STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215112	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Health Systems - Columbia	6334 Cedar Lane Columbia, MD 21044

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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. Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure proper kitchen and dining practices. Specifically, the facility failed to label and date food items; monitor refrigerator and freezer temperatures; monitor safe food temperatures; discard expired food items; maintain an ice cream freezer to ensure it remained free from excessive frost buildup; and ensure residents were served the foods listed on their meal tickets. This was evident in 1 of 1 kitchen, 2 of 3 food pantries observed, and 1 of 2 test trays audited during the Kitchen and Dining task conducted as part of the facility's annual survey. The findings include: On 1/5/26 at 8:51 AM, the surveyor toured the kitchen with the Dietary Manager (DM) and the Dietary Director (DD). The following findings were observed and confirmed by the DM and DD:-There was no documented temperature for 1/2/26 in the following refrigerators: walk-in, sandwich, soda, milk, Korean, American, and walk-in freezer. Food Labeling and Dating - Observations:Walk-In Refrigerator:-Produce stored in boxes with labels but no dates-Cottage cheese without a label or date-Prunes without a label or date-Desserts without labels or dates-Multiple containers covered with aluminum foil without labels or dates-Food carts containing beverages, sliced watermelon, and other items without labels or datesSandwich Refrigerator:-Prunes without labels or dates-Salads dated 1/5/26 without identification labels-Pickles stored in cups without labels or dates-Sandwiches dated 1/5/26 without identification labels-An item marked do not use without clear identificationKorean Refrigerator:-One container covered with aluminum foil with two dates (11/25 and 1/4)American Refrigerator:-Plastic container containing an orange substance without a label or date-Shredded and cubed cheese without labels or dates-A bottle of sesame ginger dressing dated 3/25/25. The DM stated the date reflected when it was opened and he did not know the discard date. The DM discarded the item during the observation.Walk-In Freezer:-Food items wrapped in brown paper or cellophane without labels or dates-Chicken products, fries, tater tots, chicken nuggets, pancakes without labels or datesDry Storage Area:-Individual baggies of bread stored beneath the coffee machine without labels or datesIce Cream Freezer:-Heavy frost buildup (at least 2 inches deep) inside the freezerOn 1/05/26 at 12:48 PM, the surveyor notified the Nursing Home Administrator (NHA) of the kitchen findings. The NHA stated they would start working to correct those issues. On 1/07/26 at 11:38 AM, the surveyor observed that individual sandwiches were unlabeled. Dietary Aide #28 could not identify which sandwiches were which and had to ask a coworker. The surveyor also observed that tray line temperature logs were disorganized, with multiple dates missing and several entries illegible.Findings from the temperature logs included:American Tray Line:-12/25/25 - no breakfast or lunch temperatures recorded-12/26/25, 12/27/25, 12/28/25, 12/29/25, 12/30/25 - no breakfast or lunch temperatures recorded; dinner temperatures missing except on 12/29/25 and 12/30/25-12/31/25, 1/1/26, 1/2/26, 1/3/26, 1/5/26, 1/6/26, 1/7/26 - dinner temperatures not recorded (1/4/26 omitted from the log entirely)-One sheet contained only milk temperatures for five days, with no lunch temperatures recorded and dinner temperatures missing for 2 of 7 days-11/25/25-11/28/25 - no dinner temperatures recorded-12/4/25 - no dinner temperature recorded-12/30/25 - no breakfast temperature recordedKorean Tray Line:-1/2/26, 1/3/26, 1/4/26, 1/7/26 - no breakfast temperatures (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recordedThe DM was present for the observation and confirmed the omissions and errors in the tray line temperature logs. The DM further stated that Korean breakfast temperature records were missing for 1/2/26, 1/3/26, 1/4/26, and 1/7/26 because residents received the American breakfast on those days.On 1/7/26 at 11:45 AM, the surveyor audited a resident's meal tray against the corresponding meal ticket. GNA #30 confirmed that the ticket indicated the resident should receive a double portion of tomato soup, Italian blend vegetables, fruit ambrosia salad, lemonade, and 2% milk. The tray did not contain double portions of any items, and Italian blend vegetables were not provided; instead, spinach was served. Additionally, the tray included beef, a vegetable, and rice, which were not listed on the meal ticket. GNA #30 confirmed that the tray did not match the meal ticket. On 1/07/26 at 12:23 PM, the DM was interviewed and confirmed the surveyor's concerns regarding the resident's inaccurate tray. At approximately 12:40 PM, the surveyor observed that the ice cream freezer had been defrosted on 1/6/26, following the surveyor's earlier observation of a significant layer of ice. The defrosting was documented on the temperature log. On 1/07/26 at 1:07 PM, the NHA reviewed the tray line temperature logs and acknowledged the gaps in the American log. She stated the Korean breakfast is the same as the American breakfast. On 1/07/26 at 1:30 PM, the surveyor spoke with the NHA, who provided a defrost log indicating the ice cream freezer had been defrosted on 1/4/26. The surveyor noted that this did not align with their observation of a thick layer of frost on 1/5/26. The surveyor also observed that the ice cream freezer was defrosted on 1/6/26, as documented on the freezer's temperature log. The NHA stated she would investigate and agreed to provide the surveyor with a copy of the freezer log for verification. On 1/12/26 at 11:09 AM, the surveyor returned to the kitchen and observed the sandwich refrigerator. A tray of sandwiches was labeled T with a date, and salads were labeled TC and TS with the current date; one salad was unlabeled. The Dietary Director (DD) approached the surveyor and, when asked, stated that T meant Tuna. When asked how staff would know, he explained that the same sandwiches are served to everyone on that day of the week. The surveyor pointed to a different sandwich labeled diet, and the DD stated that it was PBJ with sugar-free jelly. When asked about proper food labeling, the DD stated it should indicate the item and the date. When asked again how staff would know what T meant, he acknowledged it should be labeled and dated and remarked that he needs to review the regulations for the exact requirements.The surveyor asked the DD if the Registered Dietitian (RD) conducts audits of the kitchen. The DD stated that she does and provided a document dated 8/22/25. The surveyor noted that under the question, Food is heated to the correct temperature to remove all bacteria before being placed in the hot holding area, and temperatures are recorded, the RD had documented, Temps not recorded. When asked if this indicates that the facility had known since August that safe food temperatures were not being confirmed, the DD acknowledged the entry and stated that it appears they were aware of the issue and that, since coming on board, he has been working to implement improvements.The DD also informed the surveyor that there was an error on the ice cream freezer defrost document previously provided, noting that the wrong date had been recorded. He explained that quarterly defrosting had been skipped, and the ice cream freezer was defrosted after the surveyor's observation on 1/5/26. On 1/12/26 at 11:54 AM, the surveyor reviewed resident foods in three pantries. Deficiencies were noted in two of the pantries. 2 West:-Brown bag in the refrigerator with the resident's name but no date-Blueberries with no date or resident name-Sauerkraut labeled with the resident's name but no date or room number-A sign on the wall stating foods are to be discarded within 24 hours2 Renaissance:-Two signs posted, one stating foods should be discarded within 24 hours and one stating 48 hours-One brown bag with only the resident's name, no date-One plastic bag with no date, name, or room number-One brown bag with no label-Fruit dated 1/5/25 that had not been discardedDuring this observation, the Dietary Manager approached the surveyor at 12:35 PM. When asked to confirm the findings, he acknowledged the concern.On 1/12/26 at 4:25 PM, the surveyor interviewed the NHA regarding pantry concerns. The NHA stated signage would be updated to reflect a 48-hour discard period and staff re-educated on labeling. She acknowledged the sandwich (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refrigerator remained incorrectly labeled and confirmed the quarterly ice cream freezer defrost was not completed on 1/4/26, with documentation updated after the surveyor's observation.On 1/14/26 at 1:45 PM, the surveyor confirmed with the NHA that she was aware of all kitchen concerns. The NHA stated the facility will develop a performance improvement plan.