STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215121	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snow Hill Rehabilitation & Healthcare Center	430 West Market Street Snow Hill, MD 21863

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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 and facility staff interview, it was determined that the facility failed to safely store food items and maintain food service equipment in a manner that ensures sanitary food service operations. This was identified during multiple observations of kitchen food service operations. The findings include:On 05/04/2026 at 7:40 AM an initial tour was conducted of the facility's kitchen. During the tour, the surveyor inspected a vertical reach in cooler which revealed: two opened packs of uncooked hotdogs- no date opened label, one 48 ounce opened bottle of grape jelly- no date opened label, one two-pound opened bag of Genoa Salami- no date opened label. The Food Service Director (FSD) #4 removed the items and discarded them in the trash. On 05/04/2026 at 7:49 AM the surveyor and FSD #4 toured the walk-in freezer. The tour revealed the walk in freezer contained several brown boxes, with ice on the outside surface of the two stacked boxes directly under the internal fan and a substantial amount of ice also on the floor of the walk-in freezer- directly below the boxes and surrounding floor space. At the exit of observations of the walk-in freezer, FSD #4 stated that the boxes will be discarded, the ice removed from the floor, FSD #4 also confirmed that a refrigeration vendor was contacted less than a week ago, about the same icing situation and will be contacted again to fix the issue as soon as possible. On 05/07/2026 at 7:00 AM a follow up tour of the kitchen was conducted. The tour revealed observations of:1. Approximately 80 dark red soup bowls and ~60 black dessert bowls improperly stored, uncovered on bottom rack of storage rack- not protected from dirt/dust/splash; 2. A see through large rectangular container on an open storage rack with about 30 different cooking/serving utensils stored uncovered and not protected from dirt/dust/splash; 3. One 'Robot Coupe food processor with dried food remains seen on the interior of the work bowl. FSD #4 confirmed with the cook that the food processor had not been in use yet for the day; 4. A plastic measuring cup, sitting on a food prep station with yellow residue of dried food on inner surface; 5. No label with open date for the following items that were observed open:one 8-ounce fennel seed, one 4ounce Poultry seasoning, one 4 ounce pickle spice seasoningFSD #4 was present throughout the follow up tour of the kitchen and addressed each item as discovered.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and facility staff interviews, it was determined that the facility failed to ensure that the environment of resident care was kept clean, comfortable, safe, and sanitary for resident use. This was evident for all environmental tours conducted on the recertification survey.The findings include: During an interview with Resident #4 on 05/04/2026 at 9:20 AM, the surveyor observed the resident's split top overbed table with l food or drink residue on the top surface and within the sliding tracks. On 05/04/2026 at 10:56 AM during an observation with the Maintenance Director (MD) in Resident #4's room, the surveyor pointed out the dirt and debris on Resident #4's overbed table. Before the survey and the MD left the resident's room, the MD confirmed that the table will be replaced immediately. On 5/04/2026 at 11:10 AM the surveyor and the Maintenance Director (MD) toured the Cypress Unit and the Cypress extended Unit. The surveyor also observed extremely rusted towel racks in several resident bathrooms on the Cypress Unit. The MD confirmed that the facility will audit all resident bathrooms and replace the towel racks with new ones. Further along tour of the Cypress Unit, the surveyor and the MD observed there was a room that housed resident equipment: a large shower bed, two IV poles, one red crash cart, 28 cylindrical oxygen tanks, and 4 stacked bedside commodes. The room did not have a label on it's door, however, the surveyor observed on shower curtain hung , but tied in a knot, a shower head and hose, a toilet, a sink with faucet, a hand soap dispenser, paper towels, and two call bell devices on the wall. The MD confirmed this was a shower room but not used as a shower room - it was used as a storge room. On the Cypress Extended Unit, the surveyor observed a room labeled shower room and within it were two shower areas. One shower area was missing a privacy curtain, shower head, and half the tiles starting from under the shower body to the bottom of that wall. The MD confirmed that it was under repair which left the other shower area ready and available for resident use. The partition wall between the two shower areas was damaged- from the floor end of the wall mid-way up towards the ceiling, with internal dry wall and exposed