STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215115	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frostburg Village Rehab Center	1 Kaylor Circle Frostburg, MD 21532

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review and interview it was determined that the facility failed to ensure staff informed the physician or nurse practitioner when a resident exhibited violent and aggressive behaviors. This was found to be evident for one (Resient #119) out of 15 residents reviewed for abuse during the survey.The findings include: Review of Resident #119's medical record revealed the resident was admitted to the facility in late March 2023 with a diagnosis of dementia. Review of the medical record revealed the resident had a multiple instances of aggressive behavior both with other residents and with staff. The resident was seen on multiple occasions in April 2023 by a psychiatric provider. On 4/22/23 the resident's psychotropic medications included Ativan 0.5 mg twice a day for anxiety, Buspirone 10 mg three times a day for anxiety, and a dose of Seroquel (an antipsychotic) at bedtime. No orders were found for as needed medications to be administered for increased anxiety or agitation.Further review of the medical record revealed the resident was sent to the hospital on 4/22/23 for aggressive behaviors. Review of the hospital emergency department notes revealed documentation that the nurse at the facility reported the patient was hitting staff and other residents and difficult to control.Further review of the hospital records revealed the resident was administered the regularly scheduled oral antipsychotic; as well as injections of two different antipsychotic medications: Haldol and Zyprexa. The hospital medically cleared the resident to return to the facility during the early morning hours of 4/23/23.Further review of the medical record failed to reveal documentation to indicate any changes in the residents medications, or orders for increase in supervision upon return from the hospital on 4/23/23.Review of a nursing note, written by Nurse #28 and dated 4/23/23 at 6:36 PM revealed : This resident was pushing other resident's around in their wheel chair and when tried to redirect resident [s/he] starting to swing and hit staff. Resident then tried to hit other residents. Staff intervened and tried to redirect this resident, when this resident hit this nurse in the jaw and kicked another aide in the knee. The Resident was placed into a chair, where [s/he] would not stay seated and continued to try to go after other residents near by.Further review of the medical record failed to reveal documentation to indicate that these behaviors of hitting staff and attempting to hit other residents was reported to either the primary care or the psychiatric provider on 4/23/23.On 8/8/25 at 12:15 PM the unit nurse manager (Nurse #2) confirmed each incident of resident being aggressive should be reported to provider.Review of a nursing note, written by Nurse #33 and dated 4/24/23 at 4:38 AM revealed the resident was up at the beginning of the shift wandering throughout the unit and required some redirection out of other residents' rooms.Review of a nursing note, written by Nurse #31 and dated 4/24/23 at 2:39 PM revealed the resident was requiring 1:1 to redirect to sit in wheelchair.Further review of the medical record failed to reveal documentation to indicate the physician was made aware that the resident was requiring 1:1 supervision; no order was found for 1:1 supervision, or other documentation to indicate 1:1 supervision was implemented as an ongoing intervention for Resident #119.Review of a nursing note, written by Nurse #31 and dated 4/25/23 at 4:35 PM revealed that in the morning, the nurse heard another resident yell for help, nurse observed Resident #119 attempting to talk to the other resident and push into the room, Resident #119 thought the other resident was their spouse and was going to assist the other resident to bed. 1:1 given able to redirect res long enough to remove other res from area. this writer managed to assist res to w/c. res at that time grabbed this writers hand attempting bite. res swinging at staff, res charged this writer nearly falling. res redirected and toileted. res making statements I'm going to kill you. Give me a gun because I am going to shoot you. res appears drowsy, res unable to ambulate in hallway knees buckling, staff assisted res to bed res unable at that time to amb [ambulate - walk] on own. res cont [continue] to punch staff in stomach and several attempts to hold hand to bite. The note went on to state that the resident then slept until 3:00 PM, was given medications at that time and was at the time of the note sitting calmly in a wheelchair.No documentation was found to indicate the primary care physician, or the psychiatric provider were made aware on 4/25/23 of the resident's attempts to bite staff or the threatening statements made by the resident.Further review of the medical record revealed the resident was seen by the psychiatric provider on 4/26/23. Review of the corresponding note failed to reveal documentation to indicate the psychiatric provider was aware of the attempts to bite staff, or the verbal threats.On 8/08/25 at 1:19 PM surveyor reviewed the concern with the Director of Nursing of multiple documentation of incidents of the resident being aggressive with staff and residents but no indication that MD was notified on day of occurrences. As of time of survey exit on 8/13/25 at 11:30 AM no additional documentation was provided regarding notifications Cross reference to F 600

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, it was determined that the facility failed to protect residents from abuse. This was evident for 2 (#358494 and #358463) out of 16 facility reported incidents reviewed during the recertification survey.The findings include:1.) Resident #91 was admitted to the facility in 2022, was cognitively intact, and their own spokesperson/decision maker. On 6/08/25 Resident #91 and Resident #76 were involved in a verbal and physical altercation. A review of the facility reported incident (FRI #358494) revealed that the facility reported on 6/25/25 that Resident #91 complained that on 6/08/25 Staff #27 threatened to kick him/her out of the facility. The report further stated that the facility investigated the incident and determined that Staff #27 verbally and emotionally abused Resident #91. The report also included statements that due to the confirmation of abuse, the facility terminated Staff #27’s employment and reported Staff #27 to the state board of nursing. On 8/12/25 at 8:21 AM the Nursing Home Administrator was interviewed regarding the incident. She said that Staff #27 was on call on 6/08/25 at the time of the resident-to-resident incident and Staff #27 came in to take care of the allegation. The NHA said that on 6/25/25 Resident #91 came to talk with her and told her that on 6/08/25 Staff #27 had told the resident that he/she would have to leave the building if something were to happen again. The NHA further described that Resident #91 was crying and upset and that the resident’s behavior had changed in the two weeks since the incident on 6/08/25. The resident stayed in their room and did not participate in activities as was usual. The NHA said this was how the facility determined abuse had occurred. The NHA went on to explain that she reassured the resident that when residents were asked to leave the facility, the process involved multiple steps and written notification. The NHA said that she apologized to the resident. On 8/12/25 at 10:44 AM in an interview with the Director of Nursing (DON), he confirmed that the abuse was substantiated by the facility, and he provided copies of the facility’s report to the board of nursing for Staff #27. On 8/13/25 at 8:52 AM an interview was conducted with the DON and the NHA to review the concern that the facility substantiated that Resident #91 was verbally and emotionally abused. 