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 failed to ensure medications were kept secure. This was evident for 3 observations on 2 different units within the facility during the survey. The findings include:Controlled Medications are substances that have an accepted medical use, have potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications fall under US Drug Enforcement Agency (DEA) Schedules II-V. 1. On 1/7/26 at 1:53 PM in an interview with 2 [NAME] Unit Manager (Staff #23), it was reported that only on duty nurses possess narcotic keys to access stored narcotics in the medication room and on the medication cart. Maintenance has a master key to the medication rooms. On 1/7/26 at 2:01 PM it was observed that the 2 [NAME] medication refrigerator contained a designated narcotic storage compartment. It was a clear rectangular plastic box, with an intact lock, that contained two residents' Lorazepam, a schedule IV drug. Upon closer inspection, this surveyor found the storage compartment to be unaffixed and demonstrated that it could be removed from the refrigerator and the medication room. Staff #23 acknowledged that the narcotic compartment was unaffixed and that it could be removed. On 1/7/26 the Nursing Home Administrator was made aware of the concern. 2. On 1/9/26 at 3:20 PM a record review of Resident #47's orders dated 12/30/25 revealed admission to [NAME] Hospice Care with a terminal diagnosis of senile degeneration of brain, dysphagia, failure to thrive, and weight loss. On 1/12/26 at 9:45 AM this surveyor entered the room as a result of hearing Resident #47 yelling out and observed him/her to be agitated. Geriatric Nurse Assistant (GNA #32) offered milk to the resident and left the room. Further observation of the room revealed an open box of Morphine Sulfate 100mg/5ml sitting on Resident #47's bedside table. Surveyor remained in the room. On 1/12/26 at 10:03 AM this surveyor observed Psychiatric Nurse Practitioner, (NP #34) enter the room and assessed the resident. NP #34 exited the room at approximately 10:10 AM. On 1/12/26 at 10:10 AM this surveyor, without exiting the room, signaled for 2 [NAME] Unit Manager (Staff #23) to come into the room; she verified the Morphine Sulfate was at the bedside. On 1/12/2026 2:32 PM Staff #23 confirmed that the responsible floor nurse (LPN #35) had received disciplinary action and that the Nursing Home Administrator (NHA) and Assistant Director of Nursing were made aware of the incident. On 1/12/26 at 4:27 PM LPN #35 acknowledged, via phone interview, that the Morphine Sulfate was left in Resident #47's room. On 1/12/26 at 4:43 PM the NHA acknowledged the concern. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 1/8/24 at 10:24 AM surveyor observed a set of keys on top of a medication cart in the hall way near room [ROOM NUMBER]. No nursing staff was present in the immediate area. A housekeeper was noted in a doorway of a room nearby. During the observation of the keys on the cart, unit nurse manager #10 was observed walking down the hall, and passed the medication cart with the keys on top of cart. On 1/8/24 at 10:26 AM Nurse #33 was observed walking past the medication cart, entered a room then came out and walked past the cart a second time on the way back towards the nursing station. Surveyor stopped Nurse #33 to obtain the nurse's name. After providing her name, Nurse #33 stated: that is not my cart and left the area. After Nurse #33 left the area, Nurse #9 was observed leaving a resident's room. Nurse #9 confirmed those were his keys sitting on top of the medication cart. On 1/8/26 at 1:35 PM surveyor reviewed the concern with the Nursing Home Administrator regarding the medication cart keys being left on top of the medication cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to ensure staff appropriately wore source control (face masks) during a period of increased influenza in the community and a current facility outbreak; and failed to ensure hand hygiene was completed between resident contacts. This was found to be evident during 6 random observations during the survey.The findings include: On 12/31/25, the Maryland Department of Health (MDH) issued recommendations in response to increased rates of respiratory virus–associated hospitalizations. MDH advised that healthcare facilities implement facility-wide source control measures in patient care areas and other patient-facing settings. These measures include requiring all individuals—including clinical staff, non-clinical staff, and visitors—to wear masks in patient-facing areas. On 1/5/26 at approximately 8:24 AM, surveyors entered the facility and observed a sign notifying the public of this mask requirement. On 1/6/26 observation of the [NAME] 1 unit revealed the door to the unit was closed with an Observation sign posted on the door. Interview with the Infection Preventionist (IP) Nurse #12 revealed there was currently a flu outbreak on that unit. On 1/7/26 at 11:42 AM the Infection Preventionist (IP) Nurse #12 confirmed that the current flu outbreak was located only on the [NAME] 1 unit, a line listing (monitoring documentation) was started and the local health department was notified. She reported it was expected that in addition to a mask, a face shield should be worn if going into a resident's room on this unit. In a follow up interview, later in the survey, the IP Nurse #12 reported that the facility had a flu outbreak on a different unit in December 2025 and was able to provide line listing documentation for that outbreak. On 1/8/26 at 7:55 AM surveyor observed nurse #9 sitting at the [NAME] 1 nursing station with his mask below his mouth, thus both nose and mouth were exposed. A pharmacy delivery person was on the unit (wearing a mask appropriately) interacting with nurse #9, who was accepting a delivery. Surveyor remained at the nursing station observing Nurse #9, with the mask worn below his mouth, until 7:59 AM, at which time Nurse #9 adjusted the mask to cover his nose and mouth. On 1/8/24 at 10:26 AM surveyor observed on the front portion of the [NAME] 1 unit Nurse #9 leaving a resident's room. Nurse #9's face mask was below his mouth. Nurse #9 confirmed he just left a resident's room and that the mask was below his mouth. On 1/08/26 at 10:32 AM the IP confirmed that the expectation is that staff have a mask on when on the unit. Surveyor then reviewed the observations of Nurse #9 at the nursing station earlier in the morning and then just recently being observed leaving a resident's room with the mask below his mouth. On 1/08/26 at 10:38 AM while walking down the [NAME] 1 unit, surveyor again observed Nurse #9 come out of a resident's room with his mask below his mouth. The nurse adjusted the mask prior to surveyor intervention. On 1/8/26 at 1:35 PM surveyor reviewed with the Nursing Home Administrator the concern regarding Nurse #9's failure to correctly wear a mask on three separate occasions today. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/26 at 8:11 AM this surveyor observed two staff members reposition a dependent resident in bed; one staff, Geriatric Nurse Assistant (GNA #32) incorrectly donned the face mask below the nose while at Resident #20's bedside. On 1/8/26 at 9:19 AM further observation showed Licensed Practical Nurse (LPN #31) administered medications with incorrectly donned face mask below the nose and she did not wash her hands upon entering or leaving two random residents' rooms. On 1/8/26 this surveyor independently informed each staff member of the concern. On 1/12/26 at 11:54 AM, the surveyor observed a medical professional later identified as Nurse Practitioner (NP #22) walking down the hall wearing a procedure mask pulled down and resting across her chin, leaving her mouth and nose exposed, while talking on the phone. The surveyor waited to observe whether NP #22 would reposition her mask after finishing the call. NP #22 did not reposition the mask and continued a conversation with another employee while the mask remained on her chin. At approximately 12:00 PM, the surveyor approached NP #22, introduced themselves, and confirmed her identity. The surveyor asked whether she was aware that the facility was requiring masks due to a flu outbreak. NP #22 responded, Yes, but this floor isn't on outbreak. The surveyor then asked if she was aware of any facility-wide masking requirement. NP #22 stated, I don't know if we have to wear masks on this floor because this isn't the floor with the outbreak, and then placed her mask over her mouth and nose. On 1/12/26 at 4:25 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding concerns that NP #22 was observed not wearing a mask during the facility outbreak. The NHA stated that NP #22 knew better because MDS sent out a notice that respiratory outbreak precautions are to be maintained, and she definitely got the email. The NHA acknowledged this was a concern, especially since the facility currently had a flu outbreak.