internal structures visible; also observed on the wall adjacent to the shower area under repair, was a 12 inch by 18 inch area of damaged dry wall with an insulation type material exposed on the lower end of the wall. On 05/04/2026 at 11:23 AM, the surveyor and MD observed the shower room on the Federal Unit. The surveyor observed cracked tiles with poorly sealed areas- missing grout all over the floor of the shower room, a soiled gray plastic basin on the floor of one of the two shower areas; brown stains on one of the shower curtains and dark gray stains on the other shower curtain, the second of the two shower areas had a gray mop bucket with yellowish white stains on its outer surface, and a large clear plastic bag with trash on top of the waste receptacle at the left wall upon entrance to the shower room. The surveyor requested that the MD turn on the mechanical vent for the shower room- the MD confirmed that it was not working and it would be added to the list of work orders for that day. On 05/07/2026 at 12:00 PM the surveyor conducted an environmental tour with the Director of Nursing (DON) and the Senior Director of Life Safety (SDLS). The tour revealed that there were 42 total beds on the cypress and cypress extended unit, however, each of those two beds were in single rooms with their own showers. They both confirmed there was only one available shower for 40 beds. The SDLS said that they will have the shower area on the Cypress Unit cleared out immediately for resident use. On 05/07/2026 12:03 PM the surveyor observed an ice cooler on the Cypress Unit with an ice scooper housed within a solid white hard case. In the case was cloudy liquid with a black/gray substance on inner surface of the case- no drain holes observed, Inspection of the nourishment room on the Cypress Unit's nourishment room revealed a temperature log sheet with temperature values documented for that day, however there was no thermometer observed in cypress nourishment room. The tour continued to the Cypress Extended Unit, and the surveyor, DON and SDLS observed that in the nourishment room was an ice machine with a solid blue container that held the ice scooper. Upon further inspection, the surveyor (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted dark cloudy water on the bottom of the container and no ability for the liquid to be drained. At the time of the observation, the DON verified that she will ensure the ice scooper container will be cleaned and sanitized and the SDLS confirmed that he will ensure that all the ice scoop containers will have drainage holes in them.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and facility staff interview, facility personnel records review, and review of facility policies it was determined that the facility failed to ensure proper sanitization of multi-resident use equipment. This was evident for 3 of 3 medication administration observations for residents (#27, #14, and #21) conducted during the recertification survey. The findings include: 1) On 05/08/2026 at 8:09 AM the surveyor observed Registered Nurse, RN #31 measure Resident #27's blood pressure with a manual blood pressure measuring device. Before retrieving Resident #27's medications from the medication cart, RN #31 placed the blood pressure measuring device on the cart and did not sanitize the device. On 05/08/2026 at 8:30 AM the surveyor observed RN #31 measure Resident #14's blood pressure with a manual blood pressure measuring device. Before retrieving Resident #14's medications from the medication cart, RN #31 placed the blood pressure measuring device on the cart and did not sanitize the device. On 05/08/2026 at 9:22 AM the surveyor observed RN #31 measure Resident #21's blood pressure with a manual blood pressure measuring device. Before retrieving Resident #21's medications from the medication cart, RN #31 placed the blood pressure measuring device on the cart and did not sanitize the device. On 05/08/2026 at 9:30 AM the surveyor interviewed RN #31 and asked if the what where the facility's protocols when using multiple resident use equipment. RN #31 replied that the expectation is that certain equipment like glucometers are to be sanitized before usage on each resident. RN #31 was made aware of the surveyor's observations during his administration of medications for three residents who required that blood pressure be measured before medication administration. On 05/08/2026 at 9:43 AM the surveyor conducted an interview with the Director of Nursing (DON). The interview revealed that, per the DON, the facility's expectation is that all multiple resident equipment is to be sanitize properly between usage on each resident.