STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure kitchen staff used hair nets during food preparation and failed to ensure potentially hazardous food items were cooled according to acceptable standards. These findings have the potential to affect all residents of the facility. The findings include:During the initial tour of the kitchen on 2/1/26 at 7:59 AM, 3 kitchen staff were observed preparing breakfast trays. 1 of the 3 staff, the cook (Staff #15), was observed behind the counter putting cooked food items on plates as the other 2 staff called out what was on the meal tickets. Staff #15 did not appear to be wearing a hair net and was confirmed when asked by the surveyor if she was wearing one, she stated, No I'm not. On 2/1/26 at 8:06 AM. The Dietary Manager (Staff #2) arrived in the kitchen and accompanied the surveyor with the tour of the kitchen. On 2/1/26 at 8:22 AM, the walk-in refrigerator was inspected with Staff #2. The following cooked food items were observed:- Mechanical Beef dated 1/20/26- Bacon dated 1/30/26- [NAME] beans dated 1/29/26- Mechanical Turkey 1/29/26- 2 pans of roast beef dated 1/20/26- Pureed beef dated 1/30/26- Turkey dated 1/30/26- Pureed chicken dated 1/31/26- Mechanical chicken dated 1/31/26- Sausage patties dated 1/31/26- Beef mac dated 1/31/26- 2 pans of turkey dated 1/29/26On 2/1/26 at 8:31 AM, Staff #2 was interviewed regarding the cool down process for potentially hazardous food items. Staff #2 reported that the facility adheres to the requirement and documentation is kept in a binder. She then provided the binder to the surveyor for review. However, the latest entries for the cooling log were in September of 2025. Staff #2 stated, looks like we don't have one and indicated that it was the facility cook's responsibility to document the cool down process.In a subsequent interview with Staff #2 on 2/1/26 at 8:44 AM, the concerns were discussed that Staff #15 was observed processing breakfast trays without a hair net and failed to document the cool down process for potentially hazardous food items. Staff #2 stated, I have to talk to my staff to keep up with that and indicated that the identified food items in the refrigerator will be discarded. Staff #2 acknowledged 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide residents with information to formulate an advanced directive. This was evident for 4 (Resident #53, #52, #22, and #2) of 4 residents reviewed for advanced directives. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. 1) Resident #53 was admitted into the facility in late 2025. The resident's medical record indicated an intact cognitive ability. A review of Resident #53's medical record was conducted on 2/2/26 at 12:20 PM. The review revealed that the resident was certified as capable of understanding and making medical decisions for self that was signed and dated by the facility's medical provider on 11/12/25. However, there was no Documentation to indicate that an advanced directive was discussed/offered to the resident. The Social Services Director (Staff #8) was interviewed on 2/3/26 at 1:24 PM. During the interview, Staff #8 explained that she discusses advanced directives to newly admitted residents of the facility and provided support in filling out the necessary forms, after determining that the resident is capable. Staff #8 reported that she documents all these activities in the resident's progress notes. A review of Resident #53's progress notes was conducted on 2/2/26 at 2:19 PM. The review revealed no documentation under the social services department. In a subsequent interview with Staff #8 on 2/5/26 at 10:37 AM, she confirmed that Resident #53 was capable of making his/her own medical decision and did not have an advanced directive in place. She reported a meeting with the resident yesterday to discuss plan for possible discharge to an assisted living but was not able to offer or discuss advanced directives. The concern was discussed with Staff #8 that the facility failed to provide Resident #53 with information to formulate an advanced directive. Staff #8 verbalized understanding and acknowledged the concern. 2) Resident #52 was admitted into the facility in mid-2025. On 2/2/26 at 11:06 AM, a review of Resident #52's medical record was conducted and revealed that the resident was certified as capable of understanding and making medical decisions for self that was signed and dated by the facility's medical provider on 7/15/25. There was no indication that the resident had an advanced directive in place. A social services assessment dated [DATE] had a section (Section B) for Advanced Care Planning had questions to indicated if 1) the resident made his/her own decision, 2a) the resident/responsible party report that advanced care planning had been completed, and 2b) what had been completed? (for (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	example, health care power of attorney or living will). This section was unanswered. The Social Services Director (Staff #8) was interviewed on 2/5/26 at 10:27 AM. During the interview, Staff #8 reported her process with advanced directives for new admissions. Noting that Staff #8 started with the facility less than 6 months ago, she reported that about 2 months ago, she conducted an audit of the residents who were admitted prior to her hire for advanced directives. Staff #8 also reported that the social services assessment for Resident #52, documented on 7/21/25, was conducted by her predecessor and her audit revealed that the resident was capable of decision making and had no advanced directive in place. However, her audit was still in progress and had only completed 2 of the 3 units of the facility. Staff #8 also reported that she had not provided the necessary information to formulate advanced directives for capable residents identified in her audit. She indicated being overwhelmed and needing support to complete the different tasks assigned to her in the facility. 3) On 02/02/2026 at 10:51 AM, a review of R#22's hard chart revealed no evidence of a Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form or an advance directive. On 02/03/2026 at 10:33 AM, a review of the electronic medical record (PCC) revealed the presence of a MOLST form; however, there was no evidence of an advance directive for R#22. On 02/03/2026 at 1:20 PM, the surveyor requested an interview with the Social Services Director (Staff #8). On 02/03/2026 at 1:23 PM, an interview was conducted with Staff #8, identified as the facility's licensed social worker and grievance officer. Staff #8 stated they are responsible for discharge planning, coordinating care plan meetings, grievances, and resident concerns. On 02/03/2026 at 1:26 PM, Staff #8 stated that upon admission, residents are provided information on how to establish an advance directive and that residents may either agree or decline. Staff #8 stated, It's documented within the progress notes under social services. Staff #8 further stated that the Social Services assessment within PCC is used for new admissions, BIMS assessments, social services assessments, discharge planning review, and social determinants of health. Staff #8 stated that they complete quarterly readmission and discharge BIMS assessments and that, at times, the Minimum Data Set (MDS) Coordinator may complete the BIMS. On 02/05/2026 at 8:48 AM, a comprehensive review of R#22's medical record, including all progress notes and assessments, was conducted. The miscellaneous tab contained the resident's MOLST form. There was no evidence of an advance directive. The assessments tab contained no documentation indicating whether R#22 had been assessed for an advance directive or that the resident declined to establish one. On 02/05/2026 at 12:30 PM, during a follow-up interview, Staff #8 stated that they did not receive clear training on how to complete an advance directive with residents or how to appropriately screen residents for advance directives. Staff #8 stated that since starting at the facility in November 2025, they have begun incorporating advance directive review into social services assessments. On 02/05/2026 at 1:15 PM, these findings were reviewed with the Nursing Home Administrator. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/2026 at 2:30 PM, no additional evidence was provided to the surveyor prior to the conclusion of the survey. 4)On 2/02/26 at 10:39 AM a review of Resident #2's paper chart was conducted. No advance directives documents were found in the chart. A Maryland Order for Life Sustaining Treatment (MOLST) document was in the record. It was dated 10/02/24 and indicated that the resident was the decision maker. On 2/03/26 at 10:36 AM a review of Resident #2's electronic medical record was conducted. There were no advanced directives or power of attorney documents found in the electronic medical record. On 02/05/26 at 12:19 PM interview was conducted with the facility social worker (Staff #8), and she was asked if she was familiar with Resident #2, and Staff #8 said she has not met with the resident yet. When asked about the process for offering residents advance directive information, Staff #8 indicated that the information would be offered at the time of admission and at each care plan meeting, but there was no evidence that this was done for this resident. Staff #8 acknowledged the deficiency. On 2/06/26 at 2:00 PM an interview was conducted with the Nursing Home Administrator to review deficient findings from this survey and offer an opportunity to provide any additional evidence. No further evidence was provided by the end of the survey.

