| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215125 | A. Building<br>B. Wing | 03/03/2026 |

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| The Village at Rockville | 9701 Veirs Drive<br>Rockville, MD 20850 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation and interview, it was determined that the facility failed to ensure residents were treated in a manner that maintained dignity. This was evident for 2 (Resident #168 and Resident #57) out of 12 residents observed.The findings include:On 02/27/2026 at 12:16 PM, this surveyor observed residents on the 2 Virginia Memory Care floor being served food in the dining area.On 02/27/2026 at 12:33 PM, it was observed that a group of residents were seated together at a dining table. One resident seated at the head of the table (Resident #153) had been served at that time.On 02/27/2026 at 12:39 PM, it was observed that the remaining residents seated at the table (Residents #153, #84, #69, #59, #107, #17, #21, and #93) had received their meal trays and were eating. However, Resident #168 had not yet been served. Resident #168 was observed looking around at the other residents while they were eating.On 02/27/2026 at 12:41 PM, Resident #168 was observed receiving his/her meal tray.On 02/27/2026 at 12:45 PM, this surveyor observed Resident #87 being assisted with lunch at a dining table. Resident #57 was seated at the same table and had not yet received a meal tray.On 02/27/2026 at 12:56 PM, Resident #57 had still not been served. At that time, Resident #87 had completed his/her entire meal.On 02/27/2026 at 12:57 PM, Resident #57 was observed receiving his/her lunch tray.On 02/27/2026 at 2:22 PM, this surveyor conducted an interview with GNA #10. GNA #10 confirmed that she had been working in the 2 Virginia Memory Care Unit dining room earlier that day, assisting with tray service and feeding residents. She reported that meal trays are served in the dining room based on meal tickets and that trays are prepared and delivered in the order the tickets are received. She stated that resident seating at tables is random and that residents are assisted with meals based on when they receive their trays.GNA #10 further reported that she feeds the residents assigned to her and that additional nursing staff assist if needed. When asked whether there have been instances of residents becoming upset when others have food and they do not, GNA #10 stated that there have been occasions where residents attempt to take food from another resident's tray. She reported that, to prevent this, staff attempt to ensure that residents seated together receive their trays around the same time.On 02/27/2026 at approximately 3:00 PM, this surveyor conducted an interview with the Administrator and the Director of Nursing (DON). The concern regarding resident dignity was discussed, specifically the observations of residents seated at dining tables while other residents were eating and they had not yet received meal trays. It was explained that, in both instances observed, residents were without meal trays for approximately eight minutes or longer, including one instance in which a resident seated across the table had already completed the meal before the other resident was served. It was communicated that this practice raised concerns related to maintaining resident dignity and ensuring meals are served in a manner that allows residents seated together to begin dining at approximately the same time. The Administrator and DON acknowledged and expressed understanding of the concern. |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure that 1) the environment was in good repair in 3 (Resident rooms #3142, #3145, & #3147) out of 32 Resident rooms and 2) Residential hot water temperature was safe in 5 (#2390, #2391#2220, #2215, and #2212) out of 5 Resident rooms observed for the environment during the recertification and complaint survey. The findings include: 1) During a tour of the facility conducted on 02/25/26 at 9:07 AM, the Surveyor observed Resident room [ROOM NUMBER], #3145, and #3147 with large areas of peeling paint behind the Resident beds. The Surveyor also observed in Resident room [ROOM NUMBER] the nightstand with peeling contact paper on top. During a tour with the Maintenance Director conducted on 03/02/26 at 9:33 AM the Surveyors and Maintenance Director observed Resident room # 3142, #3145, and #3147 peeling paint on the walls behind the Resident beds and peeling contact paper on top of the nightstand in Resident room [ROOM NUMBER]. During an interview conducted on 03/02/26 at 9:52 AM, the Maintenance Director reported that he was not aware of the damage to walls or the nightstand and stated that he would get right on it.2) According to Centers of Medicare and Medicaid (CMS) regulations and state guidelines generally require that hot water temperatures at nursing home resident plumbing fixtures (sinks, showers, tubs) be maintained between 100 F and 120 F to prevent scalding while ensuring hygiene. Temperatures should not exceed 120 F, and in some areas, 110 F is recommended for residents unable to regulate water temperature.During the continued tour the Surveyors and Maintenance Director tested the hot water with the