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to provide a resident with a written notice and reason for the room change before the resident was moved. This was found to be evident in 1 (Resident #6) of 33 residents reviewed during the recertification survey. The findings include: On 5/5/2026 at 11:01 AM, Resident #6's medical records were reviewed and showed that the resident was admitted to the facility on [DATE]. Review of Resident #6's census showed that the resident had moved between room [ROOM NUMBER] and room [ROOM NUMBER], five times since 2/6/2026. A provider progress note dated 4/22/2026 included the statement, patient was examined at bedside today. [They are] upset that [they] woke up to find [their] belongings being transferred out of [their] unit as [they were] being transferred to another room. A social services (SS) progress note dated 4/22/2026 had the statement, SS met with patient at bedside to discuss room move and [their] feelings about the move. Patient reported that [they were] 50/50 about moving rooms but overall was happy with the move. [They like] the room and the window bed. Resident is doing well with building rapport with roommate. Resident #6 was interviewed on 5/5/2026 at 12:33 PM and stated that they have moved rooms multiple times over the past few weeks and never received written notice of the room changes with reasons necessitating the move. On 5/5/2026 at 1:36 PM, the facility's Social Service Director (SSD) and Minimum Data Set (MDS) Coordinator were interviewed about Resident #6's room changes. The SSD stated that the resident had multiple room changes due to room renovations. The MDS Coordinator also stated Resident #6 moved rooms one time due to another resident needing a private room for isolation precautions. The SSD stated that they verbally told the reason to Resident #6 for the room moves but did not provide a written notice. The Director of Nursing and Nursing Home Administrator were made aware of surveyor concerns at on 5/6/2026 at 3:19 PM.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and staff interview, it was determined that the facility failed to ensure information regarding advance directives was offered and documented for residents. This was evident for 2 (Residents #5 and #9) of 8 residents reviewed for advance directives.The findings include:On 05/04/2026 at 1:51 PM, review of the electronic medical record for Resident #9 showed no advance directive for the resident and no documentation indicating information regarding advance directives had been offered.On 05/04/2026 at 2:04 PM, review of the electronic medical record for Resident #5, who had a documented guardian, showed no advance directive for the resident and no documentation indicating information regarding advance directives had been offered.On 05/06/2026 at 9:35 AM, during an interview, Staff #14 was asked for assistance locating documentation showing advance directive information had been offered to Residents #5 and #9. Staff #14 stated offering advance directive information would not have been appropriate because the residents could not formulate an advance directive. The surveyor informed Staff #14 that information regarding advance directives should still be offered and documented, including to the resident representative when applicable.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews of financial statements, it was determined that the facility failed to explain or justify the proration calculation for a 3-day resident stay and applied a retroactive Medicaid billing change across multiple months without an active agency determination letter. This was found to be evident for 1 resident (Resident #72) during the investigation of complaint #2803485 during the recertification survey.The findings include:The Maryland Medicaid Contribution of Care (patient liability) is the amount of monthly income a long-term care Medicaid recipient must pay directly to their nursing home or long-term care provider.When an individual qualifies for Institutional Medicaid, they do not get to keep all their monthly income (such as Social Security, pensions, or VA benefits). Medicaid calculates their available income after allowing specific, legal deductions. The recipient pays this amount to the facility, and Maryland Medicaid pays the remaining balance of the monthly nursing home bill.Resident #72's medical records were reviewed on 5/7/2026 at 2:15 PM. The resident was admitted to the facility on [DATE] and passed away at the facility on 8/4/2025. The resident's son and their spouse were [NAME] of Attorney (POA) and the resident was enrolled with Maryland Medicaid. A financial statement provided by the facility dated 8/22/2025 was reviewed and showed a balance of $120.01 due. Additionally, a notification of determination letter dated 7/10/2025 from Maryland Department of Human Services was reviewed which showed a contribution of care determination in the amount of $1,163.35 effective 7/1/2025.Resident #72's responsible party (RP) was interviewed on 5/7/2026 at 2:33 PM. They stated their concerns were that the facility charged $1,004.01 for the first 3 days in August before Resident #72 passed away. They stated they did not believe the facility had pro-rated the amount correctly since Resident #72's contribution of care for the entire month of July 2025 was $1,163.35. The RP stated they believe the facility