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined that the facility failed to maintain resident dignity by honoring the residents clothing preferences and providing a dignified environment. This failure affected 2 residents (Resident #4 and Resident #150) of 7 residents reviewed for dignity during the survey. The findings include: 1. A record review revealed Resident #150 was a resident since 1997 with a diagnosis Cerebral Infarction (stroke), Dysphagia (difficulty swallowing) Paraplegia, Vascular Dementia and Depression. On 1/5/26 at 10:10 AM this surveyor observed a sign on Resident #150's wall, this resident is a feeder. On 1/9/26 at 8:03 AM The feeder sign remained posted on the wall while Geriatric Nurse Assistant (GNA #21) assisted Resident #150 with breakfast. In an interview, GNA #21 indicated that the facility posted the sign. On 1/9/26 at 8:11 AM, in an interview, 2 [NAME] Unit Manager (Staff #23) acknowledged the presence of the sign on Resident's #150's wall. On 1/9/26 at 8:15 AM, Licensed Practical Nurse (LPN #24) stated, the sign was moved when Resident #150 was transferred from a different room in the facility. On 1/9/26 at 2:18 PM the sign remained posted on Resident #150's wall. On 1/12/26 at 2:55 PM the sign remained posted on Resident #150's wall. On 1/14/26, the Nursing Home Administrator removed the sign from Resident #150's wall and gave it to this surveyor. 2. On 1/6/26 at 9:45 AM, Resident #4, a long-term care resident of the facility, reported a preference for wearing shoes and clothing rather than a hospital gown. On 1/6/26 at 9:47 AM, observation revealed that Resident #4 was wearing a hospital gown and was not wearing footwear. On 1/8/26 at 12:41 PM, the admission Minimum Data Set (MDS) dated [DATE], Section F (Interview for Daily Preferences), was reviewed. The review showed that Resident #4 was asked how important it was to choose what clothes to wear and responded that it was very important. The following observations were made during the survey: On 1/07/26 at 1:49 PM, observation of Resident #4 in bed revealed no footwear. The resident was wearing a hospital gown. On 1/08/26 at 10:47 AM, observation of Resident #4 in bed revealed no footwear. The resident was wearing a hospital gown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/09/26 at 1:39 PM, observation of Resident #4 in bed revealed no footwear. The resident was wearing a hospital gown. On 1/09/26 at 1:39 PM, Nurse (Staff #11) was interviewed. Staff #11 reported providing care to Resident #4 since the return from the hospital on [DATE] and stated that the resident had only been seen wearing a hospital gown and not regular clothing. On 1/9/2026 at 1:45 PM, Resident #4's legal guardian from the [NAME] County Office of Aging and Independence was interviewed by phone. The guardian reported purchasing two sets of loungewear in June 2025 and a pair of Velcro shoes in August of 2025 for Resident #4. The guardian stated that the clothing and shoes were given to the nurse unit manager (Staff #10). On 1/9/26 at 1:43 PM, an observation was conducted with the nurse unit manager (Staff #10) in Resident #4's room. Staff #10 confirmed that no clothing or shoes were present in the resident's room. On 1/9/26 at 3:05 PM, during an interview, the nurse unit manager (Staff #10) reported recalling receipt of the clothing items for Resident #4. Staff #10 stated that the clothing was placed in storage when the resident was hospitalized in October. Staff #10 reported retrieving the storage boxes and locating the resident's footwear. In addition, she reported she had been unable to locate the resident's clothes. On 1/12/26 at 9:47 AM, observation of Resident #4 in bed revealed that the resident was wearing footwear and a hospital gown. On 1/14/26 at 12:30 PM, the above concerns were discussed with the Administrator. The Administrator confirmed that the resident's clothing was not available for use. The Administrator reported that the facility had contacted the guardian and would replace the resident's clothing

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to ensure accuracy of Residents' life-sustaining treatment wishes and failed to maintain an Advance Directive/ designated point person on file. This was evident for 1 (Resident #67) out of 8 residents reviewed during an annual survey.The findings include:An Advance Directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness. An advance directive may also give a person (such as a spouse, relative, or friend) authority to make medical decisions.Record review, on [DATE] at 11:04 AM, paper chart review found that Resident Medical Order for Life-Sustaining Treatment (MOLST) certified No CPR Option A-2 Do Not Intubate (DNI) based on a discussion with and the informed consent of the patient (resident). These orders were entered by Physician Staff #38 and dated [DATE]. However, the Other Treatment section on the back page of the MOLST was dated [DATE] but was not properly checked off or signed by the facility's medical provider.Medical Orders for Life-Sustaining Treatment (MOLST) is a medical order form that relays instructions between health professionals about patient care. MOLST certified orders that were agreed to by a patient or a patient's health care agent as named in the patient's advance directive. MOLST determines resuscitation status and includes 8 other sections of treatment choices.During the interview conducted on [DATE] at 11:14 AM, Resident #67 was in bed watching TV. The resident experienced difficulties answering questions and was unable to identify their current location or the year. Additionally, the Resident could not successfully repeat words as requested.Interview, on [DATE] at 11:25 AM, the Unit Manager Staff #5 was informed of the aforementioned finding. She agreed that the back page of the MOLST form should have been completed during the discussion on [DATE], and that the form should have been properly signed on both sides. She reviewed the electronic record for any updates regarding the completion of the MOLST form or an Advance Directive on file but was unable to find any documentation.Record review, on [DATE] at 09:29 AM, it was noted that Resident #67 was admitted to this facility on [DATE] after spinal surgery for a wedge compression fracture of the first lumbar vertebra. The resident's past medical history includes hypertension, falls, lower back pain, muscle wasting and atrophy, and unspecified dementia. Additionally, the resident's Brief Interview for Mental Status (BIMS) score was recorded as a 10 during the 2024 Cognitive Patterns assessment.A BIMS (Brief Interview for Mental Status) is determined based on a resident's responses to a set of questions in the Brief Interview for Mental Status. The BIMS score interpretation categorizes scores into groups by cognitive status, signifying severe cognitive impairment to intact cognitive response, helping to understand a resident's cognitive health.13-15: Cognitively intact (normal)8-12: Moderate cognitive impairment0-7: Severe cognitive impairmentA further record review of social worker Staff #37's notes found that she contacted a specific family member, referred to as the Health Care Agent, on [DATE] regarding an upcoming care plan meeting. The family member declined the meeting. However, there was no documentation or Advance Directive on file to support that this individual had been designated as the resident's Health Care Agent.After the surveyor's intervention, progress notes dated [DATE] at 1:15 PM by Nurse Practitioner Staff #39 indicate that she contacted Resident #67's healthcare surrogate to review the MOLST form. At that time, Staff #39 voided the previous MOLST form (dated [DATE]), which had specified No CPR Option A-2 and Do Not Intubate (DNI). The practitioner then initiated a new MOLST form. While the notes stated the new form was intended for no aggressive medical workup or life-sustaining interventions (such as CPR, intubation, feeding tubes, or dialysis), but the actual new MOLST form contradicted this by indicating Full CPR Status and Yes to all life-sustaining treatments. Furthermore, there remained no documentation to verify the designated pointed healthcare agent or surrogate. Interview, on [DATE] at 11:37 AM, Director of Social Worker Staff #6 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed the inconsistent and contradicting findings mentioned above. Specifically, it contained conflicting information: notes from Staff #37 dated [DATE], identified a family member as the Health Care Agent, while notes from Staff #39 dated [DATE], referred to a family member as the healthcare surrogate.Staff #6 agreed that the facility failed to ensure the accuracy of Resident #67's life-sustaining treatment wishes and failed to obtain necessary Advance Directive documentation, such as healthcare representative or surrogacy document. She stated that she had not yet had time to complete the necessary documentation but indicated she was reviewing all residents' charts.During the final interview on [DATE] at 12:10 PM, the surveyor reviewed the findings with the Administrator. Concerns were raised regarding the facility's failure to implement accurately residents' life-sustaining treatment wishes and the failure to maintain Advance Directives on file.The Administrator agreed and stated that she was to review the process with all staff and provide necessary re-education.