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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 and interview, it was determined that the facility failed to treat residents with dignity. This was evident for 2 (Resident #48, #22) of 24 residents screened during the initial pool portion of the recertification survey. The findings include:1) The Brief Interview for Mental Status (BIMS) score is a 0–15 point assessment tool used in long-term care to measure cognitive function, focusing on memory, orientation, and recall. Scores indicate cognitive levels: 13–15 (intact), 8–12 (moderate impairment), and 0–7 (severe impairment). Resident #48 was admitted to the facility for rehabilitation after an acute hospitalization for sepsis. The resident was [AGE] years old, and cognitively intact as evidenced by a BIMS score of 15. On 2/02/26 at 11:23 AM during the surveyor's initial interview with Resident #48, a Registered Nurse (RN), Staff #6, knocked on the resident's door, said he had to check the resident's blood sugar, and entered the room without obtaining permission. Staff #6 proceeded to put on gloves, picked up the resident's hand, and performed the fingerstick blood test without asking the resident for permission. After Staff #6 left the resident's room, Resident #48 described another experience when they were provided with personal care without regard to their privacy. S/he stated the door to the room was open and the privacy curtain was not pulled around the bed while their body was exposed. The resident described that s/he felt very embarrassed during that experience. Resident #48 then described a care plan meeting with staff, which included the Assistant Director of Nursing and the social worker, that turned into a shouting match. The resident indicated that staff would not listen to either them or their family member when they discussed their specific care concerns about facility staff. On 2/04/26 at 3:00 PM an interview was conducted with the Nursing Home Administrator. She acknowledged the finding that Staff #6 entered Resident #48's room without permission. She said that staff training will be done. 2) On 02/01/2026 at 8:17 AM, during an interview with R#22 in room [ROOM NUMBER], the breakfast tray distribution on the 400 hall was underway, the surveyor observed Staff #5, a Geriatric Nursing Assistant and Staff #7, a Licensed Practical Nurse, enter resident rooms 406, 409, 410, 411, 412, 414, 415, and 416 without knocking prior to entry. This occurred in 8 of 8 resident rooms observed during the breakfast meal tray pass. The surveyor did not observe either staff member pause, announce themselves, or request permission prior to entering resident rooms. Review of the facility policy titled Resident Rights and Dignity, revised 2025, indicated that staff are expected to knock and announce themselves prior to entering resident rooms. During an interview on 02/02/2026 at 10:12 AM, Staff #5 stated, We usually just go in during meal pass because we're trying to get trays out quickly. On 02/03/2026 at 1:15 PM, the findings were reviewed with the Nursing Home Administrator and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON). The DON confirmed that staff are expected to knock prior to entering resident rooms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to notify the resident's physician of a significant change in condition and a decision to transfer the resident from the facility. This was evident for 1 (Resident #83) of 2 residents reviewed for neglect. The findings include:Resident #83 passed away in late 2025. On [DATE] at 7:39 AM, the details of complaint2729325 for Resident #83 were reviewed and revealed concerns with coordination and notifying the physician to send the resident out during a change in condition.A review of Resident #83's medical records was conducted on [DATE] at 2:26 PM. The review revealed progress notes dated [DATE] that indicated the resident's code status was updated from full code to Do not resuscitate and [DATE] that indicated emergency medical services (EMS) arrived in the facility to pronounce that the resident had passed away.A Full Code means a patient wants all possible life-saving measures, including cardiopulmonary resuscitation (CPR), chest compressions, defibrillation, and intubation, if their heart stops or they stop breathingA Do Not Resuscitate (DNR) order is a legally binding medical directive instructing healthcare providers not to perform CPR if a patient's heart stops or they stop breathing. It is a proactive decision, often in conjunction with terminal illness or advanced age, designed to allow natural death, sometimes referred to as no code or Allow Natural Death. The Director of Nursing (DON) was interviewed on [DATE] at 11:33 AM. During the interview, she reported her expectations from nursing staff when a resident is experiencing a change or decline in health status. After resident assessment, the physician should be notified immediately to determine the next steps and coordinate if EMS should be called. If the physician decides to send the resident to the hospital, an order is placed in the resident's medical order to reflect that decision. The DON further explained that all actions taken by the nurse in such events are expected to be documented in the resident's medical record as a progress note and/or change in condition evaluation.Also, during the interview, Resident #83's medical record was reviewed with the DON. The DON confirmed that EMS was called into the facility on [DATE]. However, she could not tell who or which staff called the EMS and stated, the nurse should have documented that. I would expect a change in condition (to show what the nurse did and that the physician was notified), but there is none in there. The DON also reported that there was no medical order to send the resident out to the hospital on [DATE] and explained that the nurse should have done a late entry (for progress notes and medical orders) if s/he was in a chaotic situation.The concern was discussed with the DON that there was no documentation to indicate that the nursing staff had notified Resident #83's physician of his/her change in condition or decision to transfer to the hospital. The DON verbalized understanding and acknowledged the concern.