owed money since the RP had paid the contribution of care in the amount of $1,167.35 for the month of July and had a previous credit of $880. The RP stated this $880 credit was from paying the facility incorrectly for additional supplemental insurance and found out they should have been paying the insurance company directly. The RP stated this occurred in 2024 and took over a year to get the insurance premiums incorrectly paid to the facility credited back on to Resident #72's account. The RP stated with the $880 credit and full payment of contribution of care in July 2025, a correct pro-rated adjustment for Resident #72's 3 day stay in August would show the facility owed money. The RP also stated that they received an updated bill dated 3/23/2026 for $1,660.01 which only stated previous balance with no itemized breakdown of this new amount on the bill. The RP stated they had contacted multiple individuals at the facility but never received an explanation on how Resident #72's, three day stay contribution of care was calculated and why they were now receiving a bill for $1,660.01.The Regional Business Office Consultant (Staff #26) was interviewed via telephone on 5/7/2026 at 2:59 PM. Staff #26 stated that the business office does not create billing statements, they oversee payments. Staff #26 were unable to explain the pro-rated amount calculation or why Resident #72's current bill was in the amount of $1,660.01.On 5/7/2026 at 3:56 PM, Staff #26 contacted surveyor by telephone and stated they had spoken with an individual in the corporate office. Staff #26 were told that Maryland Medicaid does not pro-rate and that the facility got an updated notice of determination letter that increased cost of care. Staff #26 was unable to provide information on how Resident #72's three day August 2025 stay was calculated or answer why the new contribution of care was retroactively applied to Resident #72's account after their passing.On 5/7/2026 at 5:30 PM, Resident #72's financial transaction report was reviewed for billing dates of August 1 - August 3, 2025. Per review, Resident #72 was billed at the full rate of $376 per day, which amounted to $1,128. Resident #72's daily contribution rate of $41.33 per day was then subtracted from this value and the amount totaled $1,004.01. Resident #72's credit of $880 was subtracted from this total which equaled the original bill of $120.01. No other financial documentation provided by the facility explained why the (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was billed at a rate of $334.67 per day in August 2025 when their daily contribution rate was listed as $41.33. On 5/8/2026 at 9:15 AM, the Director of Nursing (DON) was asked to provide the current financial bill from Resident #72's account.On 5/8/2026 at 10:18 AM, the facility's interim Business Office Manager (Staff #27) was interviewed by telephone. Staff #27 stated that they were previously employed full-time at the facility and were aware of billing issues regarding Resident #72 brought forth by their family. Staff #27 stated that corporate oversees billing and could not provide information on how Resident #72's account was calculated for their 3 days stay in August 2025 or why they currently had a bill of $1,660.01.On 5/8/2026, the Regional [NAME] President of Operations (Staff #15) showed the surveyor an itemized bill for Resident #72 dated 5/8/2026 that showed a total amount due of $1,660.01. On date 1/31/26 under patient liability, there was a charge of $1,004.01 for the resident's 3 day stay in August 2025. The bill also showed a monthly charge of $1,387.35 for the previous months of January, February, March, April, May, June, and July 2025. These charges were posted on date 1/1/26 on the billing statement. Staff #15 also showed the surveyor a letter of determination letter from Maryland Department of Human Services dated 6/7/2025 that showed a contribution of care amount effective 7/1/2025 of $1,383.35. Staff #15 stated that this determination letter showed where the value of $1,387.35 was determined for retroactive billing on the updated bill. Staff #15 was unable to explain why the retroactive charges on the bill for the months of January-July 2025 were $4 higher than the contribution of care amount of $1,383.35. Staff #15 was also shown the notice of determination letter dated 7/10/2025 that showed Resident #72's contribution of care effective 7/1/2025 and 8/1/2025 in the amount of $1,163.35. Staff #15 could not explain why Resident #72 was retroactively charged a higher amount when the newer determination letter showed a lesser amount. Furthermore, the facility could not provide a backdated notice from the Maryland Department of Human Services explicitly adjusting the months of January through July 2025, that would allow the facility the authority to retroactively bill a higher contribution of care for a period Resident #72 had already settled.Surveyor concerns were addressed with the Nursing Home Administrator, DON, and Staff #15 on 5/8/2026 at 1:00 PM.