to the facility on [DATE]. Notice of facility-initiated transfer was given to the residents and was signed and dated 10/2/25. Further review however did not show that a bed hold policy was given to the resident or their representatives.On 11/9/25 at 2:02 PM, the administrator was asked in an interview if a copy of the bed hold policy was given to Resident #10 when s/he was transferred to the hospital and he said yes, he was asked to provide the copy.On 11/19/24 at 2:25 PM the administrator came back to report that it was not given to this resident, that the nurses said they were not aware they have to give it to the resident. They thought it was only the notification of transfer that was required to be given. He was made aware that this was a concern.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on Observation, record review and facility staff interviews, it was determined that the facility 1) failed to update the care plan of Resident #2 who is on isolation precaution to reflect the actual status of the isolation and, 2) failed to conduct care plan meetings of the interdisciplinary team for Resident #11 at the time of the quarterly revision of their care plan. This was evident for 2 (Resident #2 and #11) out of 56 residents reviewed for care plans during this recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's health status, functional abilities, and needs. It is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident. Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). Contact Precautions include the use of a gown and gloves every time a caregiver enters a resident's room, regardless of care provided to the resident. Residents on Contact precautions should be in private rooms and restricted to their rooms except for cares that are medically necessary. EBP involves the use of gowns and gloves for high-contact resident care activities. Residents on Enhanced Barrier Precautions may share rooms with other residents. EBP do not impose the same activity and room placement restrictions as Contact Precautions. Residents can remain on EBP until their wound heals or their indwelling device is removed. Methicillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria that is resistant to many common antibiotics, making infections more difficult to treat. 1) On 11/19/25 at 10:20 AM during the initial tour of the facility, the surveyor observed an enhanced barrier precaution sign posted outside Resident #2's door secondary to a wound infection. The resident also shares a room with 2 other residents on EBP. Review of Resident #2's care plan on 11/21/25 at 10:02AM however revealed that resident still had an active care plan related to being on contact isolation written as: I have MRSA- Colonized in wound. Date Initiated was 05/19/2025. Further review revealed another care plan that reads: I require contact isolation precautions, R/T Multidrug-resistant Pseudomonas aeruginosa. Date Initiated: 05/19/2025 Revision on 05 /19/25. Some of the interventions were to place the resident in a private room. Review of the physicians order dated 5/19/25 revealed orders written as: Contact Precautions for MRSA in Wound: Maintain contact precautions for the duration of the infection. Discontinue (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions 72hrs after antibiotics unless symptoms continue every shift for Precautions until 06/02/2025 23:40. On 11/21/25 at 10:14 AM In an interview with staff #4, a unit manager, she was asked what sort of isolation precaution Resident #2 was on, and she said resident was on enhanced barrier precaution. She was asked if the resident was still on contact precaution and she checked the records and said that resident had an order to be on contact precaution from 5/19/25 and to come off of isolation on 6/2/25. She was asked who updates the care plan and she said it's done mostly by herself or the nurses. She was made aware that the resident's care plan has not been updated to reflect that resident was no longer on contact isolation precaution. She confirmed that the care plan was not updated. On 11/21/2025 at 11:50 AM the Director of Nursing (DON) was made aware of the concern. 