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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 record review and staff interview, it was determined that the facility failed to report an alleged violation involving abuse. This was evident for 1 (R#88) of 1 residents reviewed during the annual recertification survey. The findings include: On 02/03/2026 at 9:22 AM, Intake #2697168 dated 12/19/2025 was reviewed for R#88. The intake was a complaint filed with OHCQ by Adult Protective Services on behalf of the resident's family. It was determined that R#88 was no longer at the facility and had discharged on 01/09/2026. On 02/03/2026 at 9:35 AM, the summary included with intake described R#88's family reporting visiting R#88 at the facility to often find him in a saturated and wet brief or soiled.On 02/03/2026 at 10:10 AM, the facility's grievance logs were reviewed for the previous 12 months, and it was revealed that on 12/08/2025, Staff #8 documented R#88's family reported the resident was left sitting in a very wet brief. The documentation indicated staff delayed care due to the residents' agitation. The record showed internal review and referral to psychiatric services. There was no evidence that this allegation of neglect was reported to OHCQ.Further review of grievance documentation revealed a grievance dated 09/31/2025 in which a facility GNA was reported to have raised a fist toward a resident and stated, Don't tell me what to do. I know how to do my job. There was no evidence this allegation of staff mistreatment was reported to OHCQ.On 02/04/2026 at 3:09 PM, the Nursing Home Administrator stated that allegations of abuse and neglect are reportable. When asked why the above grievances were not reported as Facility Reported Incidents, the NHA was unable to provide a rationale and confirmed to the surveyor that the policy that was provided is the facility's use of a templated policy that is not facility-specific.On 02/06/2026 at 2:30 PM, no additional evidence was provided to the surveyor prior to the conclusion of the survey.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to ensure admission Minimum Data Set assessments were completed timely. This was evident for 1 (Resident #32) of 1 resident reviewed for respiratory care. The findings include:The Resident Assessment Instrument (RAI) identifies the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. On 02/03/26 at 12:52 PM a review of Resident #32's medical record revealed that the resident was admitted to the facility on [DATE] after a hospitalization for a respiratory infection. A review of the resident's MDS document indicated an entry date of 1/20/26, and an MDS Admission/Medicare - 5 day MDS with an ARD of 1/24/26 was listed as In Progress. Only Section F and Section K were completed. Multiple other sections of the MDS were incomplete. On 2/05/26 at 12:45 PM an interview was conducted with the MDS nurse (Staff #9). She was asked about her process for new admissions and explained that she received notification from the admissions office about new admissions, and that she had access to hospital medical records to obtain information even before the resident was admitted . She further explained that if the MDS timeliness was urgent, she would email all parties to let them know what needed to be completed. Staff #9 was asked to review Resident #32's admission MDS documentation. She confirmed that the resident was admitted to the facility on [DATE], and that the MDS set date was 1/24/26. The MDS was completed/signed/accepted on 2/03/26. When asked if the admission MDS was timely, she did a calculation, then looked up the information, and replied that it was not completed timely. It should have been completed on 2/02/26. She confirmed the deficiency that the MDS was late. On 2/06/26 at 1:16 PM an interview was conducted with the Nursing Home Administrator to review survey findings. She acknowledged the late admission MDS for Resident #32. No further evidence was provided by the end of the survey.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, it was determined that the facility failed to perform required resident assessments. This was evident for 1 (Resident #2) of 6 residents reviewed for unnecessary medications. The findings include:The Resident Assessment Instrument (RAI) identifies the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. The Brief Interview for Mental Status (BIMS) score is a 0-15 point assessment tool used in long-term care to measure cognitive function, focusing on memory, orientation, and recall. Scores indicate cognitive levels: 13-15 (intact), 8-12 (moderate impairment), and 0-7 (severe impairment).On 2/03/26 at 3:43 PM a review of Resident #2's medical record revealed that the resident was admitted in February 2024, and had diagnoses that included, but was not limited to, Parkinson's disease and unspecified dementia. Further review revealed that the resident had a quarterly MDS assessment on 12/11/25. A review of the MDS Section C revealed that no cognitive assessment was done. The space to indicate the resident's score had a dash in it, and the questions were answered with the words not assessed.On 2/05/26 at 12:45 PM in an interview with the MDS nurse (Staff #9), she was asked about the entry in Section C of Resident #2's December MDS. She reviewed the form and said that Section C was dashed for the 12/11/25 MDS assessment. When questioned further she confirmed that a cognitive assessment was required for a quarterly MDS and should have been done but that this was a question for the facility's social worker. When asked what steps were taken when a section was incomplete, she said she sent an email to any staff who had incomplete entries and if there was no response she would send a follow up email to the Nursing Home Administrator (NHA) and the Regional MDS nurses. Further review of the resident's MDS entries revealed that Section C was also dashed for the resident's September 2025 assessment, and that the resident's last BIMS assessment was done in June 2025.On 2/06/26 at 1:16 PM in an interview with the NHA, she said that she was unaware that some MDS sections were incomplete, but she acknowledged the deficiency.

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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 record reviews and interviews, it was determined that the facility failed to conduct care plan meetings after the completion of the comprehensive and quarterly assessments. This was evident for 1 (Resident #1) of 3 residents reviewed for care planning and 1 (Resident #2) of 6 residents reviewed for unnecessary medications and 1 (Resident #47) of 1 residents reviewed for activities. The findings include: 1.) Resident #1 had been a resident of the facility since 2023. The resident was admitted with multiple health concerns including stroke and dementia. An interview with Resident #1's responsible party on 2/3/26 at 11:09 AM indicated concerns with care plan meetings being missed or rescheduled. On 2/3/25 at 1:24 PM, the Social Services Director (Staff #8) was interviewed regarding care plan meetings. Staff #8 explained that care plan meetings are scheduled quarterly in conjunction with quarterly and comprehensive assessments and documentation can be found in the residents' progress notes. A review of Resident #1's medical record was conducted on 2/3/26 at 1:38 PM. The review revealed a comprehensive assessment was completed with an assessment reference date (ARD) of 8/10/25, then followed by a quarterly assessment with an ARD of 11/10/25. Progress notes under Care Plan Note for Resident #1 with an effective date of 8/6/25 at 1:51 PM indicated that a care plan meeting was scheduled, however the resident's family member did not answer the phone call. The facility staff documented a plan that read, attempt will be made to f/u with another call to reschedule Care Conference meeting by telephone or in person. A follow-up progress notes with an effective date of 8/6/25 at 2:50 PM indicated that the facility staff was unable to reach the family member and that a voice message was left. The following note for care plan meetings had an effective date of 11/5/25 at 10:44 AM. No other note was found to indicate that a care plan meeting was held after the 8/10/25 comprehensive assessment was completed. A subsequent interview with Staff #8 was conducted on 2/5/26 at 10:50 AM. During the interview, the findings were discussed with Staff #8 and she indicated that the care plan meeting and ARD of the comprehensive assessment was prior to her hire date. She reported that during that time, the care plan meetings were conducted and scheduled by the nursing staff. They (nursing staff) also used a binder to document the schedule of the care plan meetings and indicated that further documentation may be found there. On 2/5/26 at 11:02 AM, Staff #8 reviewed the binder for care plan meetings. The review revealed that a care plan meeting was scheduled for 8/6/25 at 1:20 PM with Resident #1's RP's phone number written beside it. Staff #8 No other documentation was found to indicate that a care plan meeting was held for the resident after the comprehensive assessment was completed. Staff #8 acknowledged the concern. 2.) The Resident Assessment Instrument (RAI) delineates the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. Resident #2 was admitted to the facility in February 2024 with diagnoses that included, but were not limited to, Parkinson's disease and unspecified dementia. A review of Resident #2's medical record revealed that their 2025 MDS assessment dates were 1/23/25 (quarterly), 4/25/25 (quarterly), 6/10/25 (quarterly), 9/10/25 (annual), and 12/11/25 (quarterly). Further review failed to reveal evidence of any care plan meeting held in September or December. On 2/05/26 at 12:19 PM an interview was conducted with the social worker (Staff #8), who said she had worked at the facility for three months. When asked about her process for scheduling care plan meetings, she explained that she determined the need for a care plan meeting by the MDS ARD dates and that she had reports of those dates for all residents. When she was asked when Resident #2's last care plan meeting was, she said that she had not yet met with the resident and had not had a care plan meeting with Resident #2. Staff #8 said she thought that the resident's last care plan meeting was held in May. Staff #8 retrieved a binder of documents and then confirmed that the resident's last care plan meeting was on 5/07/25 and that since then, the facility failed to have 2 care plan meetings for the resident. She said she was unable to explain the reason for the missed care plan meeting in September 2025 since she did not work at the facility at that time, and she explained that she was unable to schedule the December 2025 care plan meeting. On 2/05/26 at 2:29 PM an interview was conducted with the Director of Nursing (DON) to review the deficient practice that Resident #2 did not have a care plan meeting in September 2025 or December 2025 when they were due. The DON acknowledged the deficiency. 