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure residents were provided notice of the facility's bed-hold policy at the time of transfer to the hospital and/or that the bed-hold policy was maintained for review. This was evident for 3 (Residents #5, 58, and 59) of 3 residents reviewed for discharge process. The findings include:On 05/04/2026 at 10:41 AM, review of the electronic medical record (EMAR) revealed Resident #5 was sent to the hospital on [DATE] and no bed-hold policy was located in the EMAR. At 1:20 PM, EMAR review revealed Resident #58 was sent out to the hospital on [DATE] and no bed-hold policy was located in the EMAR.05/05/2026 at 8:07 AM, EMAR review revealed Resident #59 was hospitalized on [DATE] and no bed-hold policy was documented in the EMAR. At 10:15 AM, EMAR review revealed Resident #5 was sent to the hospital again on 04/24/2026 and no bed-hold policy was documented in the EMAR. On 05/06/2026 at 9:35 AM, during an interview with the surveyor about the missing documentation, Staff #14 stated the Business Office Manager had recently left the facility and previously handled bed-hold policy distribution. Staff #14 further stated that in the absence of the Business Office Manager, no bed-hold policies were provided to Residents #5, 58, or 59.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on medical record review and staff interviews, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days of the resident's enrollment in hospice. This was found to be evident for 1 (Resident #63) of 1 resident reviewed for hospice services during the recertification survey.The findings include:The MDS is a federally-mandated assessment tool that helps nursing home staff 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. A significant change in status MDS is required when a resident enrolls in a hospice program within 14 days of enrollment of services.On 5/5/2026 at 12:00 PM, Resident #63's medical records were reviewed and showed the resident was admitted to hospice services on 3/20/2026. Resident #63's most recent MDS (quarterly) had an assessment referral date (ARD) of 4/2/2026. Under Section O - Special Treatments, Procedures, and Programs, hospice was selected as No for the resident. There were no additional MDS assessments beyond this ARD date, including a significant change in status MDS showing that Resident #63 had enrolled in hospice services.On 5/5/2026 at 1:26 PM, the facility's MDS coordinator was interviewed and made aware that Resident #63's MDS did not reveal that they were enrolled in hospice services. The MDS coordinator stated that it's the facility's expectation that a significant change in status MDS should be completed within 14 days of hospice enrollment and that it was accidentally missed and they would correct immediately. On 5/5/2026 at 2:14 PM, the Director of Nursing was made aware of the failure to complete the significant change in status MDS assessment within 14 days of hospice enrollment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and resident and facility record review, it was determined that the facility failed to provide the resident with advance notice of care planning conferences. This was evident for 1 (Resident #43) of 1 residents reviewed for care planning during the recertification survey. The findings include: On 05/04/2026 at 9:09 AM the surveyor interviewed Resident #43. During the interview it was revealed that the resident does not and never has received advanced notification of planned care plan conferences from the facility. The resident stated that his/her representative received notifications from the facility and then would inform him/her of the conferences. On 05/05/2026 at 7:34 AM a review of Resident # 43's medical record revealed that the resident was admitted to the facility on [DATE]. Further review revealed a copy of the notice of a scheduled care plan conference was addressed to the resident's representative and no further information was found to show that that the resident was given advance notice of the care conference. Further review of the resident's medical record revealed documentation dated 01/28/2026 that notification was mailed to the resident's representative, however no mention of notification to the resident was found. On 05/05/2026 at 8:44 AM an interview was conducted with The Director of Social Work, SW #14. During the interview, SW #14 revealed that prior to their employment at the facility, on 01/26/2026, advance notification to the residents were not being done. SW #14 stated that s/he identified that and drafted a letter to be given to the residents in advance of the care conference/ meeting after s/he spoke with the residents to determine a date that works for them. The surveyor asked if Resident #43 received a letter after his/her most recent assessment on February 2026, and SW #14 stated, no. On 05/05/2026 at 9:02 AM SW #14 provided a sample copy of an advanced notification letter to be given to the residents and a separate letter to be sent to their representative.