2)Review of Resident #119’s medical record revealed the resident was admitted to the facility in late March 2023 with a diagnosis of dementia. Review of the April Medication Administration Record (MAR) revealed that on 4/1/23 the resident had orders for Ativan (an antianxiety medication) to be given every 8 hours as needed for anxiety/agitation for 14 days. The Ativan was documented as administered on 4/4/23. The resident also had orders for an Buspirone 5 mg (an antianxiety medication) to be administered two times a day, and Seroquel (an antipsychotic medication) to be administered at bedtime. Review of a nursing note, written by Nurse #28 and dated 4/4/23 at 5:59 PM, revealed the resident was showing increased agitation and aggressiveness to other residents. “Tries to grab other residents to ‘come work for [him/her]’ and if they do not go [her/his] way, the resident becomes aggressive and not able to be redirected. After getting prn [as needed] Ativan at 1130, resident settled some and rested in bed.” (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 4/5/23 psychiatric evaluation and consultation note, written by Staff #29, revealed that the resident was seen for initial evaluation and medication management for anxiety and behavioral disturbance. No documentation was found in this note about the Ativan order. Further review of the note revealed that the nursing staff was reporting that the resident tries to control other residents and gets frustrated when they are not doing what [s/he] wants them to do. The recommendations included to increase the resident’s Buspirone to three times a day and continue the resident’s antipsychotic medication in the evening. Review of the April MAR revealed the as needed Ativan was administered on 4/7/23 at 8:43 AM. Review of a nursing note, written by Nurse #28 and dated 4/7/23 at 3:00 PM, revealed the resident became agitated while receiving care, charged at staff and punched the staff in the face. The physician and family were made aware. The Ativan dose was changed to regularly scheduled at 9 am and 9 pm and a prn dose available at 2 pm only. “Will continue to monitor”. A review of the April MAR revealed the previous Ativan prn order was discontinued on 4/7/23. A new order, dated 4/7/23, was found for Ativan to be given every 6 hours as needed for agitation/anxiety for 14 days, Can be given at 3 pm only. This prn medication was administered on 4/7 and again on 4/9. There was also an order on 4/7 for Ativan to be given two times a day for 14 days, this order was discontinued on 4/9. Review of a facility reported incident (358460) revealed that on 4/7/23 Resident #119 was observed in Resident #120’s room. Resident #119 was observed punching Resident #120 on the side of the face, Resident #120 swung back and punched Resident #119 on the shoulder. Resident #119 then ran a wheelchair into Resident #120. Staff de-escalated the situation and separated the residents. Review of the medical records revealed Resident #119 and Resident #120 were not roommates on 4/7/23. Review of a nursing note, written by Nurse #28 and dated 4/7/23 at 6:07 PM, revealed the information found in the facility reported incident. It also included that a second aid went in to help and the resident grabbed the nurse’s arm and swung [his/her] fist into nurse’s hand. Review of a nursing note, written by Nurse #28 and dated 4/8/23 at 6:45 PM, revealed the resident combative with care, can not be redirected, grabs wheelchairs, when staff try to redirect the resident swings at staff. Review of a nursing note, written by Nurse #32 and dated 4/9/23 at 6:56 PM, revealed: “Resident was in the door way of another resident room with a chair in front of [him/her] and GNA tried to redirect [him/her] [s/he] started to swing at her so she tried to hold [his/her] arms back and [s/he] head butted her [GNA] full force. Supervisor on call aware.” Review of the Resident #119’s care plan revealed that on 4/10/23 a care plan addressing the resident’s physically and verbally aggressive behavior. The plan acknowledged that a resident to resident incident had occurred and that these behaviors were related to dementia, Alzheimer’s disease, confusion, agitation and being difficult to redirect at time. All of the interventions were initiated on 4/10/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the April MAR revealed the dosage of the three times a day Buspirone was increased to 10 mg on 4/10/23. Review of a nursing note, written by Nurse #30 and dated 4/11/23 at 11:27 AM, revealed the Ativan order was clarified with the nurse practitioner. Ativan was ordered qid [four times a day] as needed and only at 3 pm. Order was changed to two times a day. Review of the April MAR revealed that on 4/11 a new order was put in place for Ativan every 12 hours as needed for anxiety. Review of a nursing note, written by Nurse #28 and dated 4/12/23 at 6:53 PM, revealed: “Resident continues to try to push other residents in their wheelchairs, and when staff tries to redirect, resident hits at staff.” Review of the psychiatric note, dated 4/13/23, revealed that the resident has continued to exhibit anxiety symptoms. The note addressed the current prn [as needed] Ativan order and that the buspirone dosage was increased by the primary care provider. The recommendations included to start regularly scheduled Ativan two times a day, to continue the buspirone three times a day and the antipsychotic at bedtime. Review of the April MAR revealed the prn Ativan was discontinued on 4/14/23. A new order was put in place on 4/14 for Ativan two times a day. This order remained in place and was documented as administered as ordered until the resident was discharged from the facility. No further prn Ativan orders were found for this resident’s admission. Review of a nursing note, written by Nurse #31 and dated 4/14/23 at 7:56 PM, revealed the resident continued to wander the unit and at times had increased agitation but was able to be redirected. Review of a nursing note, written by Nurse #32 and dated 4/16/23 at 9:08 PM, revealed: “…res at change of shift observed wondering into room at end of hall this writer responded immediately running to see res in room stating ‘get out.’ This writer attempted to redirect with 1:1 res began hitting this writer on side of ribs/back which did not cause harm to writer (res slightly drowsy and weak), this writer able to back res out of room by walking sideways towards res with arm up to prevent being hit inface, other staff responded and able to help redirect res once away from environment.” Review of a nursing note, written by Nurse #28 and dated 4/17/23 at 3:04 PM, revealed: “…Resident has been wandering into others rooms, and when staff tries to redirect [him/her], [s/he] swings at staff. Will continue to monitor.” Review of the 4/20/23 psychiatric note revealed that the nursing staff reported that the resident continues to experience anxiety and irritability, especially during care. During the visit the resident wandered into another resident’s room and sat on the bed, the resident resisted leaving the room and after several attempts the resident finally complied and was rolled out of the room in [his/her] wheelchair. Recommendations included to continue the Ativan two times a day, the Buspirone three times a day and the antipsychotic at bedtime; as well as “supportive care and encourage interaction with peers and participate in activities in the facility as tolerated. Redirect as needed.” (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note, written by Nurse #28 and dated 4/21/23 at 6:49 PM revealed resident was aggressive and hard to redirect. Review of a nursing note, written by Nurse #28 and dated 4/22/23 at 3:04 PM, revealed the Resident continued to get physical with staff when providing daily care or when redirecting. Also that the resident had been “inappropriate with hands as well as kissing on staff and other residents. Will continue to monitor. ” Review of a nursing note, written by Nurse #28 and dated 4/22/23 at 5:10 PM revealed: “Resident became aggressive when tried to redirect away from another resident [who] was trying to eat. This resident would not let [him/her] eat [his/her] dinner. Resident hit staff as well as grabbing them and swinging at other staff. This resident is not able to be redirected. Stormed off down the hall into other residents rooms.” Further review of the medical record revealed the resident was sent to the hospital on 4/22/23 for aggressive behaviors. Review of the hospital emergency department notes revealed documentation that the nurse at the facility reported the “patient was hitting staff and other residents