3.) On 02/02/2026 at 10:18 AM, during an interview, R#47 stated that they did not participate in a care plan meeting. A record review completed on 02/02/2026 at 10:42 AM revealed that revisions to R#47's care plan focus areas and goals were documented with a revision date of 11/07/2025. There was no evidence of documentation in the resident's record indicating that R#47 or the resident's representative participated in or were notified of a care plan meeting on that date. On 02/03/2026 at 1:26 PM, an interview was conducted with Staff #8, the staff member responsible for coordinating care plan meetings, who has been in the role since November 2025. Staff #8 stated that care plan meetings are conducted quarterly. Staff #8 stated, Being fairly new, I picked up where they left off. We meet on Wednesday and Thursday. One day is for short-term residents and one day is (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for long-term residents. Sometimes, we will combine. Staff #8 stated that they coordinate care plan meetings with residents and/or family members and that scheduling is typically based on the next planned Assessment Reference Date (ARD). Staff #8 further stated that documentation regarding care plan meetings may be entered into the electronic record under a Social Services progress note, that dates are communicated to staff via email, and that a care plan schedule is maintained in a binder in the Social Services office. Staff #8 stated that they are responsible for updating resident care plans. On 02/03/2026 at 1:33 PM, the surveyor asked where documents related to R#47 could be found. Staff #8 stated, It would be in a Social Services Progress Note. On 02/03/2026 at 3:20 PM, a review of R#47's record revealed no evidence that Staff #8 documented coordination of, notification of, or participation in a care plan meeting for R#47 since 09/03/2025. There was no documentation indicating accommodations made to ensure resident or representative participation, nor any evidence that a care plan meeting occurred after that date. The most recent documented care plan meeting for R#47 occurred on 09/03/2025, as reflected in a Social Services Care Plan Progress Note authored by the previous social worker. No subsequent care plan meeting documentation was identified in the resident's record. On 02/05/2026 at 1:15 PM, these findings were reviewed with the Nursing Home Administrator. On 02/06/2026 at 2:30 PM, no additional evidence was provided to the surveyor prior to the conclusion of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record reviews and interviews, it was determined that the facility failed to ensure showers were provided/offered as scheduled to dependent residents. This was evident for 1 (Resident #89) of 2 residents reviewed for neglect. The findings include:Resident #83 was admitted into the facility in mid-2025 with diagnoses that include muscle weakness, morbid obesity, chronic pain, and abnormalities of gait and mobility. On 2/5/26 at 7:39 AM, an allegation related to complaint2729325, that showers were not being provided to the resident as scheduled was reviewed.During an interview with the complainant on 2/5/26 at 1:33 PM, s/he reported that Resident #83 would go 11 days with staff not providing showers.A review of Resident #83's medical record was conducted on 2/5/26 at 1:40 PM. The review revealed a medical order for showers scheduled on day shift every Monday and Thursday. However, this order was discontinued on 9/2/25. No other order was found for showers and there was no documentation in the resident's administration record to indicate showers were being provided.On 2/6/26 at 8:40 AM, further review of Resident #83's medical record revealed a quarterly assessment was conducted with an assessment reference date of 9/18/25, where section GG indicated the resident needed substantial/maximal assistance (helper does MORE THAN HALH the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) to safely complete shower activity.Facility staff had reported that shower/skin sheets are filled out whenever a shower is provided for a resident. A review of the shower/skin sheets for September 2025 was conducted on 2/6/26 at 9:05 AM. The review revealed Resident #83 had 1 documented shower provided on 9/11/25 (Thursday) for evening shift. The Director of Nursing (DON) was interviewed on 2/6/26 at 10:02 AM. During the interview, the DON reported that residents do not need orders for showers. All residents are scheduled for showers 2x a week and the schedule is dictated by the resident's room number and bed. (According to Resident #83's information, showers would have been scheduled on day shift every Wednesday and Saturday.) She also reported that aside from the shower/skin sheets, nursing aides document showers/baths under their task documentation.The DON was asked to print a copy of the nursing aides task documentation in September 2025 for Resident #83. A review of the documentation was conducted on 2/6/26 at 10:30 AM. The review revealed shower was provided on 9/13/25 (Saturday) for day shift.In a subsequent interview with the DON on 2/6/26 at 11:08 AM, the findings were discussed that in September of 2025, Resident #83 received 1 scheduled shower and 1 unscheduled shower. No other documentation was found to indicate showers were provided or refused on the other days the resident was scheduled to receive them. The DON confirmed the finding and acknowledged the concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to obtain a physician's order for oxygen and failed to perform a follow up assessment after a resident was treated for shortness of breath. These failures were evident for 1 (Resident #83) of 3 residents whose closed records were reviewed during the recertification survey. The findings include:Medical Orders for Life-Sustaining Treatment (MOLST), is a document that translates a patient's preferences for end-of-life care into specific, actionable medical orders signed by a healthcare professional. Unlike general advance directives, MOLST forms are portable medical orders that tell emergency responders and other providers exactly what treatments (like CPR, intubation, feeding tubes) to provide or withhold, ensuring patient wishes for serious illnesses are honored across different care settings.On [DATE] at 4:11 PM a review was conducted of Resident #83's medical records. Resident #83 was admitted to the facility in 2022 and was [AGE] years old when they expired at the facility in [DATE]. Their diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen.A care plan note in Resident #83's medical record dated [DATE] indicated that the resident did not show potential for discharge due to COPD and lack of support system. Resident unable to care for [themselves]. It also indicated that the resident required oxygen continuously at 2 liters/minute via a nasal cannula.A review of Resident #83's MOLST document revealed instructions to not attempt cardiopulmonary resuscitation for the resident.Further record review revealed a progress note dated [DATE] at 1:20 AM that indicated the resident had shortness of breath and was assessed to have a low oxygen saturation level of 90%. The record indicated that the resident received 3 interventions: 1) they were medicated with an as needed dose of an inhaler, 2) the head of the bed was elevated, and 3) their oxygen dose was increased to 3 liters/minute. There were no subsequent progress notes that described how these interventions affected the resident, and no physician's order for the increase in oxygen. The next progress note in the record was written on [DATE] at 7:43 AM and stated - expired - observed at 7:43 w/o [without] resp/pulse [respirations/pulse], M notified, family and funeral home notified.On [DATE] at 10:03 AM an interview was conducted with the Director of Nursing (DON) and when asked she said she remembered Resident #83 and knew that the resident had died at the facility. When asked about her recollection of the resident's care plan regarding end-of-life choices, the DON explained that although there had been discussion about hospice and palliative care for this resident, no decision had yet been made, and there were no physician orders for a hospice consult prior to the resident's death. When asked where the evidence was regarding those discussions, she said she had emails but that there was nothing documented in the resident's medical record. The DON was asked to review the progress notes regarding the resident's shortness of breath and the DON she said that she saw that interventions were provided to the resident, which included an increase of the resident's oxygen dose to 3 liters/minute. She was asked where the order was for the increase in oxygen, or if there was an order to titrate oxygen, but she confirmed that there were no such orders. She also confirmed that there was no evidence of any staff follow up to check how the resident responded to the interventions that were provided. She further confirmed that the progress note hours later showed that when staff went back into the resident's room, the resident was found without pulse or respiration.The DON confirmed the above deficient practices and provided no further evidence by the end of the survey.