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to ensure bathroom walls were kept in good repair. This was found to be evident in four out of four resident bathroom's observed.The findings include: On 1/5/26 at approximately 11:40 AM observation of the bathroom in room [ROOM NUMBER] revealed the area where the sink drain pipe met the wall was not sealed. On 1/5/26 at 11:54 AM observation of the bathroom in room [ROOM NUMBER] revealed a jagged hole in the wall where the sink drain pipe was located. This hole was approximately 3 inches in diameter. On 1/5/26 at 1:53 PM observation of the bathroom in room [ROOM NUMBER] revealed the area where the sink drain pipe met the wall was not sealed. On 1/14/26 at 9:16 AM the Maintenance Director #29 reported they complete room inspections every 6 months. Between 9:16 and 9:24 AM the surveyor and Maintenance Director observed the bathroom's in four resident rooms. Observation of the bathroom in room [ROOM NUMBER] revealed the area where the sink drain pipe met the wall was not sealed. The Maintenance Director confirmed that the hole in the wall is not suppose to be there and that there is suppose to be a trim ring. He went on to report that the pipes had recently been replaced and they must have forgotten to put the trim ring on and indicated he would fix the issue. Surveyor and Maintenance Director then observed the bathrooms in Rooms 167, 178 and 197 and confirmed the previous observations of the holes in the walls around the pipes. On 1/14/26 at 10:45 AM the Maintenance Director provided documentation that plumbing repairs were completed in June 2025 for rooms [ROOM NUMBERS]; and in July 2025 for room [ROOM NUMBER]. He stated they did the work and did not put the trim back on.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on Facility Reported Incident (FRI) file (2696293) review, record review and staff interview, it was determined the facility failed to report an unknown origin injury to the State Agency, the Office of Health Care Quality (OHCQ), immediately but not later than 2 hours after the facility was made aware of the injury's severity. This was evident for 1 (Resident #208) out of 5 residents reviewed for incidents during an annual survey.The findings include: Facility Reported Incident file review, on 1/14/2026 at 09:00 AM, it was noted that the initial report was filed with the State Agency on 12/8/2025 at 9:54 AM. The facility's investigation report contained only one on-duty staff incident statement and two staff email statements regarding an unknown origin injury involving Resident #208 on 12/06/2025 at approximately 4:00 PM. Evidently the Resident was reported to be screaming in severe pain in their left hip and was subsequently transported to a nearby hospital.Records from 12/07/2025 indicate that the facility Charge Nurse Staff #41 and the Unit Manager Staff #42 were informed that the hospital diagnosed Resident #208's injury with a left hip fracture.Interview, on 01/14/26 at 10:09 AM, Charge Nurse Staff #41 reported that on 12/07/2025 she encountered the resident's family picking up personal belongings. At that time, she learned that Resident #208 had sustained a severe left hip fracture.During the interview, on 01/14/26 at 01:01PM, the Administrator confirmed that facility staff was made aware of Resident #208's severe injury of unknown origin on 12/07/2025, however, the initial self-report was not submitted to the State agency until 12/8/2025. This was non-compliant with the FRI reporting requirements, which dictated that the Office of Health Care Quality (OHCQ) must be notified immediately, and no later than two hours after the facility became aware of a severe injury. In this instance, the report was filed one day late.The Administrator agreed with this finding of deficient practice.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on Facility Reported Incident file (2696293) review, record reviews, and interviews, it was determined that the facility failed to thoroughly conduct investigations regarding a severe injury of unknown origin. This was evident for 1 (Resident #208) out of 5 residents reviewed for incidents during an annual survey.The findings include: Facility Reported Incident file review, on 1/14/2026 at 09:00 AM, it was noted that the initial report was filed with the State Agency on 12/8/2025 at 9:54 AM. The facility's investigation report contains only one on-duty staff incident statement and two staff email statements regarding an incident involving Resident #208 on 12/06/2025 at approximately 4:00 PM. Evidently the Resident was reported to be screaming in severe pain in their left hip and was subsequently transported to a nearby hospital. Records from 12/07/2025 indicated that the facility Charge Nurse Staff #41 and the Unit Manager Staff #42 both were acknowledged that the hospital diagnosed Resident #208's injury with a left hip fracture.Interview, on 01/14/26 at 10:09 AM, Charge Nurse Staff #41 reported that on 12/07/2025 she encountered Resident #208's family picking up personal belongings. At that time, she learned that the resident had sustained a severe left hip fracture. However, she did not notify the Administrator until 12/08/2025 nor she started further investigation staff/ residents' interviews.During an interview on 01/14/2026, at 01:01PM, the Administrator disclosed that Staff #42 withheld information regarding the severe injury of unknown origin of Resident #208. Despite the severity of the injury, no further investigation was conducted. The Administrator confirmed that a thorough investigation was not completed, and interviews with the relevant shift staff and residents on the same floor were not conducted. The Administrator was informed that these findings represent concerns regarding the facility failing to thoroughly conduct investigations.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to provide the required written bed hold notice and transfer notification to the resident and/or the responsible representative upon transfer to the hospital. This was evident for 3 (Resident #201, #166, and #9) of 4 residents reviewed for hospitalization during the annual survey.The findings include:1. On 1/8/26 at 3:25 PM a record review of a progress note dated 12/18/25 at 10:28 AM revealed an entry called a Situation, Background, Assessment, and Response (SBAR) that documented Resident #201 was transferred to the hospital. On 1/9/26 at 12:33 PM a record review of the paper chart and the electronic health record revealed no evidence that the resident or representative received the required written hospital bed hold notice. On 1/9/26 at 12:35 PM in an interview, the 2 [NAME] Unit Coordinator (Staff #25) confirmed the bed hold notice was part of the transfer documents. On 1/9/26 at 12:47 PM, in an interview, 2 [NAME] Unit Manager (Staff #23) verified that she could not find a copy of the bed hold notice nor confirm that the resident and/or resident representative had received it. at transfer. On 1/9/26 at 1:02 PM Social Service Director (Staff #16) acknowledged that a bed hold notice was not sent out (via email) for this resident, It was just missed. On 1/9/26 at 2:14 PM the Nursing Home Administrator confirmed a lack of documentation related to the hospital transfer and bed hold notice. On 1/14/26 at 3:15 PM, at the time of survey exit, no further documentation was provided. 2. Review of Resident # 9's medical record revealed the resident was transferred to the hospital on [DATE]. On 1/12/26 at 4:01 PM the Assistant Director of Nursing reported that when a resident is transferred to the hospital the bed hold policy is provided to the resident and then they email this policy to resident's responsible party.The facility provided documentation of a Notice of Emergency Transfer and Bedhold Policy for Resident #9 for the 11/26/25 transfer. However, no documentation was provided to support that this notification was email or given to the resident's responsible representative. On 1/13/26 at 9:30 AM surveyor requested from admission Director #16 documentation of the email to support the Notice of Emergency Transfer and Bedhold Policy was sent to Resident #9's responsible party for the 11/26/25 transfer. admission Director #16 proceeded to look for the supporting documentation but was unable, at that time, to find the supporting documentation. On 1/14/25 at 2:50 PM surveyor reviewed the concern with the Nursing Home Administrator regarding the failure to provide the bed hold and transfer notice to the responsible representative for the 11/26/25 transfer for Resident #9. 