and difficult to control.” Further review of the hospital records revealed the resident was administered the regularly scheduled oral antipsychotic; as well as injections of two different antipsychotic medications: Haldol and Zyprexa. The hospital medically cleared the resident to return to the facility during the early morning hours of 4/23/23. Further review of the medical record failed to reveal documentation to indicate any changes in the residents medications, or orders for increase in supervision upon return from the hospital on 4/23/23. Further review of the care plan addressing the resident’s aggressive behavior failed to reveal it was updated or that new interventions were added after the resident returned from the hospital on 4/23/23. Review of a nursing note, written by Nurse #28 and dated 4/23/23 at 6:36 PM revealed : “This resident was pushing other resident's around in their wheel chair and when tried to redirect resident [s/he] starting to swing and hit staff. Resident then tried to hit other resident. Staff intervened and tried to redirect this resident, when this resident hit this nurse in the jaw and kicked another aide in the knee. Resident was placed into a chair, where [s/he] would not stay seated and continued to try to go after other residents near by.” Further review of the medical record failed to reveal documentation to indicate that these behaviors of hitting staff and attempting to hit other residents was reported to either the primary care or the psychiatric provider on 4/23/23. Review of a nursing note, written by Nurse #33 and dated 4/24/23 at 4:38 AM revealed the resident was up at the beginning of the shift wandering throughout the unit and required some redirection out of other residents’ rooms. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note, written by Nurse #31 and dated 4/24/23 at 2:39 PM revealed the resident was requiring 1:1 to redirect to sit in wheelchair. Further review of the medical record failed to reveal documentation to indicate the physician was made aware that the resident was requiring 1:1 supervision; no order was found for 1:1 supervision, or other documentation to indicate 1:1 supervision was implemented as an ongoing intervention for Resident #119. Review of a nursing note, written by Nurse #31 and dated 4/25/23 at 4:35 PM revealed that in the morning, the nurse heard another resident yell for “help”, nurse observed Resident #119 attempting to talk to the other resident and push into the room, Resident #119 thought the other resident was their spouse and was going to assist the other resident to bed. “1:1 given able to redirect res long enough to remove other res from area… this writer managed to assist res to w/c. res at that time grabbed this writers hand attempting bite. res swinging at staff, res charged this writer nearly falling. res redirected and toileted. res making statements I'm going to kill you. Give me a gun because I am going to shoot you. res appears drowsy, res unable to ambulate in hallway knees buckling, staff assisted res to bed res unable at that time to amb on own. res cont to punch staff in stomach and several attempts to hold hand to bite…. ” The note went on to state that the resident then slept until 3:00 PM, was given medications at that time and was at the time of the note sitting calmly in a wheelchair. No documentation was found to indicate the primary care physician, or the psychiatric provider were made aware on 4/25/23 of the resident’s attempts to bite staff or the threatening statements made by the resident. Further review of the medical record revealed the resident was seen by the psychiatric provider on 4/26/23. Review of the corresponding note revealed that the nursing staff reported that the resident had been experiencing increased agitation and was refusing oral medications. The note revealed nurses reported resident being combative, hit a female staff in the face, had been wandering into other resident’s rooms and resists when redirected. The note addressed the visit to the ER. During the visit the resident was observed pacing the hallway in the wheelchair. The recommendation was to discontinue the evening antipsychotic for ineffectiveness and to start Depakote sprinkles twice a day for agitation. No changes were made to the two regularly scheduled anxiety medications already ordered; or to the behavioral interventions (Supportive care and encourage interaction with peers and participate in activities in the facility as tolerated. Redirect as needed.). No documentation was found to indicate the psychiatric provider was aware of the attempts to bite staff, or the verbal threats. Review of a nursing note, written by Nurse #28 and dated 4/27/23 at 4:14 PM revealed the resident was up wandering into other resident’s room and when staff tried to redirect, resident draws fist back and tries to hit people. Staff are not able to redirect the resident at times and other residents have to be moved away. Review of the facility reported incident 358463 revealed that on 4/29/23 staff heard Resident #95 yelling “get out of my room”. When staff entered Resident #95’s room Resident #119 was observed with [his/her] right arm around resident #95’s neck. With assistance of 3 staff members residents were separated and Resident #119 was escorted from the room. Resident #119 was sent to the hospital via 911. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/23 Resident #95 and Resident #119 were not roommates. Review of Resident #95’s medical record revealed the resident has a diagnosis of dementia and a need for assistance with personal care. On 4/29/23 Resident #95 sustained a small scratch 0.4 cm in diameter on the left side of the neck from Resident #119. On 8/8/25 at 12:15 PM an interview was conducted with the unit nurse manager (Nurse #2) about aggressive residents. When asked if there was an aggressive resident who was sent to the emergency room but then returned with no change in treatment, would they do anything different? Nurse #2 responded that they would look at doing every 15-minute checks or a 1:1. She went on to report a recent incident in which a resident pushed another resident down and they were going to implement a 1:1. On 8/8/25 at 1:19 PM surveyor reviewed the concern with the Director of Nursing (DON) that the resident was having aggressive behaviors and no documentation to indicate an increase in supervision, even after the resident was sent to the hospital for these behaviors. DON indicated he would check if there was documentation to indicate an increase in supervision after the hospitalization. The DON went on to report they have a hard time with the locale hospital just giving Haldol and then sending the residents back rather than admitting to psychiatric unit. He reported a recent incident of this occurring and they had a 1:1 until the resident was transferred out. On 8/13/25 at 8:40 AM the surveyor reviewed the concern regarding the facility's failure to protect resident to resident abuse in regard to the incident involving Resident #119 and #95. As of time of survey exit on 8/13/25 at 11:30 AM no additional documentation was provided to indicate additional supervision of Resident #119 was ordered or provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that the facility failed to report injuries of unknown origin. This was evident for one facility reported incident (#358490) of sixteen facility reported incidents and 1 of 1 grievance binder reviewed during the recertification survey.The findings include:1) A review of the facility’s grievances/concerns binder on 8/6/2025 revealed a resident concern form dated 3/3/25 for Resident #23. The form indicated that on the night of 3/2/25 into 3/3/25, Resident #23’s roommate observed that a GNA (Geriatric nurse aid) had answered Resident #23’s call light. When he entered the room, he said to Resident #23, Now listen, I’m not coming in here on and off all night, is everything out of you? Because I am not coming back.” The GNA proceeded to wipe Resident #23’s peri area with a paper towel and according to the report, Resident #23 began to cry because the staff was “hurting her”. A continued review revealed another grievance dated 3/13/25 reported by Resident #23’s roommate that the same GNA had “used paper towel once again to wipe [Resident #23] and did not change [his/her] soiled brief”. The grievance report indicated that Resident #23 was “crying again”. The report also stated, “I reported this before, but nothing has been done about it”. Further review revealed that both concerns were reported to the Director of Nursing (DON), who also serves as the facility’s Abuse Coordinator. However, the review failed to show that the facility immediately reported the allegation of abuse to the state office. In an interview, Staff #6, the Social Services Director, stated that after receiving the concern dated 3/13/25, she and the Activity Director visited Resident #23’s roommate, who confirmed the concerns. Staff also added that they did notice paper towels and used gloves in Resident #23’s trash can. In an interview on 8/6/2025 at 1:40 PM, the DON indicated that when he received the first concern, he cautioned the staff on how he spoke to residents. The DON also added that the second concern was only a repetition of the first, so there was no new intervention to implement. However, earlier record review noted that it was another occurrence on a different date, and the facility failed to report the allegations of abuse to the state office immediately. 