2) On 11/19/25 at 2:43 PM in an interview with the Director of Social Work (DSW #14) when asked about care plans and care plan meetings, she stated, Basically discussing the plan of care and if they want to keep their MOLST (Medical Orders for Life-Sustaining Treatment, a medical form that translates a patient's wishes for end-of-life care into a set of doctor's orders) the same and answering questions or concerns. During the interview when asked how often care plan meetings were held, she stated, Upon admission within 21 days and quarterly for long term care residents. Additionally, she stated whenever their quarterly assessment was completed. The surveyor asked if a resident had a MDS assessment completed, for example, on 1/1/25, when would the care plan meeting be held and DSW #14 stated, Within 14 days. Finally, when asked what documentation would be in the resident's medical record after a care plan meeting, she stated, IDT (Interdisciplinary Team) Care Plan Meeting Note. During a review of Resident #11's medical record on 11/19/2025 3:01 PM, it was revealed that Resident #11's MDS assessments were completed on 5/14/24, 8/14/24, 11/14/24, 2/14/25, 5/15/25, and 8/15/25. Further review revealed the following IDT Care Plan Meeting Notes completed on 5/21/24, 8/27/24, 11/11/24, 2/10/25, 5/12/25 and 8/15/25. However, for the following dates: 11/11/24, 2/10/25, 5/12/25, the IDT Care Plan Meeting Note was held prior to the completion of the MDS assessments. On 11/19/2025 at 3:38 PM in an interview with DSW #14 she verified and confirmed that the care plan was based on the MDS assessment. When asked how 3 out of 6 care plan meetings were held prior to the completion of the MDS assessment she stated, If there's a bunch of care plans due for people, it's possible that we held the care plan meeting earlier since it was close to the MDS. During the interview when asked if care plan meetings should be held prior to the completion of the MDS assessment, DSW #14 sated, No. The surveyor shared the care plan meetings held prior to the MDS assessment being completed were a concern. DSW #14 verified and confirmed understanding.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on a complaint, record review and staff interviews, it was determined that the facility failed to administer medications to a resident timely, and as ordered by the physician. This was evident for 1 (Resident #105) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey.The findings include,On 11/18/25 at 10:15 AM in an interview with a complainant, they revealed that a hospital physician told them that Resident #105 had a stroke because s/he was not getting their blood thinning medications as prescribed. The complainant also stated that the blood thinner was later switched to a different one that required closer monitoring.A review of the residents ordered medication on 11/18/25 at 10:29AM revealed that Resident #105 was prescribed on 1/30/25 a blood thinning medication Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for Deep vein thrombosis (DVT) a blood clot to the lower extremities. This medication was later switched on 10/7/25 to a different brand - Warfarin Sodium Oral Tablet 5 MG (Warfarin Sodium) Give 5 mg by mouth at bedtime for DVT.Further review of the actual medication administration time for September and October 2025 on 11/18/25 at 10:38 AM revealed that these medications, including others, were given on some days 2-6 hours late with no documentation as to why the meds were given late. Some examples of these medications include:Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for Anxiety. Start time 09/05/2025 at 08:00. Given on 09/05/2025 at 11:58. Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT Start time 09/05/2025 at 08:00. Given On 09/05/2025 at 11:58. Metformin HCl ER Tablet Extended Release 24 Hour 500 MG Give 2 tablet by mouth every 12 hours for DM. (Diabetes Meletus). Start time 09/06/2025 at 08:00. Given on 09/06/2025 at 15:28. Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT. Start time 09/06/2025 at 08:00. Given on 09/06/2025 at 15:28.Metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 500 mg by mouth two times a day for DM Give with Food. Start time 10/28/2025 at 18:00. Given on 10/29/2025 at 01:26.Warfarin Sodium Oral Tablet 1 MG (Warfarin Sodium) Give 1 tablet by mouth in the evening for CVA GIVE WITH 2.5 MG FOR A DOSE 3.5 MG. Start time 10/28/2025 at18:00. Given on 10/29/2025 at 01:27.Warfarin Sodium Oral Tablet 2.5 MG (Warfarin Sodium) Give 1 tablet by mouth in the evening for CVA GIVE WITH 1MG FOR TOTAL DOSE OF 3.5 MG. Start time 10/28/2025 at 18:00. Given on 10/29/2025 at 01:27.On 11/18/25 at 12:15 PM in an Interview with staff #10 a Registered Nurse (RN) she was asked about their med pass policy, and she said the window is 1 hour before and 1 hour after the scheduled administration time. She was asked if the nurse should document the reason why a medication was given late, she said the nurse should. She was asked if Resident #105 refuses her medications sometimes and she said the resident did not. She was made aware that she gave meds 3-6 hours late to Resident #105 without documenting the reason for the lateness and that this was a concern.On 11/18/25 at 12:43 PM in an interview with the Director of Nursing (DON) about med administration policy, she was asked about their medication administration policy. She confirmed that it should be given one hour before or one hour after the scheduled time. She was asked if she was aware that meds are being given 3-6 hours late. She stated that she provided education to staff on med. policy. She was made aware that this was still a concern.