3. Review of Resident #166's medical record revealed the resident was a transferred to the hospital on [DATE]. Review of the progress note related to this transfer revealed the responsible representative would meet the resident at the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided documentation of a Notice of Emergency Transfer and Bedhold Policy for Resident #166 for the 10/9/25 transfer. However, no documentation was provided to support that this notification was sent to the resident's responsible representative. On 1/13/26 at 9:50 AM surveyor requested from admission Staff #18 documentation of the email to support the Notice of Emergency Transfer and Bedhold Policy was sent to Resident #166's responsible party for the 10/9/25 transfer. admission Staff #18 proceeded to look for the supporting documentation but was unable, at that time, to find supporting documentation. On 1/14/25 at 2:50 PM surveyor reviewed the concern with the Nursing Home Administrator regarding the failure to provide the bed hold and transfer notice to Resident #166's family for this hospitalization.

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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 medical record review and interview it was determined that the facility failed to ensure an interdisciplinary care plan meeting was held to review and update the resident's care plan following a quarterly Minimum Data set assessment. This was found to be evident for one (Resident #9) out of 6 residents reviewed for nutrition.The findings include:On 1/12/26 review of Resident #9's medical record revealed the resident was admitted to the facility more than 6 months ago. The resident has severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 3 out of 15. The resident's diagnosis includes, but is not limited to, heart failure; vascular dementia; diabetes; and end stage renal disease. The resident receives nutrition via a gastric feeding tube. The most recently completed Minimum Data Set (MDS) assessment had an Assessment Reference Date of 12/4/25. The MDS is a federally-mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. State regulation require a care planning conference not later than 7 calendar days after completing these assessments. On 1/12/26 further review of the medical record failed to reveal documentation to indicate a care plan meeting was scheduled for after the 12/4/25 MDS assessment. On 1/12/26 at 12:53 PM interview with the Assistant Unit Nurse Manager #19 revealed the resident is currently comfort care, stating that they have adjusted the resident's medications and the MOLST [Maryland Medical Orders for Life-Sustaining Treatment]. When asked when the resident became comfort care, the Unit Manager #19 reported it looked like on 12/4/25. The manager provided a copy of hand written orders, dated 12/4/25, that included: see MOLST dated 12/4/25; orders for morphine and lorazepam to be administered as needed; orders to discontinue weights, labs and vital signs; and an order for dietitian consult to decrease tube feedings. This order also discontinued nine of the resident's medications. The Unit Manager #19 also reported the most recent care plan meeting was held in September 2025. Review of the Social Work Progress Note, dated 12/4/25 revealed: SW will schedule care plan meeting with patient's guardian. Further review of the medical record on 1/12/26 failed to reveal documentation to indicate a care plan meeting was scheduled after this 12/4/25 note. On1/12/26 review of the resident's care plan revealed two new plans were added on 12/16/25 by the Nursing Home Administrator. One was regarding the resident's code status and desire for no resuscitation or intubation but failed to address the additional orders on the updated 12/4/25 MOLST which included: Do not give any blood products; Do not perform any medical tests for diagnosis or treatment; Do not transfer to hospital; and do not treat with antibiotics. The other new care plan was in regard to the resident being at the facility for long term care and included a goal of : will receive daily opportunities for social contact through the review date. No documentation was found in the care plans to indicate the resident was currently receiving palliative/comfort care. No updates or changes were found in the other care plans to indicate the change to comfort care. On 1/12/26 at 4:16 PM interview with Social Worker (SW) #37 revealed coverage for Resident #9's unit has been split between the social service department. SW #37 reported they schedule care plan meetings based on when the quarterly MDS assessments. She indicated they use to schedule the meetings for after the quarterly assessments but recently a little earlier.Surveyor then reviewed the concern that the resident had a MDS with ARD of 12/4; SW note written on 12/4 revealed SW will schedule care plan meeting with patient's guardian. But no documentation was found to indicate a meeting has been scheduled or held and no recent update to the care plan. Surveyor also addressed the concern that the resident became palliative care around this time but the care plan does not reflect this change. Surveyor requested any additional information they may have regarding a care plan meeting for this resident. On 1/13/26 further review of the medical record revealed a Social Work Progress Note, dated 1/12/26 at 4:57 PM that stated the SW spoke with the resident's guardian and scheduled a care plan [meeting] for 1/22/2026 at 1:30 PM via phone. On 1/14/26 at 2:50 PM surveyor informed the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Administrator of the concern regarding the failure to have a care plan meeting after the 12/4/25 MDS assessment and the failure to update the care plan to reflect the palliative/comfort care status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interviews, it was determined that the facility failed to ensure acceptable standards of practice to accurately reconcile controlled medications. During observation of the facility narcotic books, it was observed that 2 of 2 narcotic reconciliation were not documented per acceptable standards of practice during the annual survey.The findings include:Standard practice for narcotic reconciliation count is conducted at the end-of-shift with two licensed personnel, the on-coming licensed personnel and the out-going licensed personnel, count all controlled medications verifying the count accuracy and documenting their initials in the narcotic book. Reconciliation refers to a system of recordkeeping that ensures an accurate inventory of medications by accounting for controlled medications. The reconciliation process identifies loss or potential diversion of controlled medications so as to minimize the time between the actual loss or potential diversion and the time of detection and follow-up to determine the extent of loss. On 1/7/26 a record review of 2 [NAME] narcotic books (cart 1 and 2) both revealed that that morning's reconciliation count lacked the on-coming nurse' signature. On 1/7/26 at 9:20 AM on-coming Licensed Practical Nurse (LPN #24) confirmed that he had not signed the narcotic reconciliation that day. At 9:23 AM the 2 [NAME] Unit Manger (Staff #23) acknowledged the lack of narcotic reconciliation per acceptable standards of practice. The Nursing Home Administrator was made aware of the concern.