2) A review of the facility’s grievances/concerns binder included a concern for Resident #53 dated 4/24/25. The form indicated that the Resident #53 voiced concern that a GNA “was rough” and “touched [him/her] in a way [s/he] did not like” during care. Further review showed that the DON and the Nursing Home Administrator were notified of Resident #53’s concern. However, the review failed to show that the facility immediately reported the allegation of abuse to the state office. In an interview on 8/7/2025 at 9:44 AM, the social service director indicated that what had initially been told to the DON, then to her regarding Resident #53, seemed like an abuse allegation. That was why both she and the DON went to speak to Resident #53. However, the interview failed to show that the concern was immediately reported to the state office. (continued on next page)

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Frostburg Village Rehab Center	1 Kaylor Circle Frostburg, MD 21532

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/2025 at 10:17 AM, the Nursing Home Administrator stated that she had signed off on the concern form, indicating she was aware of the issue, but did not view it as an abuse allegation before the surveyor’s intervention. 3) A review of the facility reported incident #358490 revealed that on 4/08/25 Resident #87 was observed on the floor next to his/her bed and with a laceration to the head. The report included a statement that indicated that no witnesses were able to verify the alleged incident. The resident was transferred to a local hospital emergency room for sutures. Further review revealed that staff became aware of the resident’s injury on 4/08/25 at 11:30 PM, and that the Director of Nursing (DON) was notified on 4/08/25 at 11:35 PM. Further review of the initial report revealed that the report of the injury of unknown origin was submitted to the Office of Health Care Quality (OHCQ) on 4/10/25 at 11:00 AM. On 8/12/25 at 10:34 AM in an interview with the Director of Nursing (DON), he was asked about the initial report timeframe, which was two days after the incident. He said he was not sure why he did not report it sooner and acknowledged that it was reported later than the regulation required. No further evidence was provided prior to the end of the survey.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that the facility failed to thoroughly investigate allegations of abuse and injuries of unknown origin. This was evident for 2 residents (Resident #23 and Resident #53) reviewed during review of the grievance log and one facility reported incident (#358482) of sixteen facility reported incidents reviewed during the recertification survey.The findings include:1) During a review of the facility’s grievances/concerns binder on 8/6/2025, it was noted that Resident #23’s roommate had filed a grievance regarding Resident #23. The grievance indicated that on the night of 3/2/25 into 3/3/25, a GNA (geriatric nurse aid) had answered Resident #23’s call light and said to him/her, “Now listen, I’m not coming in here on and off all night, is everything out of you? Because I am not coming back.” Then staff proceeded to give Resident #23 incontinence care by wiping him/her with a “paper towel”. According to the report, Resident #23 began to cry because the staff was “hurting her”. A continued review noted an additional complaint dated 3/13/25 from Resident #23’s roommate regarding the same staff member, stating that he used a paper towel again to wipe Resident #23, and the soiled brief was not changed. The report indicated Resident #23 was crying again. The roommate also reported that previous concerns had been raised without resolution. Both concerns were reported to the Director of Nursing (DON), who also serves as the facility’s Abuse Coordinator. However, the review failed to show that the facility completed a thorough investigation of both allegations including a head to toe assessment of Resident #23, statements from the staff involved, interview and/or assessment of other residents who had been in the care of the staff involved to ensure no one else had similar complaints and interview of other staff who may have known about the incident. In an interview on 8/6/2025 at 1:40 PM, the DON indicated that when he received the first concern, he cautioned the staff involved on how he spoke to residents. The DON also noted that the second concern was merely a repetition of the first, so no new intervention was required. However, it was another occurrence on a different date, and there was no evidence of a thorough investigation of the complaint. 2) A review of the facility’s grievances/concerns binder included a concern for Resident #53 dated 4/24/25 that stated that a GNA “was rough” and “touched [Resident #53] in a way [s/he] did not like” during care. The DON and Nursing Home Administrator (NHA) were notified of Resident #53’s concern. However, the review did not show that the facility thoroughly investigated the allegation. There was no evidence of a head-to-toe assessment of Resident #53, no interviews with other residents cared for by the same staff, and no statements from staff, including the one involved in the incident. During an interview on 8/7/2025 at 10:17 AM, the Nursing Home Administrator verbalized understanding of not thoroughly investigating allegations of abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3), A review of the facility reported incident (FRI) #358482 revealed that Resident #107 was found on the floor in the hallway on 1/25/25 and was injured. The resident was sent to the emergency room where it was determined that he/she had a fractured tibia. The report further stated that there were no witnesses, no perpetrator was identified, that both the resident and the resident’s roommate were deemed incapable, and that staff who were on duty the day the injury was identified were interviewed and none had knowledge of the injury. A review of the facility’s investigation file revealed a witness statement written 1/25/25 at 2:00 pm by Staff #38 which indicated that she was the nurse who cared for the resident that day and that the resident refused to get out of bed, was assessed in the morning with no abnormal findings, but around noon/lunch time the resident complained of pain, the doctor was notified, an x-ray was ordered, and pain medication was administered. Further review of the facility’s investigation file failed to reveal any other staff witness statements from that day. The file lacked evidence that other residents were interviewed or assessed. There were no staff assignment sheets or resident census documents to identify staff and residents who were present on that day. There was no documentation of Resident #107’s physical assessment other than the staff witness statement. On 8/11/25 at 3:45 PM in an interview with the Director of Nursing (DON), he provided an explanation for how the resident’s injury occurred but acknowledged that this information was not included in the investigation file nor in the resident’s medical records. He confirmed the deficiency that the facility’s investigation was incomplete.