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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 medical record review and interviews, it was determined that the facility failed to 1) provide adequate supervision to prevent accidents as evidenced by a resident eating solid food while on nothing by mouth (NPO) diet restrictions and 2) ensure adequate supervision for a vulnerable, cognitively impaired resident which resulted in elopement. This was found to be evident in 2 (Resident #6 and #9) of 5 residents reviewed for accidents during the recertification survey. The facility implemented effective and thorough corrective measures following these incidents prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be past noncompliance with a compliance date of 4/25/2026. The findings include: NPO most commonly stands for the Latin phrase nil per os, meaning nothing by mouth. It is medical instruction requiring a patient to avoid eating or drinking. Someone with enteral feeding (tube feeding) is often placed on an NPO diet primarily to prevent aspiration pneumonia - when food or saliva enters the lungs 1) Resident #6's medical record was reviewed on 5/5/2026 at 10:35 AM. Resident #6 was admitted to the facility on [DATE] and had medical diagnoses including cerebral ischemia, dysphagia, respiratory failure, bilateral hand contractures, and chronic obstructive pulmonary disease. Resident #6 had an active medical order for enteral feeding by percutaneous endoscopic gastrostomy (PEG) tube and an NPO diet order (placed by physician on 12/29/2025). A facility progress note dated 4/20/2026 by Registered Nurse (RN) #16 was reviewed that stated Resident #6 was accidentally fed a grill cheese sandwich by a Certified Nursing Assistant (CNA) instructor. On 5/5/2026 at 11:06 AM, RN #16 was interviewed and stated that a CNA student misidentified Resident #6 with their roommate when requesting a grilled cheese sandwich from dietary. RN #16 stated that a facility Geriatric Nursing Assistant (GNA) then witnessed the CNA instructor of the student feeding the sandwich to Resident #6 and alerted RN #16. RN #16 immediately alerted the CNA instructor that Resident #6 was NPO, alerted the facility's Respiratory Therapist (RT) to assess resident, and alerted the Assistant Director of Nursing (ADON) to begin a facility investigation. Per RN #16, Resident #6 exhibited no signs of distress, no dyspnea, and no evidence of aspiration. The facility's Medical Director (MD) was notified for assessment, and a stat X-Ray order was placed. The facility's investigation report and corrective actions were reviewed on 5/6/2026 at 9:00 AM. The facility's RT and MD assessed Resident #6 on 4/20/2026 and a chest X-Ray was completed with no evidence of aspiration. Resident #6 had vital signs and respiratory assessments every 4 hours for 48 hours and their care plan was reviewed and revised to reinforce strict NPO status and aspiration precautions. The CNA instructor was immediately re-educated on diet verification and resident identification. All other facility residents on NPO diets and enteral feedings were audited to ensure accuracy. Re-education to nursing staff, dietary staff, and students/instructors regarding resident verification, adherence to diet orders, and communication protocols was provided by the facility. A policy reinforcement was implemented requiring no food to be given by students without direct licensed staff verification. Meal observation audits were conducted, and weekly audits of diet order accuracy were implemented for 4 weeks. The compliance date for the facility's plan of correction was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed as 4/25/2026. On 5/6/2026 at 3:19 PM, surveyor reviewed the incident and facility response with the Director of Nursing and Nursing Home Administrator. 2) On 5/5/26 at 12:37 PM, review of the electronic medical record for Resident #9 revealed that the resident resided on the facility's secure Federal unit. The resident was found to have a BIMS score of 3, indicating significant cognitive impairment. At 12:46 PM, review of facility reported incident #2989264 revealed that Resident #9 was observed, through a window on the Federal unit, to be outside the building unsupervised by GNA Staff #30 on 4/17/26 at approximately 2:15 PM. Documentation indicated GNA Staff #30 notified unit nurse Staff #29 that Resident #9 had been observed outside the facility in close proximity to an exit door. Resident #9 was immediately escorted back into the facility without difficulty. Review of the facility's investigation revealed an immediate head count was conducted after the resident was returned to the building. The resident was assessed head-to-toe and Resident #9's responsible party was notified on 4/20/26 at 3:20 PM. Documentation further revealed maintenance adjusted the delayed locking mechanism on the exit door involved in the incident on 4/17/26. The timing of the lock was found to be set for 15 seconds until relocking when the resident eloped and was changed to 0.5 seconds. Staff monitored the exit until the necessary adjustments were completed. Resident #9 was found to have exited the facility by following a maintenance department employee through the locked door before the magnetic lock engaged. The facility investigation led to a plan of correction being created with a compliance date of 4/22/2026. On 5/5/26 at 8:45 AM, interview with the Administrator confirmed the facility completed re-education regarding elopement and wandering policies following the incident. She explained that the exit door code is only known to 3 employees in the facility to further ensure this incident would not be repeated. At 10:22 AM, the surveyor tested the exit door on the secure unit involved in the incident and confirmed that it had a different code than the other secured doors on the unit. Based on the above actions taken by the facility and verified by surveyors on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of 4/25/2026.