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview and record review, it was determined that the facility failed to provide an activity program according to the resident's comprehensive assessment and personal choice. This deficiency was evident for 1 of 4 residents (Resident #4) reviewed for activities during the survey.The findings include:On 1/6/26 at 9:45 AM, during an interview, Resident #4, who required ventilator assistance to aid respirations, reported a desire to have a wheelchair to go outside.On 1/8/2026 at 12:41 PM, review of admission material dated 2/24/25, Section F, revealed the resident was asked, How important is it to you to go outside to get fresh air when the weather is good? Continued review revealed that the resident responded that this was very important.On 1/8/2026 at 12:36 PM, review of Resident #4's progress notes under activities dated 2/24/2025 documented that the resident preferred individual activities and spending time outside.On 1/8/26 at 1:01 PM, the Activities Director, Staff #8, was interviewed. Staff reported that resident attendance was recorded for both group and one-on-one activities. During the interview, the Activities Director, Staff #8, provided the attendance record for Resident #4, which was reviewed. Staff reported that refusals to participate in one-on-one activities were also documented.On 1/8/26 at 1:15 PM, review of Resident #4's activity records failed to reveal that the resident was provided with an opportunity to go outside during the stay at the facility.On 1/12/2026 at 9:47 AM, the Respiratory Therapist, Staff #17, was interviewed. The staff reported that from the end of May through September, Resident #4 did not require ventilator assistance or suctioning. The staff further reported that the resident had no respiratory impediments to going outside during this time period.On 1/12/26 at 9:50 AM review of the facility census revealed that on 5/27/25 Resident #4 was transferred form the unit that provided care to resident on ventilators to a regular care room. He remained in this room until 10/1/2025. On 1/14/2026 at 12:30 pm, the above concerns were discussed with the administrator. The administrator confirmed that Resident #4 was not provided with the opportunity to go outside after her/his medical condition improved and s/he had the ability to go outside.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews, it was determined that the facility failed to ensure physician orders were followed. This was evident for one (Resident #171) out of five residents reviewed for unnecessary medications.The findings include:Type 2 diabetes is a chronic condition that requires routine blood glucose monitoring and administration of prescribed medications to maintain blood sugar levels within a safe range. Failure to monitor blood glucose levels and administer ordered insulin can result in uncontrolled blood sugar levels and places a resident at risk for serious complications, including dangerously high or low blood sugar levels and long-term organ damage.On 1/14/26 at 10:07 AM, the surveyor conducted a record review of Resident #171's medical record and identified a diagnosis of Type 2 Diabetes Mellitus. Review of the Medication Administration Record (MAR) revealed the following physician orders:Novolog FlexPen (Insulin Aspart) 100 units/mL: Inject 3 units subcutaneously with meals for Type 2 diabetes. Hold Novolog if blood sugar is below 100. Start date: 9/15/25.Blood glucose monitoring: Check blood sugar before meals and at bedtime. Call MD if blood sugar is less than 60 or greater than 300. Start date: 8/14/25.Further review of the MAR revealed no documentation of a blood sugar reading on 1/9/26 at 2:30 PM and no documentation of Novolog administration on 1/9/26 at 3:00 PM, both of which were scheduled per physician orders.On 1/14/26 at 12:07 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding the blank entries on the MAR dated 1/9/26. The ADON stated that A blank space indicates the medication or treatment was not signed off as completed.The surveyor asked the ADON to review Resident #171's MAR for 1/9/26. The ADON confirmed that neither the blood sugar check nor the Novolog administration was documented. The ADON reviewed the nursing notes and was unable to locate documentation explaining why the ordered care was not completed. When asked if the resident may have been out of the facility, the ADON stated she did not see documentation indicating this and acknowledged that the lack of documentation was concerning.On 1/14/26 at 12:19 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding the missed blood sugar monitoring and insulin administration. The NHA agreed this was a valid concern.On 1/14/26 at 12:53 PM, the surveyor reviewed Resident #171's medical record and identified documentation indicating the resident had a neurology appointment on 1/9/26.On 1/14/26 at 12:59 PM, the surveyor returned to interview the ADON about the facility's process to ensure residents receive ordered treatments and medications when returning from off-site medical appointments. The ADON stated that blood sugar checks are expected to be completed upon the resident's return and that insulin should be administered if indicated. When asked if the medical record should reflect that the resident was out of the facility and that required assessments and medications were completed upon return, the ADON confirmed this should have been documented. Later, at 1:44 PM, the ADON acknowledged that the facility failed to document both the blood sugar check and the administration of Novolog for Resident #171 on 1/9/26 and recognized this was a concern.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, medical record review and interviews it was determined that the facility failed to ensure wound treatment was completed as ordered and that orders coincided with treatments being documented by the wound care physician. This was found to be evident for one (Resident #13) out of three residents reviewed for pressure ulcers during the survey.The findings include: Review of Resident #13's medical record revealed the resident was admitted in the spring of 2025 with a stage 2 pressure ulcer on the sacrum. The sacrum is located at the base of the spine.A stage 2 pressure ulcer involves partial thickness skin loss presenting as a shallow open ulcer.The resident has been seen weekly since admission by the wound physician. Starting on 7/18/25 the wound physician notes indicated the sacral wound was a stage 3 pressure ulcer.A Stage 3 pressure ulcer involves full thickness skin loss and subcutaneous fat may be visible.Review of the 9/5/25 wound physician note revealed the dressing used at that time was Collagen and Bordered dressing once daily, with Betadine to the periwound area.Betadine is an anti-infective that contains povidone-iodine and is brown in color. The periwound is the area of skin surrounding the wound.On 1/08/26 at 10:05 AM surveyor observed Nurse #11 perform the dressing change for Resident #13's sacral wound. The nurse cleaned the wound with normal saline, and applied betadine to the periwound area. The nurse applied a gel to a white collagen dressing sheet and then applied this to the wound prior to covering the collagen dressing with a Cosmopor brand adhesive dressing. After the dressing change surveyor confirmed the product names for the gel (Plurogel) and the collagen sheet (PLUS) with Nurse #11.After the dressing change observation review of the electronic health record revealed the current order for the dressing change, with a start date of 9/6/25, revealed Puracol Dressing: Apply to Sacrum to Rt/Lt buttock topically every day shift for wound care Cleanse Sacrum extending to Rt and Lt Buttock wound with NSS [normal saline], apply Collagen sheet, apply betadine to PW [periwound], and cover with bordered dressing daily.Review of the Treatment Administration Record (TAR) revealed this wound care order was listed twice, once for the Puracol Dressing and another specifically for the use of the Betadine.Review of the 12/26/25 and the 1/2/26 wound physician notes revealed the current dressing was for Col-active (collagen) plus Ag [silver] dressing once daily and as needed; Bordered dressing once daily and betadine to the periwound area.On 1/8/26 at 12:30 PM the unit nurse manager #10 reported the PLUS dressing is a collagen dressing and that Puracol is also a collagen dressing. The unit manager was able to show the surveyor a package of PLUS Ag but confirmed that Nurse #11's cart just has the PLUS on it.Review of the medline.com website revealed: Puracol is the name of a brand of wound dressings. Puracol Plus is a collagen dressing. Puracol Plus Ag+ contains silver chloride which is a known antibacterial agent.During the 1/8/26 at 12:30 PM interview, the unit nurse manager #10 confirmed no order was found in the electronic health record for the Plurogel.On 1/8/26 at 12: 39 PM nurse #11 confirmed she used the regular PLUS dressing, not the one with silver. Nurse #11 also reported that there was an order for the Plurogel, stating: I signed it off. She then identified the Purocal dressing order indicating that is for the gel.Review of the medline.com website revealed PluroGel is not the same product as Puracol. No documentation was found to indicate the PluroGel contains silver.On 1/8/26 at 12:45 PM surveyor informed the unit nurse manager #10 that the nurse reported the Puracol dressing order was for the Plurogel. The unit manager then confirmed that none of the products used by Nurse #11 contained silver.On 1/8/26 at 1:13 PM the wound physician #40 reported the current dressing order should be Col-Active Plus Ag, then betadine around the periwound. The wound physician reported Plurogel is a hydrogel with debriding properties and confirmed that Plurogel is not supposed to be used for Resident #13's wound. He also reported that Puracel is just the brand name of a collagen dressing. Surveyor then reviewed the concern that nothing in the order or observation indicated silver was being used; and that the current order has been in effect since September. Also reviewed that Plurogel was used without an order. The Nursing Home Administrator (NHA) was present in the conference room while the wound physician was being interviewed.On (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/8/26 at 1:35 PM surveyor reviewed the concerns with the NHA regarding the failure to have an order for the silver as indicated in the wound physician notes, and the use of Plurogel without an order.Review of the Statement of Deficiencies and Plan of Corrections for a complaint survey conducted at this facility in September 2025 revealed a deficiency was cited regarding pressure ulcer care. Review of the findings from that survey revealed concerns regarding discrepancies between what the wound physician was documenting as the ongoing treatment and what was actually being provided to the resident. The Plan of Correction indicated all nursing staff were educated on the importance of following the physicians' orders with correct order entry. The plan failed to indicate that a root cause analysis had been completed to determine the cause of the deficient practice or that a systemic change in the process was implemented.