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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 observations, record reviews, and interviews, it was determined that the facility failed to ensure residents at risk for developing pressure injuries receive appropriate services for treatment and prevention. This was evident for 1 (Resident #3) of 2 residents reviewed for pressure injuries. The findings include:Resident #3 had been residing in the facility since early 2024. On 2/2/26 at 1:42 PM, during a family interview, the resident's responsible party indicated that the resident had a wound. It was also observed at this time that the resident's bed was equipped with an air mattress with the control box located at the foot of the bed. The control had a dial to set the firmness based on weight. The setting was dialed up to max weight of over 350 lbs. A review of Resident #3's medical records was conducted previously on 2/2/26 at 10:46 AM. The review revealed the resident's most recent weight was taken on 1/27/26, and was documented as 160.2 lbs.On 2/3/26 at 8:27 AM, Resident #3 was observed in bed. The weight setting for the air mattress was still set to max.The Assistant Director of Nursing who happened to be the facility's wound nurse (Staff #1) was asked to accompany the surveyor in Resident #3's room on 2/3/26 at 8:33 AM. Staff #1 confirmed that the resident's air mattress setting was turned up to max firm/weight and stated, it should be set between 150 and 180 lbs. We had a town hall meeting a couple of months ago and we went over the settings of the low air loss mattress. Our staff should be familiar with that. Then proceeded to turn the dial down to an area between the 150 and 180 markers. Staff #1 reported that nurses sign off an order to indicate that these settings are checked and appropriate.The interview with Staff #1 was continued in her office on 2/3/26 at 8:39 AM. During the interview, Resident #3's medical orders was reviewed, and Staff #1 showed the surveyor the order that read, Ensure low air loss mattress is on and in adequate working order. This order had a start date of 1/27/26 and was marked as done for all shifts on 2/1/26 and 2/2/26. Staff #1 explained that in adequate working order includes making sure the weight setting of the air mattress was appropriate. Staff #1 stated, sounds like we need to reeducate. Continue ongoing education with staff on low-loss air mattress. Thank you for letting me know.The Braden Scale is a widely used healthcare tool to assess a patient's risk of developing pressure injuries/ulcers (bedsores) by evaluating six key factors: Sensory Perception, Moisture, Activity, Mobility, Nutrition, and Friction/Shear. Scores range from 6 (severe risk) to 23 (no risk), with lower scores indicating higher risk (e.g., 18 or less suggests at-risk status), guiding interventions for prevention. On 2/3/26 at 12:48 PM, a review of Resident #3's medical record revealed the most recent BRADEN scale dated 5/2/25 that indicated the resident to be very high risk. The resident also had orders for weekly skin check scheduled on day shift every Thursday with a start date on 12/19/24. The administration record showed that the nurses are signing that the skin checks were done as scheduled on 1/1/26, 1/8/26, 1/15/26, 1/22/26, and 1/29/26. However, review of the assessment documentation titled weekly skin assessment was only documented on 1/15/26 and 1/22/26. No other weekly skin assessment was documented for the month of January 2026.A subsequent interview was conducted with Staff #1 on 2/5/26 at 9:12 AM. During the interview, Staff #1 explained that nurses document in the electronic treatment administration record (eTAR) that weekly skin assessment are done, then documentation of the actual assessments are found under the assessments tab in the electronic health record The finding that nurses had documented in Resident #3's eTAR that skin assessments were completed 5x in January, however only 2 of the 5 assessments were documented under the assessments tab, was discussed with Staff #1. She confirmed the finding and reported that nurses potentially could have done a progress note or documented on the skin sheet (paper document used for shower days).The binder containing the skin sheet was in the Director of Nursing's (DON) office. On 2/5/26 at 9:34 AM, after reviewing the skin sheet binder and Resident #3's medical record, Staff #1 confirmed that there was no documentation to indicate that skin assessments were completed in 3 of the 5 scheduled days in January 2026.On 2/5/26 at 9:39 AM, the concern was discussed with the DON and Staff #1 that the nursing staff failed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to ensure Resident #3, who had a very high risk, receive appropriate care for prevention of pressure ulcer/injury, as evidenced by an over inflated air mattress and absence of skin assessments. Both staff verbalized understanding and acknowledged the concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 monitor a resident's safety device. This was evident for 1 (Resident #51) of 1 resident reviewed for wandering/elopement. The findings include:A wanderguard is a wearable, electronic security device -typically a bracelet or tag-designed for senior living and healthcare facilities to monitor residents at risk of elopement. It uses radio frequency or Bluetooth technology to trigger alarms or lock doors when a patient nears unauthorized exits.Resident #51 was admitted to the facility in September 2025 with diagnoses that included, but was not limited to, Alzheimer's disease. On 10/08/25 an elopement assessment indicated that they were at high risk for elopement. On 11/13/25 the resident's cognition was assessed as severely impaired. A review of their Minimum Data Set (MDS) assessment dated [DATE] indicated a significant change in their condition related to a new onset of wandering behavior, and that a wanderguard device was placed on the resident to monitor them for safety.On 2/03/26 at 8:44 AM Resident #51 was observed as they propelled themselves in a wheelchair down the hallway of the 500 unit. The resident was neatly dressed in street clothes, easily engaged in small talk, but was oriented only to themselves - they were not aware that they were in a nursing facility, or to whom they were speaking. A wanderguard device was observed around their right ankle.On 2/03/26 at approximately 9:00 AM Resident #51 was observed as they self-propelled in the unit 200 hallway towards the dining hall near the lobby.On 2/03/26 at 12:02 PM a review of Resident #51's medical record failed to reveal documented evidence that the wanderguard device was regularly monitored for placement and functionality. On 2/03/26 at 2:31 PM an interview was conducted with agency nurse (Staff #10). She explained the process for how she checked Resident #51's wanderguard device. During the interview Resident #51, who was present in the hallway, self-propelled up to the nurse and the nurse showed the surveyor that the device had a flashing green light which indicated that the battery was sufficient. Staff #10 further explained that there were replacement devices on the unit if a check revealed that a device was not functional. When asked where she documented that she had checked the wanderguard device, Staff #10 said she documented on the Treatment Administration Record (TAR) in the resident's chart, but also added that this was her first day to work at the facility.On 2/03/26 at 2:45 PM an interview was conducted with the Director of Nursing (DON) to review Resident #51's care needs and the DON said that she was aware the resident had a wanderguard device. When asked where staff documented that they checked the wanderguard for placement and function, the DON said it should be documented on the TAR. She reviewed the resident's record and found that there was no documentation that the wanderguard device was monitored. She confirmed that there was no evidence that the resident's wanderguard was monitored. On 2/06/26 at 2:00 PM a review was conducted of the facility's policy for elopement. The policy stated, in part: If interventions include a wander guard/secure band, a physician order needs to be in place. 1.) Check location and placement of wander guard every shift (please include expiration date and identify the location). 2.) Check function of wander guard transmitter daily. 3). Check skin integrity at wander guard location every shift. All orders should be placed on the TAR and signed off by nursing.On 2/04/26 at 3:00 PM an interview was conducted with the Nursing Home Administrator. She acknowledged the deficiency that Resident #51's wanderguard was not monitored. No further evidence was provided by the end of the survey.