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on record review and staff interview, it was determined that the facility failed to ensure a nurse aide completed required dementia training and competency evaluation within 120 days of employment. This is evident for 1 (Staff #22) of 5 employee records reviewed during the annual survey.The findings include:On 05/06/2026 at 2:00 PM, review of the employee file for Staff #22 revealed no documentation of completed dementia training or competency evaluation. Staff #22 had been employed by the facility for at least 9 months, with a hire date in July 2025.On 05/07/2026 at 8:29 AM, during an interview, Staff #8 was informed of the concern regarding the absence of dementia training and competency evaluation documentation for Staff #22. Staff #8 stated she would look in the former Director of Nursing's files for the documentation.On 05/07/2026 at 8:34 AM, the Director of Nursing (DON) stated that if the dementia training and competency evaluation program documentation was not in the employee folder, it was probably not completed for Staff #22.No further documentation was provided by the time of survey exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and facility staff interview, it was determined that the facility failed to properly contain garbage and refuse. This was evident for 2 of 2 observations conducted during the recertification survey.The findings include: On 05/04/2026 at 7:35 AM the surveyor observed two blue dumpster containers located at the back of the facility. The two dumpsters were uncovered overflowing with bagged trash, and loose trash items on the ground between the two containers. On 05/04/2026 at 8:14 AM, the surveyor observed that the loose trash was removed from the ground between the two dumpsters, however, the trash remained uncovered, overflowing at the top of both dumpsters.On 05/04/2026 at 10 AM the Maintenance Director (MD) confirmed that trash pick up was to occur since Thursday 04/30/2026 and he placed a call to the trash removal company on 05/04/2026 to inquire about the missed service and to expedite removal on 05/04/2026.

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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 medical record review and interviews, it was determined that the facility failed to maintain documentation of Covid-19 vaccine administration. This was found to be evident in 1 (Resident #15) of 5 residents reviewed for immunizations during the recertification survey.The findings include:On 5/7/2026 at 9:15 AM, the facility's Covid-19 vaccination policy was reviewed. Section 21 subsection b. stated that The resident's medical record will include documentation of the following: b. Each dose of the vaccine administered to the resident.On 5/7/2026 at 1:15 PM, Resident #15's 2025 vaccine consent form was reviewed. It was signed by the resident on 10/16/2025 and stated yes to consent for the Covid-19 and flu vaccinations. Additional review of Resident #15's medical chart showed documentation that the flu vaccine was administered on 10/16/2026 but did not reveal documentation that the resident received the Covid-19 vaccine.On 5/8/2026 at 9:54 AM, the Director of Nursing (DON) provided the billing statement for Resident #15 for their flu vaccination. The DON stated the facility did not have documentation that Resident #15 was administered the Covid-19 vaccination. Resident #15 was interviewed on 5/8/2026 at 10:04 AM and stated that they had been administered both the Covid-19 and flu vaccines in October 2025.On 5/8/2026 at 11:17 AM, the surveyor addressed concern about the lack of documentation showing that Resident #15 was administered the Covid-19 vaccine.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff interview, it was determined that the facility failed to make the results of the most recent survey readily available and accessible to residents and visitors. This was evident for the facility's survey results binder.The findings include:On 05/04/2026 at 7:55 AM, the survey team observed the survey results binder located in the conference room. The conference room was down a hallway past several administrative offices and through a metal door and not readily accessible to visitors. Multiple observations were made by the survey team from 05/04/2026 through 05/07/2026. At no time during these observations was the survey results binder observed to be readily accessible to residents or visitors, and no sign was posted indicating the binder's location or availability.On 05/06/2026 at 8:52 AM, the surveyor was unable to locate the survey results binder in the front lobby area.On 05/07/2026 at 12:11 PM, the surveyor asked the Director of Nursing (DON) for the survey results binder. The DON went to the fireplace mantel in the visitor lounge and stated the binder was normally kept there; however, the binder was not present and no sign indicated its location.On 05/07/2026 at 12:13 PM, the Regional [NAME] President stated she had been using the survey results binder and that this was why it had been kept in the conference room near the entrance. The surveyor informed the Regional [NAME] President that the survey team had checked for the binder daily and it had not been available or accompanied by signage indicating its location. The binder was then placed on the fireplace mantel in the visitor lounge.