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview it was determined the facility failed to assist with feeding for a resident at risk for aspiration. This was evident for 1 (Resident #16) of 2 residents reviewed for Nutrition during the recertification/complaint survey.The findings include:According to guidelines from the Centers for Disease Control and Prevention (CDC) Aspiration is the inhalation of foreign material such as food, liquids, saliva, stomach contents (including acid/vomit), or foreign objects/airborne particles into the respiratory tract or lungs. Aspiration precautions are the practices used to prevent these substances from entering the airway and lungs instead of the esophagus and stomach.On 11/18/2025 at 8:43 AM, an observation was made of Resident #16 attempting to feed his/herself while lying in bed, there was no staff member present.On 11/18/2025 at 3:21 PM, a review of Resident #16's medical record revealed a physician order for Aspiration Precautions, dated 06/23/2025. Instructions included: position patient upright during meals, provide oral care before and after meals, 1:1 meal assistance, small sips/bites, alternating liquids and solids, allowing extra time for swallowing, and discontinuing the meal if increased coughing or difficulty swallowing solids/thin liquids occurs. On 11/18/2025 at 3:26 PM, a review of Resident #16's medical records showed a care plan (dated 06/24/2025, revised 07/21/2025) identifying an actual/potential aspiration risk due to dysphagia, evidenced by coughing or choking during meals or medication swallowing. An intervention dated 06/24/2025 included 1:1 assistance with meals.On 11/19/2025 at 8:25 AM, an observation was made of Resident #16 lying in bed, with a tray of food, and no staff member present. On 11/19/2025 8:28 AM, during an interview, Staff #11 Licensed Practical Nurse (LPN, Unit manager) defined a 1:1 assist: sitting facing the resident, assisting with each bite and drink, and immediately reporting choking, pocketing, or changes to the nurse. She confirmed Resident #16 was alone with a breakfast tray and there were no staff members present. She was made aware of the concern, which included this second observation that Resident #16 was not receiving 1:1 assistance for feeding from staff during the meal.On 11/19/2025 at 9:18 AM, the Director of Nursing (DON) clarified her expectation that a physician order and care plan for 1:1 feeding assistance (due to aspiration/choking risk) requires continuous staff presence with the resident. The DON was informed of this concern during the interview.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interviews, it was determined that the facility failed to 1) maintain a nasal cannula in a sanitary manner and administer Oxygen according to the prescribed physician order (Residents #6), and 2) failed to provide necessary respiratory care services for Resident #30. This was evident for 2 (Residents #6 and #30) of 3 residents reviewed for respiratory care during the recertification/complaint survey.The findings include: 1) On 11/17/2025 at 11:20 AM, during an observation and interview, Resident #6 was seated in a wheelchair. The oxygen tubing was on the floor next to the bed, not dated, and not connected to the oxygen concentrator. Resident #6 was observed without oxygen and stated that oxygen causes his/her nose to bleed. On 11/17/2025 at approximately 11:25 AM, during an interview, Staff #3, Registered Nurse (RN), confirmed that Resident #6 was not receiving Oxygen (O2) as ordered by the physician. Staff #3 verified that the oxygen tubing was on the floor, was not bagged or dated, and was disconnected from the oxygen concentrator. Staff #3 stated that the oxygen tubing should be properly bagged, dated, administered according to the physician's order, and should not be on the floor. On 11/18/2025 at 8:37 AM, an observation was made of Resident #6 sitting up in a wheelchair, no oxygen was present. The Oxygen concentrator was in the room and had no further supplies available of nasal cannula tubing or water bottle (humidifier used to add moisture to oxygen to prevent dryness and irritation to the nasal passages). On 11/18/2025 at 8:56 AM, in review of Resident #6's medical record revealed a Physician order dated 10/24/2025 for Oxygen at 2L/min (Liters per minute) via Nasal Cannula continuously. Further review of Resident #6's Medication Administration record revealed the oxygen was administered