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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 reviews and interviews, it was determined that the facility failed to ensure pain management was provided to residents according to professional standards of practice. This was evident for 2 (Resident #52, #19) of 2 residents reviewed for pain management. The findings include: 1) Resident #52 was admitted into the facility in mid-2025. During an interview with the resident on 2/2/26 at 9:18 AM, s/he indicated that pain medications don't always help and non-pharmacological interventions (NPI) are not provided or attempted for pain management. A review of Resident #52's medical orders was conducted on 2/0/26 at 9:26 AM. The review revealed an as needed (PRN) pain medication with a start date of 7/14/25. A pain assessment order also had a start date of 7/14/25, included NPI's with instructions that read, Do you have pain? If Denies - Stop here. If Yes - Indicate Pain score 0-10, Offer a nonpharmacological intervention: 1. Repositioning/Turning, 2. Distraction, 3. Massage, 4. Hot/Cold Compress, 5. Emotional Support, 6. Quiet Environment, 7. Other, 8. Not Applicable. every shift for Pain Monitoring Pain assessment every shift, Document Non-pharmacological interventions attempted prior to PRN medications. 1. Repositioning/Turning, 2. Distraction, 3. Massage, 4. Hot/Cold Compress, 5. Emotional Support, 6. Quiet Environment, 7. Other, 8. N/A. The electronic medication administration record (eMAR) of Resident #52 for January 2026 was reviewed on 2/4/26 at 9:40 AM. The review revealed that the PRN pain medication was administered on 1/12/26 at 10:58 PM, for an initial pain score of 0/10. The progress note corresponding to the medication administration failed to indicate location of the pain. Furthermore, there was no documentation to indicate that NPI's were provided/attempted prior to the administration of the medication. The Director of Nursing (DON) was interviewed on 2/4/26 at 10:34 AM. During the interview, the DON explained her expectations from the nursing staff when a resident complaint of pain. Proper assessment of the pain characteristics (pain score, location, intensity, etc.) must be documented and NPI's offered/attempted prior to administering PRN pain medications. She also indicated that all interventions should be reflected in the resident's administration record, where some would prompt the nurse to write a progress note to complete the documentation. The DON gave the example, when a PRN pain medication is administered, the nurse must go back to reassess the resident and document efficacy, to complete the documentation of the medication administration. All of which is reflected in the resident's progress notes where the DON indicated the pain characteristics can be found as well. Resident #52's medical record was reviewed with the DON on 2/4/26 at 10:43 AM. The DON confirmed that the PRN pain medication was administered on 1/12/26 for a 0/10 pain, no documentation of pain characteristics, and no evidence that NPI's were attempted/provided prior to the medication administration. The concern was discussed with the DON that the nursing staff failed to provide pain management to Resident #52 according to professional standards of practice. The DON verbalized understanding and acknowledged the concern. 2) Resident #19 was admitted to the facility in November of 2024, with diagnoses that included but was not limited to, chronic respiratory failure and right sided weakness from a stroke. On 2/03/26 at 8:45 AM an observation and interview was conducted with the resident in their room as part of the initial screening process of the recertification survey. The resident was awake, alert, and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oriented and denied any discomfort at that time. On 2/05/26 at 3:05 PM a review of the resident's medication records revealed an entry for the administration of an as needed (PRN) dose of narcotic pain medication (oxycodone) on 2/05/26 at 8:49 AM, which had a corresponding pain level documented as NA, that was administered by Certified Medicine Aide (Staff #14). Further review revealed additional entries for PRN oxycodone doses documented as given on 2/02/26 at 8:49 AM, on 2/03/26 at 8:57 AM, and on 2/04/26 at 8:50 AM by Staff #14, and each of those corresponding pain scores was documented as NA. On 2/06/26 at 10:17 AM an interview was conducted with Staff #14, and Licensed Practical Nurse (Staff #13) to review the facility's process for resident pain assessments and administration of PRN pain medications. Staff #13 explained that a nurse would assess the resident, attempt to provide non-pharmacological interventions (NPI), and then if still needed, would administer the ordered pain medication and document the resident's location and level of pain, and then follow up to document whether the medication was effective or not. He further explained that this was accomplished through documentation in the electronic medication administration record (eMAR) portion of the facility's electronic medical record, that an entry on the eMAR automatically created a progress note of the entry. Staff #14 added that because she was not a nurse, she was not able to assess resident's pain, but she was able to administer PRN pain medications once the nurse had assessed the resident's need. She explained that as a Certified Medicine Aide (CMA) she had to enter NA as the pain score on the eMAR, but that the nurse was then required to enter the resident's pain score in the same screen. Staff #13 added that the software required the nurse to enter the information before any additional medication administrations were able to be documented for that resident. On 2/06/26 at 10:30 AM an interview with the Director of Nursing (DON) was conducted. Resident #19's eMAR was reviewed and the DON said that there was no evidence that the nurse who worked on 2/05/26, Staff #4, assessed the resident for pain, or attempted NPI prior to medication administration. The DON reviewed the eMAR entries for 2/02/26, 2/03/26, and 2/04/26 and confirmed the deficiency that there was no evidence that the resident's pain was assessed prior to the PRN administration of oxycodone on those days. No additional evidence was provided by the end of the survey.