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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 medical record review, interview and observation it was determined that the facility failed to ensure an underweight resident was provided diet as needed. This was found to be evident for one (Resident #137) out of six residents reviewed for nutrition.The findings include: Review of Resident #137's medical record revealed a 9/4/25 dietitian note that indicated the resident was underweight with a current weight of 102 lbs. The dietitian recommended a regular consistency diet with double portions of vegetables and entree. Review of the 12/19/25 dietitian note revealed the resident weight was down to 94.6 lbs. On 1/7/26 at 1:29 PM surveyor observed the resident in bed, lunch tray was observed on the resident's overbed table but resident appeared to be asleep at this time. At 1:32 PM observation of the lunch tray, with the unit nurse manager #10, revealed rice and peas on the plate but failed to reveal a protein on the tray. The meal ticket revealed the resident should also have had 2 chicken salad sandwiches. There was no evidence on the lunch tray that the sandwiches were delivered, and the resident confirmed that s/he had not gotten the chicken salad. The unit nurse manager proceeded to call the kitchen and reported they would be sending the sandwiches up. On 1/7/26 at 1:55 PM interview with the dietary manager #27 revealed the resident is to receive double portions of entree and vegatables. He confirmed that today the resident should of received two chicken salad sandwiches. He indicated they sent them to the resident after being notified by staff. On 1/9/26 at 10:38 AM registered dietitian (RD #44) confirmed the resident is on double portions.

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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 record review and interview it was determined that the facility failed to ensure pain management was provided in accordance with professional standards of practice. This was found to be evident for one (Resident #137) out of three residents reviewed in relation to faciity reported incidents of injury of unknown origin.The findings include:Review of facility reported incident 2639787 revealed the facility reported an injury of unknown origin for Resident #137 on 10/9/26. The injury was a fracture to the right leg.Review of Resident #137's medical record revealed the resident diagnosis included, but was not limited to, diabetes, heart failure, end stage renal disease and memory deficit following a stroke. Review of the 10/6/26 primary care provider note revealed that the resident was in no acute distress that day, and the resident was able to move all extremities but with right sided weakness and muscle wasting. Review of the Treatment Administration Record for October 2026 revealed documentation that staff completed pain assessments every shift and the pain level was documented as 0 (indicating no pain) for each shift from 10/1 through 10/8/26.Review of the physician orders revealed an order, with a start date of 9/18/25, for acetaminophen 500 mg two tablets to be given every 8 hours as needed for mild to severe pain. Acetaminophen is a medication used for pain relief and fever reduction.Review of the Incident Investigation Statement Form signed by Nurse #43 on 10/9/25 revealed that on Tuesday [10/7/25] the resident's spouse said the resident's right knee was hurting to light touch. The Nurse went to the room with scheduled BioFreeze for the resident's left arm and asked the resident if he could apply it to the knee. The resident agreed and when he re-checked a half an hour later the resident denied pain and declined an offer of acetaminophen. A phone interview was conducted with Nurse # 43 on 1/12/26 at 10:56 AM, the Assistant Director of Nursing (ADON #3) was present for this interview. When asked about the process if a resident or family member reports the resident is having pain, Nurse #43 reported that he would address the pain, and would check the MAR to see if there was any medication he could administer, and if not then contact the provider with recommendations. Review of the medical record revealed an order, with a start date of 10/2/25, for Biofreeze Gel (a topical pain reliever) to be applied to the left arm every morning and at bedtime for pain. No documentation was found for the Biofreeze to be used on the resident's knee. No documentation was found to indicate the nurse reported the new presence of pain in the resident's knee to the primary care provider or that an order to use the Biofreeze on the knee was obtained.During the phone interview with Nurse #43 on 1/12/26 Surveyor reviewed the concern that the statement provided by Nurse #43 revealed that the nurse applied the Biofreeze to the resident's knee without an order and no documentation was found to indicate the physician or nurse practitioner was notified about this new pain. Nurse #43 responded that he was not sure if he notified anyone or not.Further review of the Incident Investigation Statement Form signed by Nurse #43 on 10/9/25 revealed that on Wednesday [10/8/25] the resident's spouse asked the nurse if he had spoken to the physician and he informed the spouse that the resident had indicated it no longer hurt and that the resident said s/he did not need any pain relief. During the phone interview with Nurse #43 on 1/12/26 Surveyor reviewed with the nurse that his statement revealed that the spouse had asked if you had spoken to the physician and statement indicates you had not. Nurse #43 did not dispute this statement. Review of the October 2025 Medication Administration Record (MAR) revealed the acetaminophen was administered by Nurse #43 on 10/8/25 at 7:38 PM for a pain level of 0 and was documented as effective with an E. Further review of the medical record failed to reveal documentation to indicate the resident was experiencing pain on 10/8/25, or a rationale for the administration of the acetaminophen.During the 1/12/26 at 10:56 AM interview, Nurse # 43 reported pain should be documented prior to administration of an as needed pain reliever and stated that there is a part of the software that asks for the level of pain and if it was reduced. After the interview with Nurse #43, the ADON reviewed the MAR in the electronic health record with the surveyor and confirmed that the nurse had documented pain at a zero prior to the administration of the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acetaminophen on 10/8/25 and then documented that it was effective.Review of the primary care physician note for a visit on 10/9/25 revealed the resident was seen in follow-up of reported right lower extremity (leg) pain. Patient noted to have right lower extremity pain over the last 2 days on review with staff and patient's [spouse]. The physician noted knee swelling and ordered an x-ray.Further review of the medical record failed to reveal documentation of lower extremity pain prior to 10/9/25.Review of progress notes revealed that on 10/9/25 at 10:52 PM Nurse #43 documented that the x-ray results revealed an acute fracture of the right tibia and fibula (lower leg bones). The resident was administered acetaminophen and transferred to the hospital.On 1/14/26 at 2:50 PM surveyor reviewed with the Nursing Home Administrator the concerns regarding the failure to report the new onset of pain, the administration of a pain medication without an order and the failure to ensure documentation of the indication for the use of an as needed pain medication.