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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 reviews and interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #25) of 1 resident reviewed for hospice care and 1 (Resident #5) of 12 residents reviewed for accidents.The findings include: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. MDS assessments need to be accurate to ensure each resident receives the care they need. 1) Resident #25 had been a resident of the facility since 2018. A review of the facility matrix indicated that the resident was under hospice care. On 8/1/25 at 12:05 PM, a subsequent review of Resident #25’s medical record revealed an MDS assessment for a significant change with an assessment reference date (ARD) of 3/17/25 coded the resident as receiving hospice care. The next MDS assessment was a quarterly assessment with an ARD of 6/17/25 that coded the resident as not receiving hospice care. A review of Resident #25’s medical orders was conducted on 8/6/25 at 9:29 AM. The review revealed the following orders pertaining to hospice care:a) Refer to UPMC WM Hospice-End of Life Care -dated 3/4/25b) UPMC Hospice admitted -dated 3/7/25 The MDS nurse coordinator (Staff #14) was interviewed on 8/6/25 at 9:50 AM. During the interview, Staff #14 reported that Resident #25 was currently receiving hospice care. She also reported that the significant change assessment done on 3/17/25 was due to the resident going under hospice care. A review of the quarterly assessment with an ARD of 6/17/25 was conducted with Staff #14, particularly section O where Resident #25 was assessed if s/he was receiving hospice care. Staff #14 confirmed that the resident was coded wrong and stated, “That should have been a yes” and indicated that she would fix it. The Nursing Home Administrator and Director of Nursing was interviewed on 8/13/25 at 8:43 AM. During the interview the concern was discussed that Resident #25 was inaccurately coded for hospice care on the 6/17/25 quarterly assessment. Both staff also confirmed that Resident #25 was currently receiving hospice care and acknowledged the concern. 2) A care plan addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Bi-level positive airway pressure (BiPAP) is a non-invasive ventilation machine used to assist in the work of breathing- both inspiration and exhalation. On 8/6/25 a record review revealed Resident #5 had a diagnosis of Chronic Respiratory Failure with hypoxia, Congestive Heart Failure (CHF), and Chronic Pulmonary Obstructive Disease (COPD). On 8/7/25 at 5:53 AM, a record review of the Care Plan identified BiPAP therapy and a record review of physician orders revealed BiPAP settings 15/5 with 5L oxygen continuous at 5L NC every shift for Respiratory Failure. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/25 at 6:52 AM, a record review of the MDS Annual assessment dated 4/2025, Section O reflected that Resident #5 did not use BiPAP therapy. In an interview on 8/7/2025 at 8:33 AM, the MDS nurse Coordinator (Staff #14) confirmed that she is responsible for completing section O on the MDS. Staff #14 verified that BiPAP therapy was not reflected on the MDS and confirmed that there was an order for BiPAP as of 3/31/25. She acknowledged the MDS was coded inaccurately.

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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 medical record review, interview and observations it was determined that the facility failed to ensure care was provided in accordance with professional standards of practice. This was evident for 3 (Resident # 114, #4, and #5) out of the 78 residents included in the sample. The findings include: 1) Review of Resident #114's medical record revealed the resident was admitted to the facility in 2023 with diagnosis that included, but not limited to, dementia and high blood pressure. Further review of the medical record revealed a Change in Condition note, with an effective date of 3/22/25 at 7:36 AM that was complete by a Licensed Practical Nurse (Nurse #39). This note revealed that the resident sustained a fall on 3/22/25 at 12:25 AM. The nurse documented that the resident was observed on the floor next to the bed sitting on his/her bottom and the resident had no explanation; the physician was notified at 3:00 AM. No documentation was found to indicate the nurse had completed a set of vital signs (heart rate, pulse, respirations, temperature) at the time of the initial assessment after the resident was found on the floor or prior to the notification of the physician at 3:00 AM. On 8/8/25 at 12:00 noon Licensed Practical Nurse (Nurse #41) reported that if a resident falls she completes an assessment which would include neuro checks and vital signs. Further review of the 3/22/25 Change in Condition note revealed in Section C Background (Evaluation) the nurse documented yes to the question: Are these the most recent vital signs taken after the change in condition occurred. The documentation indicated the blood pressure and heart rate measurements were from 3/21/25 at 9:08 AM, the respiration rate, temperature and oxygen saturation rate were from 3/16/25, and the blood glucose reading was from 2024. Further review of the medical record revealed an additional nursing note, written by Nurse #39 with an effective date of 3/22/25 at 8:00 AM that includes a statement that “full assessment completed upon observation of resident on the floor” but failed to mention that vital signs were obtained as part of that assessment. This note was entered as a Late entry and was created on 4/5/25. On 8/8/25 at 2:16 PM the Director of Nursing (DON) reported his expectation after a fall was that staff complete a full assessment before the resident was moved and confirmed this assessment would include vital signs. The Surveyor then reviewed the concern that the medical record failed to reveal documentation that a set of vital signs was completed at the time of the fall and that the Change in Condition form referenced vital signs from before the fall occurred. The Surveyor then reviewed the electronic health record with the DON; the first documentation of blood pressure and heart rate post fall was found for 3/22/25 at 10:53 AM. The 3/22/25 at 10:53 AM blood pressure was recorded by Nurse #42 and was included in the documentation for the administration of a medication to be given for high blood pressure that was scheduled to be given at 9:00 AM. On 8/13/25 at 8:40 AM the surveyor reviewed the concern with the Nursing Home Administrator regarding the failure to ensure a thorough assessment after a fall. As of time of survey exit, on 8/13/25 at 12 noon, no additional documentation was provided to indicate a set of vital signs was completed at the time of the initial assessment after the fall. 2) On 7/31/25 Registered Nurse (RN #15) was observed entering Resident #4’s room. From the hall, the surveyor heard RN #15 ask the resident, “where do you want your insulin?” The reply, “in my arm.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at approximately 9:30 AM, the Surveyor and RN #15 entered Resident #102’s room. RN #15 administered insulin into the resident’s right upper arm after the resident stated that s/he preferred to have the insulin injected into his/her belly. On 8/4/25 at 3:59 PM in an interview, the Licensed Practical Nurse (LPN #12) indicated the insulin administration sites were “usually” rotated and documented in the Medication Administration Record (MAR) of the electronic health record. A record review of Resident #4’s MAR revealed that insulin was administered in the same location without rotating sites on 7/30/25, 7/28/25, 7/27/25, and 7/25/25. And Resident #102’s MAR revealed insulin was administered in the same location on 7/31/25, 7/27/25, 7/26/25, 7/24/25 and 7/23/25. On 8/5/25 at 3:14 PM in an interview with Unit Managers (UM) LPN #1 and LPN #2, they acknowledged that the facility does not adhere to any standard of care or practice for administering insulin and rotating sites. A review of DIABETES CARE, VOLUME 27, SUPPLEMENT 1, JANUARY 2004, pg. S109 revealed the standard of care for rotating sites: Rotation of the injection site is important to prevent lipohypertrophy or lipoatrophy. Rotating within one area is recommended (e.g., rotating injections systematically within the abdomen) rather than rotating to a different area with each injection. In a follow-up interview at 3:30 PM the Nursing Home Administrator