on 11/17/2025 and 11/18/2025 during the day shift. However, during observation on those dates Resident #6 was not receiving any Oxygen. On 11/18/2025 at 9:04 AM, further review of Resident #6's Treatment Administration Record (TAR) revealed a physician's order, dated 10/27/2025, for weekly oxygen tubing changes, including changing and dating the tubing, washing the filter, and changing and dating the water bottle (if applicable). Although the TAR indicated that this was completed during the Monday night shift on 11/17/2025, an observation made on 11/18/2025 at 8:37 AM of Resident #6 sitting in a wheelchair without wearing oxygen, and the oxygen concentrator in the room had no oxygen supply tubing attached. On 11/18/2025 at 9:16 AM, an interview with Staff #5 Licensed Practical Nurse (LPN), confirmed that Resident #6's continuous oxygen was signed as it was administered for the 11/17/2025 night shift. Staff #5 verified that Resident #6 was not receiving the prescribed oxygen, the tubing for Oxygen and a water bottle were absent from the room. Staff #5 stated that a resident ordered continuous oxygen should have the oxygen in place. On 11/18/2025 at 9:29 AM, a continued review of Resident #6's medical record revealed a care plan for Oxygen with an intervention to administer Oxygen per Physician orders. On 11/18/2025at 12:06 PM during an interview, the Director of Nursing (DON) stated that night shift staff change oxygen supplies weekly, adhering to the physician's order. If a continuous oxygen order (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is in place, the DON expects the oxygen concentrator and necessary supplies to be in the room and the oxygen administered continuously. This concern was shared with the DON at the time of the interview. 2) On 1/17/2025 at 12:49 PM, the surveyor observed Resident #30 resting in bed with eyes closed, no acute distress noted. The resident had a tracheostomy which was connected to machine via a trachea mask and tube. The surveyor observed a bag of clear fluid hanging on the humidifier machine dated 10/31/2025; there was no identifiable descriptive label of the fluid that is connected to the machine. There was an undated open bottle of distilled water stored underneath the humidifier machine. The surveyor also observed that the resident's suction canister and tubing was dated 11/5/2025. On 11/17/2025 at 12:55 PM, the surveyor asked the resident's nurse (Staff #29), if there was a Respiratory Therapist (RT) in the facility, he explain that there was a contract agency that provides respiratory care services, but he was uncertain how often they provide service to Resident #30. He stated that whenever the respiratory therapist visits, they would change all the tubing related to the tracheostomy including suction. The surveyor alerted him to the unlabeled open bottle of distilled water at the bedside, he was asked about the purpose of the distilled water, and he explained that the distilled water was used in the humidifier machine by pouring the water in the clear pouch that hung above the humidifier machine. He was asked when the distilled water bottle was first opened and he explained that he was not sure, but he knew it was not there for very long because the bottles were used and emptied often. He was informed that the distilled water bottle was not labeled. On 11/17/2025 at 1:00 PM, The surveyor spoke with Staff #4 (unit manager), she was asked about how often the RT comes into the facility to provide care and she stated she was not sure. She was asked who was responsible for changing the tubing related to the suction and she stated that the nurses were capable to change the tubes but she was not sure how often they were required to change it, she explained that the Director of Nursing (DON) could provide further clarification. On 11/18/2025 12:17 PM, the DON was informed about the above-mentioned respiratory care findings for Resident #30. She was asked who is responsible for changing the respiratory tubing for residents with a tracheostomy and she stated that the RT (who comes in weekly) or the unit manager. She was informed that the unit manager was questioned but she was unable to provide an answer to the surveyor. On 11/18/2025 1:10 PM, a second observation made for Resident #30's respiratory care equipment and the surveyor observed the same concerns minus the open distilled water bottle. On 11/18/2025 at 2:30 PM, an observation of Resident #30's room was made with the DON and nursing consultant. The DON was shown the hanging fluid that was connected to the humidifier with a date of 10/31/2025. The suction set-up and tubes were dated 11/5/2025. The DON was asked who was responsible for suctioning and she stated the nurses are responsible for suctioning