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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 reviews and interviews, it was determined that the facility failed to ensure the provider had a response and rationale to a medication regimen review recommendation and/or identified irregularity and that the response was documented in the resident's permanent medical record. This was evident for 2 (Resident #48, #3) of 6 residents reviewed for unnecessary medications. The findings include:1) Resident #48 was admitted to the facility in November 2025 after a hospitalization which included treatment in intensive care. The resident's diagnoses included but were not limited to, type 2 diabetes, heart failure, and malignant neuroendocrine tumors. On 2/02/26 at 12:13 PM an interview with Resident #48 was conducted in the resident's room. The resident was alert and oriented and described in detail their complicated medical history and recent treatment at a tertiary hospital where they were so sick they needed a ventilator. They also detailed their medication orders which they described as a complicated regimen with doses of insulin that were unusual. The resident stated that when they were admitted to the facility, they were concerned that their hospital discharge medication orders were altered by the facility provider because they were so unusual. A review of Resident #48's medical record on 2/04/26 revealed a progress that the pharmacist had reviewed the resident's medication regimen and made recommendations, but it indicated to see the report which was not found in the resident's record. On 2/04/26 at 1:10 PM an interview was conducted with the Director of Nursing (DON) who provided copies of pharmacy recommendations for Resident #48. The pharmacy report dated 11/30/26 described the pharmacist's review of insulin and fingerstick glucose testing orders and suggested the provider assess the need for adjustments and consider an endocrine consult. At the bottom of the form was a handwritten notation that said No response required. The notation was unsigned and undated. The DON confirmed that this notation was not evidence of a physician review, response, or rationale of the pharmacy recommendation. On 2/06/26 at 1:52 PM an interview was conducted with the Nursing Home Administrator (NHA) to review that the physician response to Resident #48's pharmacy recommendation was non-compliant. She acknowledged that the facility was cited previously for this same deficiency. The NHA said that the former DON did audits after the last recertification survey, but she acknowledged the current deficient practice found on this survey. 2) Resident #3 had been residing in the facility since early 2024. A review of the resident's medical records on 2/4/26 at 8:56 AM, revealed progress notes from the consultant pharmacist that indicated medication regimen reviews (MRR) were conducted for the past 6 months in 2025 (December to June in descending order). All notes indicated that the review was done with no irregularities identified. However, no other documentation was found to indicate an MRR was conducted in the other months of 2025 or January 2026. The Director of Nursing (DON) was interviewed on 2/4/26 at 10:24 AM. During the interview, the DON explained the process for MRR and reported that the consultant pharmacist sends her, Regional Director, Nursing Home Administrator (NHA), and the [NAME] President of Nursing, the monthly reports of identified irregularities and/or recommendations with MRR. Then she prints it out for the provider to write their response on the report. Once completed by the provider and orders are (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented, she makes a copy of the report. One copy is provided to medical records for them to scan and uploaded to the resident's chart, then the other is faxed back to the pharmacist (so they know it was addressed) and kept in a binder with the DON. The finding was discussed with the DON on 2/4/26 at 10:33 AM. The DON reported that the consultant pharmacist usually does the MRR towards the end of each month and the reports are usually sent about a week after, indicating that she had not received MRR's for January 2026 yet. She also reported that she would review Resident #3's medical records and her binder to see MRR notes or reports from January 2025 to May 2025 and report back to the surveyor. On 2/4/25 at 1:07 PM, the DON provided printed copies of the progress notes by the consultant pharmacist from January 2025 through May 2025. The 2/23/25 MRR text read, See report for comment. The DON was asked to provide a copy of the report. On 2/4/26 at 1:23 PM, further review of Resident #3's medical record failed to show provider response to the identified irregularity and/or recommendation from the 2/23/25 MRR. On 2/4/26 at 1:50 PM, the NHA provided the surveyor with a copy of the MRR report for 2/23/25. The report had a provider signature, however there was no date to indicate when it was signed. Furthermore, the top part of the document indicated that it was faxed to the facility, dated 2/4/26 at 1:32 PM. The NHA reported that the report was signed on 3/6/25 when the provider came to the facility to see Resident #3. In a subsequent interview with the DON on 2/4/26 at 2:42 PM, she confirmed that she was responsible for ensuring MRR reports are provided to the providers for their response. The DON was also asked if she could verify that the 2/23/25 MRR report was signed by the provider on 3/6/25. She answered, No. The DON showed the surveyor the email dated 2/25/25, that she received from the consultant pharmacist containing the report. However, there was no credible evidence to show when the provider responded to the report and the DON confirmed that the report was faxed to the facility as indicated on the date on the top part of the document. The concern was discussed with the DON that provider response to MRR's need to be part of the resident's medical record. The DON acknowledged the concern. Further review of Resident #3's medical record on 2/4/26 at 3:02 PM, revealed a progress note by a medical provider (different from the medical provider named in the 2/23/25 MRR report) that indicated the resident was seen in the facility with no mention of addressing the MRR recommendation. A review of the facility's policy for MRR was conducted on 2/4/26 at 3:04 PM. the review revealed item #10 that read, Copies of drug/medication regimen review reports, including physician response, will be maintained as part of the permanent medical record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review it was determined that the facility failed to administer medications timely. This was evident for 1 (Resident #48) of 1 resident reviewed for insulin. The findings include:Resident #48 was admitted to the facility in November 2025 following an acute hospitalization that included care in an intensive care unit. Their diagnoses included, but were not limited to, type 2 Diabetes Mellitus, heart failure, and malignant neuroendocrine tumors. A review of their medical record revealed that they required multiple medications, which included significant doses of insulin before meals, and as needed at bedtime.On 2/02/26 at 11:23 AM an interview was conducted with Resident #48 in their room. The resident was alert, oriented, and able to describe their medical needs, including their medication regimen, in detail. On 2/04/26 at 11:42 AM an observation and interview were conducted with Resident #48 in their room. The resident stated that they had just received all of their morning medications together, which included insulin but was supposed to have been administered before breakfast. When asked if the resident had eaten breakfast yet, they replied no, and said their habit was to sleep until around 11:00 AM but that they still usually received their morning medications, including insulin, at around 8:00 AM, as long as their blood glucose level was not too low.On 2/04/26 at 12:22 PM a review of Resident #48's medical record revealed that the morning medications were signed as given on the electronic Medication Administration Record (eMAR) by Registered Nurse (Staff #6). The actual administration times were not listed on the eMAR.On 2/04/26 at 1:10 PM an interview was conducted with the Director of Nursing (DON) regarding the resident's statement that their morning medications and fingerstick glucose check were given and done at approximately 11:30 AM today even though some of the medications were scheduled to be given as early as 7:30 AM. She was asked to provide a medication audit record to show the actual time of administration for the resident's morning