confirmed that the facility does not adhere to a standard of care when administering insulin and in particular rotating sites. “It would make sense for us to do it here.” 3) On 8/6/25 at 11:00 AM this surveyor observed Resident #5 lying in bed with an alternating low air mattress set at 290 pounds per square inch (psi) and alternating every 20 minutes. Resident #5 stated, “I used to weigh over 300 pounds about a year ago.” On 8/7/25 at 5:53 AM a record review of the Care Plan revealed use of a pressure reducing mattress. Alternating pressure mattress. Nurse to check functioning and settings. On 8/7/25 at 7:11 AM this surveyor observed Resident #5 asleep on alternating low air mattress with settings at 290 psi and alternating flow every 20 minutes. On 8/7/25 at 7:45 AM in an interview, LPN #12 confirmed Resident #5’s low air mattress was set at 290 psi and alternating every 20 minutes. On 8/7/25 a record review of Resident #5’s monthly weights from January to August revealed 195.4, 198.8, 191.1, 191.8, 189.0, 187.0, 189, 186.6, respectively. On 8/7/25 at 8:00 AM the Maintenance Director, Staff #13 provided the Operation Manual for the Protekt Aire 8000 model. On 8/7/25 at 9:54 AM in an interview, LPN #12 indicated that the mattress settings are determined by the resident's weight. It was confirmed in the electronic medical record that Resident #5 currently weighed 186.6. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/25 at 10:09 AM, LPN #12 acknowledged that the mattress was set for a weight interval of 220-290 and that she had adjusted the weight interval to 150-220 after surveyor intervention.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record reviews, interviews, and review of facility investigation documents, it was determined that the facility failed to ensure residents were free from accidents as evidenced by the resident sustaining an injury while being assisted by staff in transferring. This was evident for 1 (Resident #104) of 12 residents reviewed for accidents. The deficient practice resulted in actual harm to resident # 104.The findings include:A review of Resident #104’s medical records on 8/7/25 at 11:40 AM, revealed a comprehensive assessment with a reference date of 1/7/25 that indicated the resident had severely impaired cognition and was dependent on staff for transfers and mobility. The review also revealed the resident’s care plan with interventions that include a) dependent bed mobility, b) Full lift for all transfers. A review of the intake information on 7/31/25 at 12:10 PM, related to incident 358487 and complaint 358486 indicated that Resident #104 sustained a fracture of the left leg on 2/20/25. The investigation packet related to incident 358487 was reviewed on 8/6/25 at 2:27 PM. The investigation indicated that Resident #104 was being treated for passive range of motion on 2/20/25 at 10:15 AM by Physical Therapy Assistant (Staff #34), when she noticed a change in the appearance of the resident’s left leg. This was reported to the Licensed Practical Nurse (LPN #35) assigned to the resident at that time. LPN #35 assessed the resident and noted swelling and bruising on the resident’s left lower leg and reported it to the attending physician, who ordered imaging to be taken. The attending physician then ordered for the resident to be sent to the emergency department (ED) for further evaluation and treatment for possible fracture. The ED then confirmed the resident had a broken left lower leg. Simultaneously in the facility, the incident was reported to the Director of Nursing (DON) who initiated an investigation. The DON took statements from all the staff assigned to Resident #104 at that time. The Geriatric Nursing Assistant (GNA #36) wrote on her statement that on 2/20/25 at 7:10 AM, she was transferring the resident to the wheelchair and the resident’s leg got twisted as she was sitting the resident down. An interview was documented by the DON with GNA #36 dated the same day at 4 PM. During the interview, GNA #36 confirmed that the resident’s transfer status was a 2 person assist but failed to seek another staff to help in transferring the resident. Further review of the investigation documents revealed that GNA #36 was suspended while the investigation took place. When the facility concluded that Resident #104’s fracture was the result of improper transfer, the facility’s corrective action was to educate the GNA on transfer status with return demonstration. However, documentation in the investigation packet revealed that GNA #36 was terminated on 2/27/25 and reported to the Board of Nursing on 3/3/25. No other corrective action was documented in the investigation packet. On 8/7/25 at 1:04 AM, GNA #18 was interviewed about her process when a resident needs assistance with transfers. She reported that resident information regarding required assistance for transfers are found in the Kardex (Kardex is the computer system that GNA’s use to document the tasks/care they had provided to the residents) or assignment sheet (assignment sheet is the paper document that GNA’s typically write on when they are getting reports during change of shift). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	GNA #18 showed the surveyor her assignment sheet which had a column titled “Transfers”. This column indicated the assistance required for residents to safely complete a transfer. She also showed the surveyor the Kardex which also indicated the required assistance for transfers, noting that she checks to verify that the information from the two matched. Resident #104’s information was reviewed with GNA #18. She reported that the resident was a full lift for all transfers and indicated that it meant she would need to use a mechanical lift to perform the transfer and required two staff members to complete the task. On 8/7/25 at 3:53 PM, the DON was interviewed about the incident. He confirmed that per his investigation, GNA #36 failed to secure assistance from another staff to safely transfer a dependent resident. He reported that the facility’s initial plan was to bring GNA #36 back for education about transfers but when the incident was forwarded and reviewed by corporate staff, they instructed the facility to terminate GNA #36. He also reported that the facility did a whole house education but did not include it in the investigation documents. He stated, “I keep a soft file in my office” and indicated that he would provide the surveyor with evidence that all clinical staff were educated on transfers. On 8/7/25 at 4:34 PM, the DON provided the surveyor with the attendance sheets for the employee education that included transfers as one of the topics, dated 2/25/25. A review of the attendance sheets was conducted on 8/8/25 at 12:15 PM. The review revealed that not all clinical staff attended the education. A subsequent interview with the DON was conducted on 8/8/25 at 12:53 PM. During the interview, the DON reported again that all clinical staff attended the education. He added, “if they failed to attend, they would have been written up.” The finding that not all clinical staff attended the education was discussed and the DON was asked if he had a list of staff who failed to attend. He indicated Human Resource (Staff #9) can give him that information. On 8/11/25 at 9:23 AM, Staff #9 printed a list of staff who failed to attend the education regarding transfers. The list consisted of 7 nurses and 4 GNA’s. Staff #9 was asked if staff on the list were written up for not attending and she answered, “No.” A review of GNA #36’s employee record was conducted on 8/11/25 at 12:13 PM. The review revealed the last education regarding transfer was done on 1/13/21 and last performance evaluation was dated 9/5/22. There was no other documentation found to indicate a performance evaluation was conducted in the last 2 years. On 8/13/25 at 8:43 AM, the findings were reviewed with the Nursing Home Administrator (NHA) and the DON, and the concern was discussed that GNA #36 had failed to follow the appropriate transfer status of a resident resulting in harm as evidenced by Resident #104’s lower leg fracture. Also, there was no evidence to indicate that all clinical staff were educated on transfers after the 2/20/25 incident with Resident #104. Both staff acknowledged the concern.