the resident. She was then asked about the responsibility of the RT company for changing the tubing and she stated that she would have to reach out to the respiratory company to get the frequency of change required and report back. They were also shown the concern for the unidentified hanging fluid attached to the humidifier and the DON acknowledged the concern. On 11/18/2025 3:39 PM, a review of the Treatment Administration Record revealed that resident had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order for: Tracheostomy Collar Equipment: change and date corrugated tubing, water bottle if applicable, oxygen tubing, and tracheostomy mask, a review of the suction tubing and canister every night shift every Tue -Start Date: 03/04/2025 11 PM. The documentation on the TAR suggested that the above-mentioned respiratory care services was provided on 11/4/2025 and 11/11/2025 by staff; however, the surveyor's observation on 11/17/2025 and 11/18/2025 revealed that the suction tubing and canister was last changed on 11/5/2025 and the water pouch was last changed on 10/31/2025. On 11/19/2025 3:04 PM, the DON stated that the suction tubing and the water pouch were to be changed every month according to the respiratory company. On 11/20/2025 10:35 AM, The DON was notified that an order for weekly change of the respiratory equipment was ordered and documented on the TAR. Therefore, was still a concern for the surveyor, no additional comments offered by the DON at that time.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff interview it was determined that the facility staff failed to ensure parameters used to determine if a resident was to be administered pain medication was adhered to by nursing staff, and failed to have a physician's order for non- pharmacological interventions for residents on pain medications. This was evident for 3 (Resident #6 and #84, #4) out of 3 residents reviewed for pain during the recertification/complaint survey. The findings include: A pain scale is a numerical scale, usually 0-10, used to determine the severity of a person's pain. Parameters (Instructions in order on when a medication can be given) for a pain scale are used to determine which pain medication would be given according to a person's severity of pain. Non-pharmacological interventions are methods that manage or reduce pain without the use of pain medication. 1) On 11/17/2025 at 11:09 AM, during an interview with Resident #6 he/she reported pain and inadequate pain medication, noting he/she had informed multiple staff members. On 11/18/2025 at 9:37 AM, review of Resident #6's medical record revealed a Physician order that was dated 10/24/2025 for Oxycodone to be given every 8 hours as needed for a pain level scale for 6-10. On 11/18/2025 at approximately 9:40 AM, review of Resident #6's medical record revealed a physician's order dated October 28, 2025. The order was for Acetaminophen Oral Tablet 500 MG (Acetaminophen), with instructions to give 2 tablets by mouth every 8 hours as needed for pain. Do not exceed more than 3 grams per day from all sources. The order, however, lacked any pain parameters to indicate the appropriate pain scale for administering the medication. On 11/18/2025 at 9:43 AM, further review of Resident #6's MAR (medication administration record) for the month of November 2025, showed Oxycodone was administered 17 times for a pain level below a pain level of 6. And the Tylenol was given twice for a pain level of 6 and 7 on 11/16/2025 and 11/17/2025. On 11/18/2025 at approximately 9:45 AM, further review of Resident #6's physician orders indicated that there was no physician order for non-pharmacological interventions. 2) On 11/17/2025 at 12:39 PM, during an interview with Resident #84, he/she reported having to wait on pain medications. On 11/18/2025 at 10:34 AM, Resident #84's medical record revealed two physician orders for pain management. The first order, dated 10/27/2025, was for oxycodone Oral Tablet 15 MG, to be given 15 mg by mouth every 4 hours as needed for pain. The second order, dated 10/21/2025, was for Acetaminophen Oral Tablet 500 MG, instructed to give 2 tablets by mouth every 8 hours for pain. However, the record lacked any specified pain parameters to guide the administration of either medication. Furthermore, there was no corresponding order for non-pharmacological interventions. On 11/18/2025 at 11:59 AM, during an interview with the Director of Nursing (DON), the DON stated the expectation that residents receiving as needed (PRN) pain medication must have pain parameters established and followed. Non-pharmacological interventions, which are documented as a physician's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order, should be implemented prior to administering pain medication. At this time, the DON was informed of the concerns. 