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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 interview, it was determined that the facility failed to have an effective process to ensure that pharmacy recommendations were reviewed by the resident's provider. This was evident for 1 resident (Resident #2) of 5 residents reviewed for unnecessary medications during the survey.Findings included:On 1/7/26 at 10:38 AM, the medical records of Resident #2 were reviewed. The review revealed that a pharmacist had reviewed the resident's medical records at admission. Further review failed to show documentation that the provider received the pharmacist's recommendations.On 1/7/26 at 2:00 PM, the Administrator provided the admission Pharmacy Review for Resident #2 dated 12/10/25. The Administrator confirmed that the review had not been uploaded to the resident's electronic health record or hard chart.On 1/7/26 at 2:00 PM, the admission pharmacy review revealed several recommendations. Review showed that the provider reviewed the document and ordered labs and an EKG (electrocardiogram). The pharmacy medication review was signed by the provider but was not dated. On 1/7/26 at 2:10 PM, review of orders failed to reveal an order for an EKG prior to surveyor intervention. Further review of Resident #2's orders revealed an EKG was ordered in the morning for drug monitoring, dated 1/7/26 at 3:24 PM.On 1/7/26 at 3:43 PM, the Assistant Director of Nursing (ADON, Staff #3) was interviewed. The ADON reported that the pharmacy review was signed by the provider only after surveyor intervention. ADON stated that the pharmacy review had not been sent to the provider before that time. The ADON explained that the facility expected pharmacy recommendations to be sent to the nurse manager, who then communicates them to the provider. ADON confirmed that the 12/10/25 pharmacy recommendation had not been provided to the provider before surveyor intervention and was signed by the provider on 1/7/26. This was not timely and did not meet the facilities policy of 14 days.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to maintain a complete and accurate medical record. This was evident for 1(resident #202) out of 199 residents review during an annual survey.The findings include: On [DATE] at 10:17 AM, the surveyor completed a closed record review for Resident #202 who was deceased on [DATE], no hard copy medical record was available. The review revealed the Resident's MOLST form and death certificate were not in the electronic record even though the electronic record indicated see new MOLST on [DATE].Medical Orders for Life-Sustaining Treatment (MOLST) is a medical order form that relays instructions between health professionals about patient care. MOLST certified orders that were agreed to by a patient or a patient's health care agent as named in the patient's advance directive. MOLST determines resuscitation status and includes 8 other sections of treatment choices.Interview, on [DATE] at 11:09 AM, Medical Record Staff #7 responded that every page of medical record should be in the electronic record system. Interview, on [DATE] at 11:21 AM, the Administrator was made aware that their electronic record was missing Resident #202's MOLST forms and the death certificate.On [DATE] at 11:33 AM the Administrator stated that the death record was just scanned into the electronic record, however, no last MOLST from [DATE] was found. She contacted the floor and learned that the MOLST from [DATE] was shredded mistakenly by the floor clerk. The Administrator agreed that this was a deficit practice concern. And it was an area that needed to be improved.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on pertinent document review and interviews, it was determined the facility failed to ensure that the appropriate party signed the arbitration agreement or that the resident received information and understood the arbitration agreement. This was evident for one of three residents reviewed for arbitration during a survey. The findings included:On 1/5/26 at 9:15 AM, during the entrance conference, the administrator reported that the facility had an arbitration agreement that was given to the resident upon admission. The administrator reported that admission to the facility was not dependent on signing the arbitration agreement. The administrator reported that the arbitration agreement was not binding. On 1/7/26 at 9:48 AM, the Chief Clinical Officer (Staff #20) was interviewed regarding the facility's arbitration agreement. Staff #20 reported that the agreement was voluntary and that residents had thirty days to rescind their signature after signing the arbitration agreement. In addition, Staff #20 reported that the arbitration agreement was not binding. During the interview, Staff #20 provided the surveyor with the arbitration agreement. On 1/7/26 at 9:52 AM, review of the arbitration agreement revealed the following documentation in bold letters and all capitals:THE PARTIES UNDERSTAND AND AGREE THAT BY ENTERING THIS ARBITRATION AGREEMENT THEY ARE GIVING UP AND WAIVING THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM DECIDED IN A COURT OF LAW BEFORE A JUDGE AND JURY. On 1/07/26 at 12:36 PM, the Director of Admissions (Staff #16) was interviewed. During the interview, Staff #16 reported that the arbitration agreement was part of the admission package and was completed by the person completing the admission paperwork. Staff #16 reported that the hospital discharge summary was reviewed and if the resident was alert and oriented to person, place, and time, then the resident was asked to sign the arbitration agreement. On 1/7/26, the Director of Admissions provided three signed arbitration agreements, two for residents currently residing in the facility and one for a resident that had been discharged from the facility. On 1/7/25 at 1:00 PM, review of the signed arbitration agreements revealed that Resident #168's arbitration agreement was signed by a family member and not by the resident. On 1/14/26 at 2:00 PM, review of Resident #168's hospital Discharge summary dated [DATE], failed to document any cognitive decline or incapacity. Further review revealed that the resident did not have an advance directive. On 1/9/26 at 2:37 PM, review of Resident #168's Minimum Data Set admission agreement, Section C, dated 12/18/25, revealed the resident did not have any cognitive decline. On 1/9/26 at 2:40 PM, Resident #168's medical record titled Physician Certification Related to Medical Condition, Substitute Decision Making, and Treatment Limitations was reviewed. The review revealed that Resident #168 was able to understand and sign admission documents along with other information and was able to effectively communicate decisions. On 1/9/26 at 3:00 PM, an interview with Resident #168 in the room was conducted. The resident reported not knowing what an arbitration agreement was and was not aware that a family member had signed the agreement. The resident reported not having an advance directive but expressed a desire to have one. The administrator was advised of the resident's request for an advance directive and reported that social work would be notified. On 1/14/26 at 12:40 PM, the above concerns were discussed with the administrator. The administrator reported being under the impression that the arbitration agreement was not binding but after her recent review she agreed the language does not indicate that it is not binding. In addition, the administrator confirmed that Resident #168 had been deemed by a physician to have the ability to sign admission documents and that Resident #168 did not have an advance directive or documentation indicating that the family member, who signed on behalf of the resident, was legally authorized to do so.