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review and staff interviews, it was determined that the facility failed to administer oxygen as ordered by the physician. This was evident for 1 resident (Resident #5) reviewed as a complaint, #358479, during this survey.The findings include: Oxygen therapy is the administration of oxygen at concentrations greater than that in room air with the intent of treating or preventing hypoxia- low oxygen level in the blood.On 8/6/25 at 11:00 AM this surveyor observed Resident #5 lying in bed with oxygen (O2) via nasal canula (NC) at 4 liters (L). In an interview, Licensed Practical Nurse (LPN #10) confirmed O2 NC at 4L. On 8/7/25 5:49 AM a record review of Resident #5's Treatment Administration Record (TAR) revealed: Respiratory: Oxygen - Continuous at 5L NC every shift for Respiratory Failure. On 8/7/25 at 5:53 AM A record review of physician orders revealed 5Liters (L) oxygen (O2) continuous via nasal cannula (NC) every shift for Respiratory Failure.On 8/7/25 at 7:11 AM this surveyor observed Resident #5 asleep with 4L O2 NC. On 8/7/25 at 7:45 AM in an interview, LPN #12 confirmed Resident #5's oxygen was O2 NC at 4L. LPN #12 acknowledged the oxygen order was 5L NC.On 8/7/25 at 8:07 AM a second surveyor confirmed O2 at 4L NC.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of medical records and other pertinent documentation, and interviews it was determined that the facility failed to ensure staff had adequate training. This was evident for one geriatric nursing assistant (GNA #25) out of two GNAs reviewed for mechanical lift training.The findings include: A review of Resident #45's clinical record revealed that they were admitted to the facility in 2022 and they required assistance to transfer from bed to wheelchair.A review of the facility's mechanical lift policy titled Lifting Machine, Using a Mechanical, revealed the statement that read, in part, that when lowering the resident, care should be taken ensure the sling bar did not hit the resident. On 8/06/2025 at 3:28 PM a record review of Resident #45's medical record revealed a progress note written on 7/10/25 by Licensed Practical Nurse (Staff #23) which described an incident when the resident developed a forehead hematoma (bruise) when they were hit on the forehead by the mechanical lift while being transferred into the wheelchair. The note explained that 2 Geriatric Nursing Assistants (GNA) assisted the resident with the transfer.On 8/07/2025 at 11:10 AM an interview was conducted with the unit manager Staff #2 to review the incident. When asked about the incident she said that GNAs were trained to use the mechanical lift but that she herself did not provide the training. She was asked to provide evidence of training for the two GNAs (Staff #24, Staff #25) who assisted the resident during the incident,.On 8/07/2025 at 11:57 AM Staff #2 brought training documents for Staff #24 and Staff #25. A review of Staff #25's training competency checklist revealed that it was a self-evaluation. There was no evidence that Staff #25 had received training in the use of a mechanical lift or that she had been deemed competent to perform a transfer with a mechanical lift.On 8/07/2025 at 12:03 PM an interview with Human Resources Director, Staff #9 was conducted to review the GNA training records for Staff #25. Staff #9 reviewed the document and concurred that the documents did not show evidence of training or competency. When asked for further evidence, Staff #9 replied that Staff #25 was an agency GNA and that there were no other training documents available.On 8/07/2025 at 12:43 PM the Director of Nursing confirmed that documentation in the resident's medical record confirmed that the mechanical lift bar hit the resident in the head and resulted in a bruise, and he also confirmed that there was no evidence that Staff #25 was competent to use the mechanical lift.

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	215115	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frostburg Village Rehab Center	1 Kaylor Circle Frostburg, MD 21532

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of pertinent documentation and interviews it was determined that the facility failed to ensure a registered nurse was working for at least 8 consecutive hours every day. This was found to be evident for 3 out of 16 weekends of staffing reviewed during the survey but has the potential to affect all residents.The findings include: On 8/11/25 surveyor reviewed the staffing sheets for the weekends during January, February and March of 2025, as well as the staffing sheets for 7/15 -7/30/25 for the presence of a registered nurse (RN). These schedules reflected 24 hour periods that started and ended at 7:00 AM. The nurses usually worked 12 hour shifts, either day shift 7:00 AM to 7:00 PM or night 7:00 PM to 7:00 AM.Review of the Friday 1/10/25 staffing sheet failed to reveal an RN on duty for the night shift.Review of the Saturday 1/11/25 staffing sheet failed to reveal an RN on duty for the day or night shift.Review of the Sunday 1/12/25 staffing sheet failed to reveal an RN on duty for the day or night shift.This represents a continuous 60 hours without an RN working in the building.Review of the 7/25/25 staffing sheet failed to reveal an RN on duty for the day or night shift.Review of the 7/26/25 staffing sheet failed to reveal an RN on duty for the day or the night shift. A separate report provided by the facility for hours worked per patient day (PPD) included documentation to indicate the Director of Nursing (DON) had worked for 4 hours on 7/26/25. An interview with the DON on 8/11/25 at 3:01 PM revealed that he has worked on the floor a couple of times and indicated that he recently had worked from 11:00 AM to 3:00 PM to cover the medication cart. When DON was told this was in regard to Saturday 7/26, the DON responded that he probably came in to help out on the weekend. On 8/11/25 at 3:32 PM surveyor reviewed with the Nursing Home Administrator the above findings for July 25 and 26, and January 11 and 12. On 8/12/25 surveyor requested the staffing sheets for 8/9 and 8/10/25.Review of the Saturday 8/9/25 staffing sheet failed to reveal an RN on duty for the day or night shift.Review of the Saturday 8/10/25 staffing sheet failed to reveal an RN on duty for the day shift.On 8/12/25 at 11:28 AM the Human Resources Director confirmed that this past weekend there was no RN coverage from Saturday 8/9 at 7 AM until Sunday 8/10 at 7:00 PM.This represents a 36 hour period with no RN in the facility.On 8/13/25 at 8:40 AM surveyor informed the NHA of the concern regarding multiple days when the facility failed to ensure an RN was working for 8 consecutive hours, including this past weekend.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of pertinent documentation and interviews it was determinted that the facility failed to ensure annual evaluations were being completed for geriatric nursing assistants (GNA). This was found to be evident for three (GNA #48, #18 and #49) out of three GNAs who were selected for review of annual training. The findings include: Review of a list of employees with their hire dates revealed GNA #48 was hired in March of 2023; GNA #18 was hired in June of 2004; and GNA #49 was hired in March of 2021. On 8/7/25 surveyor requested from the Human Resource Director documentation of the the annual evaluations for these three GNAs.On 8/11/25 review of the documentation provided failed to reveal documentation to indicate an annual review had been completed for GNA #48. The most recent Annual Performance Appraisal for GNA #18 was dated 8/13/22. The most recent Annual Performance Appraisal for GNA #49 was dated May 2023.On 8/11/25 at 11:55 AM the Human Resource Director reported she generates a list of who suppose to get an evaluation and sends it to nursing and then it is nursing's responsibility to complete them. She confirmed that GNA #48 has not had an evaluation; and that the most recent evaluations for GNA #18 and #49 were completed prior to 2024.On 8/13/25 at approximately 8:45 AM surveyor review the concern with the Nursing Home Administrator and the Director of Nursing regarding the failure to ensure evaluations are being completed annually for GNAs.Cross reference to F 689