3) This surveyor reviewed Resident #4's clinical record on 11/20/25 at 8:30 AM. This review revealed that the resident's primary physician wrote an order on 10/17/25 for Oxycodone 150 mg every 6 hours as needed for breakthrough pain (6-10). A review of the Medication Administration Record (MAR) revealed the resident reported a pain level of 4 on 10/29/25 and 5 on 10/30/25. The medication was administered even though the pain scores were below the threshold. The Director of Nursing was interviewed on 11/20/25 at 9:10 AM. She was shown the MAR, the finding was explained, and she was asked if she had an explanation. She said she would review the clinical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interviews, it was determined that the facility failed to report irregularities identified by the pharmacist to the attending physician for follow up. This was evident for 1 (Resident #7) of 5 residents reviewed for unnecessary medication during the recertification/complaint survey.The findings includeOn 11/19/2025 at 9:22 AM review of the physician's order revealed orders for pain medication written as: Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug*give 1 tablet by mouth every 8 hours for Pain and Oxycodone HCl Oral Capsule 5 MG (Oxycodone HCl) *Controlled Drug*Give 1 tablet by mouth every 3 hours as needed for breakthrough pain. The facility was asked to provide a monthly pharmacy review from January to October 2025.On 11/20/2025 at 9:02 AM review of the pharmacist monthly report revealed that the pharmacist recommended in March 2025 to add Narcan, a drug used to reverse the effect of narcotics. Resident #7 was on oxycodone which is a narcotic medication used to treat moderate to severe pain. The facility did not follow the pharmacist recommendation and documented that Resident #7 was hospitalized at the time. Review of the census, however, revealed that the resident was not hospitalized . The Director of Nursing (DON) was asked to clarify.On 11/20/2025 at 10:03 AM the DON confirm that the March recommendation was not carried out and that resident was still in the facility and not hospitalized at the time when the recommendation was made. She was made aware that this was a concern.

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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 observation and interview it was determined that the facility staff failed to 1) ensure treatment carts were locked and secure, and 2) failed to store all drugs in a locked compartment as required. This was evident for 1 out of the 4 nursing units observed in the facility during the recertification/complaint survey.The findings include: 1) This surveyor observed on 11/17/25 at 8:23 AM the treatment cart across from room [ROOM NUMBER] was unlocked. The contents included: gauze pads, a tube of triple antibiotic ointment, a tube of hydrocortisone ointment, a container of wound cleanser solution, a tube of Lidocaine cream (name of resident was worn out), a container of hydrogel, a tube of Mupirocin ointment labelled for Resident #145, Medi honey wound and burn dressing patches sizes 4x5 and 2x2, one pair of bandage scissors, a tube of Vitamin A&D ointment, a tube of antifungal cream, a tube of Santyl ointment labelled for Resident #102, a tube of Nystatin cream, a tube of ketoconazole cream, a tube of bacitracin, a container of Triamcinolone acetonide cream, a container of terbinafine hydrochloride cream, a tube of ACTi vice gel for pain relief, a container of Greer's goo with a label for Resident #42, Bisacodyl suppositories, 2 containers of Vashe wound solution -- one labelled for Resident #145 and another for Resident #117. This surveyor stood at the unlocked treatment cart with the drawers open till 8:36 AM. While standing by the cart, no one approached or spoke to this surveyor. This surveyor approached staff #5 who was an LPN at 8:39 AM and told him that the treatment cart was unlocked. He acknowledged what was said, verified that he could see the unlocked treatment cart, and walked up to the cart and locked it. 2) On 11/17/2025 at 10:19 AM, the surveyor observed an unattended open bottle of aspirin 81mg (containing several white pills) on top of a medication cart on the Ocean Pines Unit (odd side, adjacent to room [ROOM NUMBER]). On 11/17/2025 at 10:20 AM, in an interview with the unit manager (Staff #4), she was notified and shown the bottle of aspirin left unattended on the top of the medication cart. She said she would talk to the nurse who was responsible for that medication cart. The unit manager spoke with nurse #28 and she reported to the surveyor that the nurse stated that it was an oversight. The surveyor notified the unit manager that the unattended medication will be a concern, and she acknowledged the surveyor's findings.