medications. When asked if she was familiar with this resident's particular habits, the DON said sometimes the resident awakened briefly, agreed to have their fingerstick glucose test done and take their medications and then fell back to sleep and would not remember it. On 2/04/26 at 2:42 PM a review of the medication audit for Resident #48's medications administered that morning was conducted with the DON. The report indicated that there were medications scheduled for 7:30 AM, 8:00 AM, and 9:00 AM, but they were signed as given at 11:37 AM by Staff #6. The DON was asked what was considered a timely medication administration and she said within one hour before or one hour after the medication was scheduled. The DON confirmed that the medications were given late and that this was a deficiency. She offered no explanation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interviews, the facility failed to ensure that 1) staff performed hand hygiene during 8 of 8 breakfast observations and 2) failed to perform hand hygiene during 2 (R#37 and R#55) of 3 medication administration observations, and 3) failed to maintain a sanitary medication storage environment in 1 of 2 medication storage rooms observed.The findings include:1) On 02/01/2026 at 8:17 AM, the surveyor observed Staff #5, a Geriatric Nursing Assistant, and Staff #7, a Licensed Practical Nurse, delivered meal trays to resident rooms 406, 409, 410, 411, 412, 414, 415, and 416 on the 400 hall. Staff #5 and Staff #7 exited 8 of 8 resident rooms without performing hand hygiene before entry or after exit.No alcohol-based hand sanitizer was observed on the meal cart. The surveyor observed three wall-mounted hand hygiene dispensers in the 400 hallway and one dispenser inside each resident room.2) On 02/04/2026 at 8:35 AM, during medication administration observation on the 500 hall, the surveyor observed Staff #6, a Registered Nurse, fail to perform hand hygiene before and after administering medications to R#37. Staff #6 also failed to perform hand hygiene prior to administering medications to R#55.3) On 02/04/2026 at 10:45 AM, Staff #4, a Registered Nurse, provided the surveyor access to two medication storage areas located behind the nursing station. Upon entering the medication storage area containing the Omni-Cell for resident medication storage, the surveyor observed disposable gloves, paper towels, sugar packets, and flip-top medication caps littered on the floor. The floor was visibly soiled.The handwashing sink basin in the medication storage area was filled with packaging and wrapping debris and was not accessible for use.Staff #4 notified Staff #9, the Assistant Director of Nursing and facility Infection Preventionist. Staff #9 arrived and conducted a dual observation with the surveyor and Staff #4, validating the surveyor's concerns regarding the conditions of the medication storage area.On 02/04/2026 at 12:10 PM, Staff #9 stated that hand hygiene audits are conducted. However, Staff #9 was unable to provide documentation of completed hand hygiene audits, the audit frequency, or evidence of staff education or reinforcement related to hand hygiene practices. On 02/04/2026 at 1:15 PM, these findings were reviewed with the Nursing Home Administrator and Director of Nursing.On 02/06/2026 at 2:30 PM, no additional evidence was provided to the surveyor prior to the conclusion of the survey.

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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 interview and record review it was determined that the facility failed to offer COVID-19 vaccinations to staff and residents and failed to educate staff and residents regarding the COVID-19 vaccination. This was evident for 7 (Staff #6, #11, #12, #16, #17, #18, #19) of 7 staff members, and 4 (Resident #2, #8, #48, and #51) of 5 residents, reviewed for vaccinations during the infection control task during the recertification survey. The findings include:On 2/05/26 at 8:31 AM an interview was conducted with a Registered Nurse (RN) who was the facility's infection preventionist (Staff #1). She was asked about the facility's process for offering information regarding COVID-19 vaccinations to staff and residents. She explained that the new admission packet for residents included education sheets for COVID-19 vaccinations and that the education sheet had a place to indicate consent for the vaccine. She further explained that each year the facility's pharmacy let her know what vaccines were available and then she ordered what was needed and offered and gave vaccines to current residents who consented.She went on to explain that although the facility held a flu clinic each year for staff, they did not do this for the COVID-19 vaccine even though the vaccine was available. She said she did not currently have any evidence that staff had been educated about or had been offered the COVID-19 vaccine.On 2/05/26 a review of immunization records for Resident #2, #8, #48, and #51 failed to reveal any documented evidence that they had been educated about the COVID-19 vaccine or been offered the COVID-19 vaccine.On 2/06/26 at 11:17 AM a review of immunizations records was conducted for Staff ##6, #11, #12, #16, #17, #18, and #19, and there was no evidence that they had been educated about or offered the COVID-19 vaccine.On 2/05/26 at 11:11 AM in an interview with the Nursing Home Administrator, she acknowledged that there was no evidence that the COVID-19 vaccine was offered to staff or residents. No further evidence was provided by the end of the survey.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident interview, the facility failed to ensure the call bell system was accessible. This was evident for 1 (Resident #45) of 1 residents reviewed during the annual recertification survey. The findings include: 02/01/2026 at 8:05 AM, the surveyor observed R#45 in room [ROOM NUMBER] with the call bell cord partially disconnected from the wall outlet and out of reach while R#45 was positioned near the edge of the bed, asking for assistance.R#45 stated to the surveyor that delayed staff response to call light activation was not unusual and reported waiting up to one hour for staff to respond.The surveyor reconnected the call bell and instructed R#45 to activate the adaptive pendant-shaped call button. The call signal was activated; however, after approximately eight (8) minutes, no staff responded.The surveyor assisted R#45 back into bed and ensured the call bell was placed within reach.On 02/03/2026 at 1:15 PM, these findings were reviewed with the Nursing Home Administrator and Director of Nursing.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNA) received required training. This was evident for 2 (Staff #11, #12) of 2 agency GNAs reviewed for training requirements during the recertification survey. The findings include:On 2/01/26 at 8:25 AM an interview was conducted with the Nursing Home Administrator (NHA) as part of the entrance conference for the annual survey. When asked about the percentage of agency staff the facility used, she said approximately 80%.On 2/03/26 at 5:31 PM an interview was conducted with the facility's staffing scheduler, (Staff #20). When asked what percentage of scheduled GNAs were from an agency, she replied about 80%.On 2/04/26 at 9:30 AM an interview was conducted with the facility's Human Resources Director, Staff #21 to ask about staff training. She said she was responsible for staff training but only for facility hired staff, and she explained the process for orientation and monthly training. When asked specifically about agency staff training, Staff #21 explained that she did not do anything for any agency staff - not even monthly training and added that she was not involved in any way with agency staff.On 2/04/26 the NHA was asked about agency staff training records and she said that she had access to the agency's portal where the license and training information was located. She was asked to provide evidence of training for Staff #11 and Staff #12, and she said she would print out what she could from the portal.On 2/06/26 at 11:17 AM the NHA provided information for Staff #11 and Staff #12. A review of the documents failed to reveal any evidence of training for Staff #12, and Staff #11 had a packet of training information, but it did not specify who the instructor was, the length of time for the training, or whether Staff #11 passed any test or was graded on the content. The NHA was asked if she could provide any additional information and she said she would call the agency representative to see if they could give any further information. No additional evidence was provided by the end of the survey.