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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 medical record review and interview it was determined that the facility failed to ensure residents were free from significant medication errors. This was found to be evident for one (Resident #114) of 15 residents reviewed for potential abuse.The findings include: Review of Resident #114's medical record revealed the resident was admitted to the facility in 2023 with diagnosis that included, but not limited to, dementia and high blood pressure. The resident had an order for Metoprolol extended release 25 mg give one tablet one time a day related to hypertension (high blood pressure) and to Hold if the pulse (heart rate) was less than 60 or if the SBP(systolic blood pressure - the top number of a blood pressure reading) was less than 130. This order was in effect from 9/26/24 until it was discontinued on 3/28/25.Review of the March 2025 Medication Administration Record (MAR) revealed the metoprolol was administered on the following dates when the blood pressure and or heart rate were within the parameters to hold the medication:3/1 SBP was 1263/6 SBP was 121; HR: 553/10 SBP was1263/15 SBP was 1263/16: SBP 1263/22: SBP was 124 On 8/8/25 at 2:16 PM the Director of Nursing reported that he expects staff to follow the parameters that are included in orders for a medication. Surveyor reviewed the concern the metoprolol was administered on 6 occasions in March when, based on the ordered parameters, the medication should of been held. On 8/13/25 at 8:40 AM surveyor reviewed the concern regarding the failure to keep the resident free from a significant medication error with the Nursing Home Administrator.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on a review of pertinent documents, observations and interviews, the facility failed to have a place to ensure residents were provided with water and other fluids to support their hydration and preferences. This was evident in two out of three units reviewed for dining during the survey.The Findings include:On 8/06/25 at 2:30 PM, a review of resident council minutes revealed that residents reported they were not receiving ice or water between the hours of 11:00 PM and 7:00 AM In addition review of complaint #358470 8/11/25 revealed a concern that the residents were not provided water. On 8/07/25 at 5:32 AM, a nighttime observation was conducted from 4:00 AM to 5:15 AM. The observation revealed that GNA Staff #19 and Hospitality Aide (Staff #21) were in the process of delivering water to residents. Staff #19 reported typically beginning water delivery around 5:00 AM.On 8/07/25 at 4:28 AM, an observation in Resident #92's room revealed an empty cup of water with the date 8/6 written on the top rim.On 8/07/25 at 4:29 AM, an observation in Resident #73's room revealed a cup with a small amount of water remaining and no date written on the top.On 8/07/25 at 4:38 AM, the above observations were confirmed by GNA Staff #4.On 8/07/25 at 4:49 AM, an observation in Resident #129's room revealed an empty cup on the bedside table. Continued observation failed to reveal any additional water containers in the room.On 8/07/25 at 4:52 AM, an observation in Resident #49's room revealed a cup on the bedside table containing a small amount of brown liquid.At 4:52 AM, a brief interview was conducted with Resident #49, who was noted to have no documented cognitive decline. The resident reported that the cup had contained Pepsi from the previous day and that no water had been provided on 8/06/25.On 8/07/25 at 4:54 AM, an observation in Resident #83's room revealed a single cup with a very small amount of water and the date 8/5 written on the top.On 8/07/25 at 4:56 AM, the observations for Residents #49 and #83 were confirmed by GNA Staff #3.On 8/07/25 at 7:44 AM, an interview was conducted with the Administrator and the Director of Nursing (DON). Both reported recent experience working the night shift and familiarity with the 11:00 PM - 7:00 AM water distribution process. The DON stated an understanding that new water cups were dated and distributed around 5:00 AM to ensure residents had water for the morning pass. The Administrator stated an understanding that new cups were distributed at the beginning of the night shift to ensure residents had access to water throughout the night. Both confirmed there was no consistent procedure in place to ensure residents received water to support hydration.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on pertinent document review, observation and interview, it was determined that the facility failed to provide a nutritional snack to Residents when meals were scheduled more than 14 hours apart. This was evident in one unit out of four unit reviewed for Dining during a survey.The findings include:7/31/25 at 11:13 AM during an interview, Resident #3, a long-term resident of the facility, reported that s/he had not received snacks at night. 7/31/25 review of the facility meal schedule revealed that the New Horizons Unit Hall (400 hall) had dinner scheduled at 5:00 PM, that breakfast was served at 7:35 AM, which is more than 14 hours apart. On 8/04/25 at 11:55 AM, the kitchen manager provided the food committee meeting minutes for the following months: July, April, and May of 2025. A review of food council revealed that residents reported not receiving evening snacks. In addition, review on 8/11/24 of the most recent Resident Council minutes, held on 8/6/25, revealed that residents reported they were not being offered evening snacks. On 8/04/2025, the surveyor observed evening snacks being delivered along with the dinner trays to the New Horizons Unit (400 Hall) at 5:22 PM. Upon closer observation, there were eight individual snacks, each labeled with a resident's name.On 8/4/25 at 6:27 PM an observation was made of the refrigerator and freezer on the New Horizon Unit. The observation failed to reveal any additional snacks other than the eight individual snacks, each labeled with a resident's name.On 8/4/25 at 6:28 PM Geriatric Nursing Assistant (GNA) (Staff #16) reported to the surveyor that the only snacks available to residents on the New Horizons Unit were individual snacks, each labeled with a resident's name. The GNA and the surveyor conducted an observation of the room that the GNA identified as the location where snacks were kept. The observation revealed a few saltine crackers; There were not enough snacks available for all the residents on the unit to receive a evening time snack.On 8/4/25 at 7:00 PM during a brief interview with the nighttime cook (Staff #17), she reported that all the snacks were delivered to the New Horizons Unit with the evening meal cart. She confirmed that all the snacks that had been delivered to the New Horizons Unit were individually labeled with residents' name, and no other snacks are to be delivered tonight. On 8/5/25 observation of the breakfast in New Horizon Unit revealed that the breakfast trays were still being distributed at 8:15 AM. On 8/6/25 The GNA documentation (TASKS) under HS snack was reviewed. The review revealed that 16 residents received snacks in the evening of 8/4/25. However, only 8 snacks were brought up by the kitchen and no other generic snacks were available on the unit.HS snack is a snack specifically to be given at bedtime or before going to sleep.On 8/6/2025 3:14 PM a phone interview with conducted with GNA Staff #18. She reported that she did provide snacks to the residents on the Horizons Unit the evening of 8/4/25. She reported that she provided snacks to the residents that did not receive the induvial snacks from the kitchen with their names on them. GNA #Staff 18 stated that sometimes the facility does not have snacks available for residents that are not ordered individual snacks, so she brings in her own snacks for the residents. She reported that she did provide some of her own snacks to the resident on the evening of 8/4/25. On 8/6/25 during an interview the administrator reported the staff have been educated not to provide snacks brought from home to the residents but use the snack provided by the facility. She reported that her expectation is that the residents HS snacks be provided by the facility. On 8/11/2025 at 12:55 PM Speech Therapist (Staff #37) was interviewed. During the interview, she reported that residents' diets are designed for the specific nutritional and safety needs, (resident ability to swallow) of the resident. She reported she had not approved of any snacks being brought in from outside to be served to the residents. Her expectation was that all snacks being served to the residents by the facility be approved by the kitchen, physician or speech therapy. The exception was food broughy in by the residents or family.