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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 medical record review and interview, it was determined the facility staff failed to 1) maintain a medical record in the most accurate form for residents and 2) maintain medical records for residents from other licenses professionals. This was evident for 2 (Resident #12 and #11) out of 46 residents reviewed during the facility's recertification/complaint survey. The findings include:A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.1) On 11/21/25 at11:27 AM review of Resident #12's medical record revealed his/her profile documented him/her as his/her own responsible party (RP); however, further review of the medical record revealed 2 certificates of incapacity that were signed and dated 5/9/25 and 5/13/25 by two different physicians as required and a surrogate document which was uploaded into the electronic medical record (EMR) on 6/12/25.On 11/21/25 at 11:34 AM the surveyor requested the face sheet for Resident #12. On 11/21/25 at 12:22 PM in an interview with Unit Manager (UM #4) when asked if all medical records for residents were electronic, she stated yes. During the interview when asked if there were any hard copy, paper charts for residents, she stated no.On 11/21/25 at 12:27 PM in an interview with Unit Manager (UM #11) when asked who Resident #12's RP was she stated it was his/her spouse. On 11/21/25 at 12:35 PM in an interview with the Director of Nursing (DON) a dual observation was conducted of Resident #12's face sheet, surrogate document, and his/her 2 certificates of incapacity. The surveyor pointed out that the face sheet lists himself/herself as his/her own RP which the DON validated. The surveyor asked if the face sheet lists Resident #12 as his/her own party; however, he/she has two certificates of incapacity and a surrogate form, was the face sheet an accurate record. The DON stated it was not accurate. The surveyor shared this was a concern and the DON verified and confirmed understanding. 2) On 11/20/25 at 11:59 AM the surveyor requested the psychiatry notes for Resident #11 from November and December 2024. On 11/20/25 at 12:43 PM in an interview with the Regional Clinical Director when asked about the psychiatry notes for Resident #11 from November and December 2024 she stated, We haven't located them, so we're having someone else look. On 11/20/25 at 3:12 PM in an interview with the DON she stated, We do not have those psych (psychiatry) notes. When asked why she said, I'd have to look into that. The surveyor shared this was a concern and the DON verbalized understanding.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff, it was determined that the facility staff failed to ensure residents and/or residents' representative (RP) were provided education regarding the benefits and potential side effects of the pneumococcal and/or influenza immunization. This was evident for 2 (Resident #26 and #12) out of the 5 residents reviewed for immunizations during the facility's recertification/complaint survey.The findings include:The Centers for Disease Control and Prevention (CDC) recommend a pneumococcal vaccine for adults age [AGE] and older, as well as for younger adults (19-49) with certain risk conditions including, but not limited to, diabetes, chronic liver disease, alcoholism, cigarette smoking, chronic heart disease, chronic lung disease, and/or sickle cell anemia. It is important for nursing home residents to get a pneumococcal vaccine because they are at a higher risk of developing serious complications from pneumococcal disease, which can spread easily in the close living quarter environments. The vaccine protects against serious infections like pneumonia, meningitis, and bloodstream infections, which can be life-threatening for older adults, especially those with chronic health conditions. Getting vaccinated also contributes to herd immunity within the facility, helping to protect everyone, including staff. According to the Mayo Clinic, in North America flu season usually runs between October and May. Additionally, the CDC's website states that the Advisory Committee on Immunization Practices (ACIP) recommends routine annual influenza vaccination for all persons aged ˆ6 months who do not have contraindications and furthermore, that adults aged ˆ 65 years preferentially receive an influenza vaccine. It is important for nursing home residents to get an influenza vaccine because they are at a much higher risk of developing severe complications, hospitalization, and even death from the flu. Living in close quarters makes the virus spread rapidly, and their weakened immune systems make them more vulnerable to infection. Vaccination helps prevent the virus from spreading within the facility and protects the vulnerable residents who live there. On 11/21/25 11:00 AM the surveyor reviewed 5 residents' electronic medical records for their immunizations. The review revealed the following:- Resident #26 refused both the pneumococcal and influenza vaccines on 10/28/25; however, in the field marked Education Provided it was documented as No. Additionally, the field marked Education Comments had no information documented. Further review of Resident #26's medical record failed to reveal documentation to support that education was provided as to the benefits and potential side effects of the pneumococcal and/or influenza vaccines. - Resident #12 refused the pneumococcal vaccine on 5/7/25; however, in the field marked Education Provided it was documented as No. Additionally, the field marked Education Comments had no information documented. Further review of the medical record failed to reveal documentation to support that education was provided as to the benefits and potential side effects of the pneumococcal vaccine.On 11/21/25 at 12:47 PM in an interview with the facility's Infection Preventionist (IP) and the Director of Nursing (DON) when asked where consents/declinations, education, and any other documentation related to immunizations would be found, the DON stated in the Miscellaneous tab of the electronic medical record. Additionally, she stated, Everything is in PCC (Point Click Care, the facility's medical record). There are no hard charts. When asked if education of the benefits and potential side effects of the vaccines was provided to the resident and/or RP, the IP stated, If a rt and/or RP declines an immunization, yes, they would be educated on the risks and benefits. The surveyor reviewed the facility's policies for flu and pneumococcal vaccinations on 11/21/25 at 1:30 PM. The flu vaccination policy, entitled Influenza Vaccination stated, It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. The policy also stated, The resident's medical record will include documentation that the resident and/or the resident's RP was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not receive the immunization due to medical contraindication or refusal. The pneumococcal vaccination policy, entitled Pneumococcal Vaccine stated, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy also stated, Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. On 11/21/25 at 1:56 PM the surveyor requested documentation from the medical record that indicated that Resident #26 and Resident #12 were educated on the benefits and potential side effects of the pneumococcal and/or influenza vaccines.On 11/21/25 at 2:13 PM in an interview with the IP, he stated that the facility did not have education documentation for any of the residents whom the surveyor had requested. The surveyor shared this as a concern and the IP verified and acknowledged understanding.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview with facility staff, it was determined that the facility failed to ensure staff were provided education regarding the benefits and potential side effects associated with the COVID-19 vaccine. This was evident for 1 (Staff #30) out of 5 staff members reviewed for immunizations during the facility's recertification/complaint survey.The findings include:COVID-19 is an infectious disease leading to a range of respiratory illnesses from mild to severe. It can be very contagious and spread quickly. Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised (have a weakened immune system), have certain disabilities, or have underlying health conditions. While most people recover without special treatment, some may become seriously ill, particularly older people and those with underlying conditions like heart disease, diabetes, or cancer. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death.On 11/21/25 at 9:13 AM review of Staff #30's health records revealed she last received a COVID 19 booster on 3/24/22; however, further review failed to reveal any documentation to support that education was ever provided as to the benefits and potential side effects associated with the COVID-19 vaccine. On 11/21/25 at 2:21 PM in an interview with Human Resources Director (HRD #22) when asked if she had evidence that Staff #30 had been educated on the risks and potential side effects of COVID-19 vaccine she stated no, the facility did not maintain records of staff COVID-19 education. On 11/21/25 at 2:23 PM in an interview with the Director of Nursing (DON) the surveyor shared the concern that there was no maintenance of staff COVID-19 education. The DON verified and acknowledged understanding.