Maintenance Director's thermometer. The sink hot water was tested in the private bathrooms of the following Resident rooms: #2391 had a temperature of 123 degrees Fahrenheit (F), #2390 had a temperature of 124 degrees F, room [ROOM NUMBER] had a temperature of 125 degrees F, room [ROOM NUMBER] had a temperature 123 degrees F, and room [ROOM NUMBER] had a temperature of 124 degrees F. During an interview conducted with the Maintenance Director conducted on 03/02/26 at 10:30 AM, the Maintenance Director reported that the Residential hot water had a set point of 125 degrees F because the water temperature will decrease by a few degrees as it reached the Resident. During an observation conducted on 03/02/26 at 10:40 AM, the Surveyors observed the Residential hot water temperature set point at 124.8 degrees F in the boiler room. The Maintenance Director reported that he would reduce the hot water temperature. During a follow up interview conducted on 03/02/26 at 11:49 AM, the Maintenance Director reported that he had adjusted the set point hot water temperature down to 115 degrees F. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, it was determined that the facility failed to ensure food items were stored in accordance with professional standards for food service safety. This was identified during the kitchen facility task conducted as part of the annual/complaint survey.The findings include:On 02/25/2026 at 8:41 AM, this surveyor observed items in the refrigerator of the facility's kitchen that were labeled for discard but had not been removed, including:Salad bar cut vegetables labeled Discard by 02/23/2026 07:27 PM.Cut green and red peppers wrapped in plastic wrap with no label or date.On 02/25/2026 at 9:02 AM, this surveyor observed items in the deep freezer that were labeled for discard or were unlabeled and undated, including:A tray of carrots labeled Veg with a discard date of 02/15.Pieces of naan bread in an opened bag with no label or date.Red velvet iced sheet cake labeled Discard 02/20.A bag of meatballs (unopened) with no label or date.A bag of chicken (opened) labeled Good thru 02/23.An additional unopened bag of chicken with no label or date.A bag of croissants labeled Discard 02/16/2026.Mashed potatoes labeled Discard 02/22/2026.On 02/25/2026 at 9:10 AM, this surveyor conducted an interview with the Dining Director regarding the process for discarding food items. The Dining Director reported that night shift staff are responsible for reviewing items in the refrigerator and freezer each evening and discarding expired items during closing. She stated that she routinely reminds staff of this responsibility but acknowledged that items are sometimes missed.On 02/25/2026 at approximately 10:00 AM, this surveyor and the Dining Director conducted a dual observation of the refrigerator and freezer items identified as expired or unlabeled. The Dining Director was shown the items past their discard dates as well as those without labels or dates (including the meatballs, chicken, naan bread, and peppers). It was explained that unlabeled or undated items present a food safety concern because staff are unable to determine the appropriate discard date. During the dual observation, the Dining Director acknowledged understanding of the concern and began discarding the identified items.On 02/27/2026 at 2:42 PM, this surveyor conducted an observation of the 3rd floor kitchen pantry on the Maryland Unit. It was observed that there were no temperature recordings documented for 02/27/2026 at the time of observation. Signage posted on the refrigerator door indicated: Follow these easy steps to keep food safe: Guest Food Only. All food must be labeled with Guest's name, room number and date. All food will be discarded after 3 days. Store food tightly in sealed container. Label with name or number and date. Food will be discarded after 3 days. A second sign stated: Refrigerator cleaning: Refrigerator will be cleaned every other Friday at 2:30 PM. Any food not labeled or out of date will be discarded. The date of observation was Friday after 2:30 PM. Inside the freezer, this surveyor observed a box of spicy chicken sandwich melts labeled with a room number but no date; a box of Stouffer's roast turkey dated 01/09/2026; and a box of Eggo waffles dated June 11, 2021. These findings were inconsistent with posted labeling, dating, and food safety practices.On 02/27/2026 at approximately 3:00 PM, this surveyor conducted an interview with the Administrator and the Director of Nursing (DON). The concerns identified in the main kitchen and in the 3rd floor kitchen pantry on the Maryland Unit were reviewed. The Administrator and DON confirmed understanding of the findings and stated they would ensure the identified food items were addressed.On 03/03/2026 at approximately 11:30 AM, this surveyor conducted a follow-up observation of the 3rd floor kitchen pantry on the Maryland Unit. It was observed that the spicy chicken sandwich melts, box of Stouffer's roast turkey, and box of Eggo waffles had been discarded. The temperature log was up to date for 03/03/2026. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate a resident's allegation of abuse. This was evident for 2 (Resident #74 and Resident # 140) of 4 residents reviewed for abuse during the annual recertification and complaint survey. The findings include:1) On 03/02/2026 at 11:12 AM, a review of the initial report form for the facility reported incident #357580 regarding Resident #74 submitted on 04/23/2025, for the injury of unknown origin, the steps listed by the facility immediately to ensure residents are protected did not list resident interviews or assessments. The action items listed were: investigation initiated; family notified; physician notified; medical director notified and ombudsman notified. On 03/02/2026 at 11:14 AM, a review of the facility's investigation for abuse revealed no resident interviews or assessments were located within the facility's investigation file. However, there were 8 documented staff interviews.On 03/03/2026 at 11:15 AM, A review of the follow up investigation report form under the steps taken to investigate the allegation confirmed interviews were only completed with staff. On 03/03/2026 at 12:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) for completion of allegations of abuse investigations. The NHA confirmed that the copy in my possession was the full investigation. When asked why resident interviews were not included, she responded I know its best practice to include both. NHA stated she was under the impression the social worker had done them. When asked how they would assess residents that are non-interviewable, she responded we interview residents that they can speak to and staff.She stated that usually the nurse managers or social workers complete resident interviews. On 03/03/2026 at 1:03 PM an interview with the Director of Nursing (DON) was conducted and she stated they do not interview residents that are nonreviewable, instead they look for signs or symptoms for abuse, and they will reach out to family to ask if they have noticed any changes. When asked how or where the facility would document the screening the DON stated through skin assessments. When questioned about the incomplete investigation the DON stated she was not sure why the assessments were not included in the facility incident investigation. On 03/03/2026 at 1:23 PM, The DON brought in copies of Resident Treatment Administration investigations (TARs) for residents that reside in the same hallway as the Resident and it showed that the residents had ongoing orders to be monitored daily for any change in condition. The monitoring orders on the TAR were not related to the investigation of abuse. On 03/03/2026 at 1:30 PM, The DON provided copies of skin assessments for 4 of 14 non-interviewable residents. 2 resident skin assessments were completed on 04/22/2025 and 2 resident skin assessments were completed on 4/23/2025. The DON was not able to produce any other documentation. 2)On 03/02/2026 at 10:00 AM, a review of the initial report form for the facility reported incident #2709082 regarding Resident #140 submitted on 01/05/2026, for the injury of unknown origin, the steps listed by the facility immediately to ensure residents are protected did not list resident interviews or assessments. The action items listed were: investigation initiated; Head to toe assessment completed; Resident medicated for pain; physician notified; responsible party notified, medical director notified; x-ray ordered; care plan updated. Resident interviews and assessments were not listed as an action item. On 03/02/2026 at 10:05 AM, a review of the facility investigation for abuse revealed no resident interviews or assessments were located within the facility investigation. There were 9 documented staff interviews included in the facility investigation.On 03/02/2026 at 10:10 AM, a review of the follow up investigation report form under the steps taken to investigate the allegation confirmed that only staff and the Resident were interviewed for the incident. On 03/03/2026 at 12:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) for completion of allegations of abuse investigations. The NHA confirmed that the copy in my possession was the full investigation. When asked why resident interviews were not included, she responded I know its best practice to include both. NHA stated she was under the impression the social worker had done them. When asked how they would interview residents that are non-interviewable, she responded we interview residents<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that they can speak to and staff.She stated that usually the nurse managers or social workers complete resident interviews. On 03/03/2026 at 12:59 PM, NHA was able to provide a copy of an email where the social worker reported she interviewed three residents in the same hallway on the day of incident. The NHA stated if they are not interview-able then we can't conduct an interview. The NHA could not provide copies of documented interviews with the three residents. 03/03/2026 1:03 PM interview with The Director of Nursing (DON) and she stated they do not interview residents that are nonreviewable, they look for signs or symptoms for abuse, and they will reach out to family to ask if they have noticed any changes. She was not sure why the assessments were not included in the facility incident chart. DON given time to make copies of the assessments. On 03/03/2026 at 1:33 PM, the DON was not able to provide any documentation of completed Resident assessments. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days of the resident's disenrollment in hospice services. This was evident for 1 (Resident #43) out of 2 residents reviewed during recertification survey process. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected on the MDS drives Resident care planning decisions. The nursing home should complete a Significant Change in Status MDS assessment within 14 days of a major decline or improvement in a resident's status after the determination that a significant change has occurred.On 2/27/2026 at 1:48 PM, review of Resident #43's electronic medical record revealed that the resident was admitted to [NAME] Hospice Services on 12/23/2023.On 03/01/2026 at 11:15 AM, record review of the resident's medical record revealed a hospice physician certification of terminal illness for the benefit period beginning 12/23/2023 under services provided by the [NAME] Hospice Services, indicating the resident was receiving hospice services during that period.Further review of records on 03/01/2026 at 2:00 PM revealed a physician's progress note documenting that Resident #43 was disenrolled from [NAME] Hospice Services due to extended prognosis, effective 1/23/2026, indicating the end of the hospice benefit period. On 3/2/2026 at 7:00 AM, a review of Resident #43's significant change Minimum Data Set (MDS) assessment revealed a reference date of 2/5/2026. The assessment was completed and signed in Sections V0200B2 and Z0500B on 2/11/2026, 20 days after the resident's disenrollment from hospice services and 5 days late. On 03/02/2026 at 9:59 AM, the Director of Nursing (DON) was interviewed and stated that Resident #43 was admitted to hospice services on 12/24/2023 and disenrolled from hospice on 1/23/2026. The DON further confirmed that a significant change MDS assessment with a reference date of 1/5/2026 was completed and signed on 2/11/2026.On 03/02/2026 at 11:15 AM, the surveyor reviewed the significant change Minimum Data Set (MDS) assessment for Resident #43 with the Director of Nursing (DON). During the review, the DON confirmed that the assessment was completed late. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on interviews and record reviews it was determined that the facility failed to ensure a Resident care plan was developed. This was found to be evident for 1 (Resident #166) out of 32 Resident care plans reviewed during the recertification and complaint survey.The findings include: A review of complaint #2607648 submitted to the Office of Health Care Quality (OHCQ) was conducted on 02/27/26 at 8:00 AM. The complainant reported that the facility failed to provide accommodations for Resident #166. During a phone interview conducted on 02/27/26 at 8:46 AM, the complainant reported that Resident #166 was blind and that the facility failed to have interventions in place to accommodate the Resident's needs. Category 4 blindness is a severe classification of vision impairment defined by the World Health Organization (WHO) as having a best-corrected visual acuity worse than (roughly) but still retaining light perception. It often includes severe visual field restrictions (less than), indicating very limited functional vision compared to total blindness.During a review of Resident #166's medical records conducted on 02/27/26 at 9:02 AM, it was discovered that the Resident had a diagnosis of blindness in right and left eye category 4. A care plan is a personalized, living document that outlines a person's health conditions, specific care needs, goals, and the tailored interventions required to manage their well-being. Developed collaboratively between individuals, families, and professionals, it guides caregivers by organizing, prioritizing, and ensuring consistent care.During a review of Resident #166's care plan conducted on 02/27/26 at 9:07 AM, it was discovered that the Resident did not have a care plan for his/her blindness. During an interview conducted on 3/02/26 at approximately 10:30 AM, the Director of Nursing (DON) reviewed Resident #166's care plan with revisions with the Surveyor and confirmed the Resident did not have a care plan for blindness. The DON explained that it is the facility's expectation that a Resident with a vision impairment such as blindness has a care plan with interventions that would address the needs of the Resident. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on record reviews and interviews it was determined that the facility failed to provide services that met professional standards of practice. This was found to be evident for 1 (Resident #166) out of 1 Resident reviewed for professional standards of practice during the recertification and complaint survey. The findings include: 1)A review of complaint #2607648 submitted to the Office of Health Care Quality (OHCQ) was conducted on 02/27/26 at 8:00 AM. The complainant reported that the facility failed to hold a blood pressure medication and notify the physician when the Resident blood pressure was low. Systolic blood pressure, the top number in a reading (e.g., the 120 in 120/80 mmHg), measures the maximum pressure in your arteries when your heart muscle contracts and pumps blood. It indicates how hard your heart is working to pump blood to the rest of the body with each beat.A review of Resident #166's Medication Administration Record (MAR) conducted on 03/02/26 at 8:19 AM showed the following orders: Amlodipine Besylate Oral Tablet 10 mg (milligram) (Amlodipine Besylate). Give 1 tablet by mouth at bedtime for HTN (hypertension) hold for SBP (Systolic Blood Pressure) less than 110. Metoprolol Succinate ER (Extended Release) Tablet 24 Hour 50 mg. Give 1 tablet by mouth one time a day for HTN hold for SBP less than 110. HR (Heart Rate) less than 60. Further review of the MAR showed that Registered Nurse (RN) #28 administered Metoprolol Succinate ER (Extended Release) Tablet 24 Hour 50 mg on 03/13/25 between 8-10 am. However, the Resident's Systolic Blood Pressure reading was 101 which was less than 110 and should have been held. During a review of Resident #166's Blood Pressure (BP) readings conducted on 03/02/26 at 8:24 AM it was discovered that the Resident's Systolic Blood Pressure reading was below the acceptable parameter of 110. On 03/13/25 the BP was 103/57, on 03/13/25 the BP was 101/58, on 03/14/25 the BP was 102/57, and on 03/16/25 the Resident had two readings 94/51 and 98/56. A review of Resident #166's medical records conducted on 03/02/26 at 8:29 AM did not show that the physician was notified of the Resident's Systolic Blood Pressure reading was less than 110 and the medication was not administered. During an interview conducted on 03/02/26 at approximately 9:10 AM, the Director of Nursing (DON) reported that she reviewed the MAR and confirmed Resident #166 was administered the Blood Pressure medication in error. She also confirmed that the physician was not notified that the Resident's Systolic Blood Pressure was less than 110 and the BP medication was not administered. The DON explained that it is the facility's expectation that the physician is notified when a Resident falls below a parameter and/or a medication cannot be administered.2) During a review of the Maintenance hot waterlogs conducted on 03/02/26 at 11:00 AM, the Surveyor discovered the following: 02/16/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/17/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/21/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/22/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/23/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/24/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/25/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/26/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.2/27/26 the hot water temperature was recorded at 119 F with a line and an arrow<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pointing downward through each box for each resident room in place of the actual temperature. 02/3/26 the hot water temperature was recorded at 121 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.During an interview conducted on 03/02/26 at 11:52 AM, the Maintenance Director acknowledged that the hot waterlogs were not documented completely or accurately. The Maintenance Director stated that he reviewed the logs and was in the process of educating his staff on the importance of capturing the accurate hot water temperature for each room accurately completing the sheet. |

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|---|---|---|---|
| | 215125 | A. Building<br>B. Wing | 03/03/2026 |

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| The Village at Rockville | 9701 Veirs Drive<br>Rockville, MD 20850 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and interviews it was determined the facility staff failed to follow procedures for Residents with a pressure ulcer. This was evident for 2 (#7 & #122) out of 2 residents reviewed for pressure ulcer care during the recertification survey. The findings include:A pressure ulcer, also known as a bed sore or decubitus ulcer, is a localized area of skin damage that develops when prolonged pressure or shear forces disrupt blood flow to the tissues resulting in damage to the underlying tissue. Pressure ulcers are staged based on their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). 1. During a review of the Treatment Administration Record (TAR) for Resident #7 on 3/03/26 at 8:07 AM it was revealed that the Resident was being treated for a Stage II pressure ulcer. He/she had an order that stated, Left buttock stage II: Cleanse with Normal Saline Solution, pat [NAME]. Apply xeroform and cover with bordered gauze every dayshift for wound management for 14 days. The order ended on 2/06/2026. It was discovered that this order for pressure ulcer wound care was not renewed until 2/09/2026. There was no documentation of this wound treatment being completed on 2/07/2026 and 2/08/2026.During continued medical record review for Resident #7 a Skin: Pressure Ulcer Assessment form completed on 2/05/2026 was discovered, it reported the Stage II pressure ulcer would be treated with xeroform. There was no documentation of this wound treatment being completed on 2/07/2026 and 2/08/2026.During an interview with Registered Nurse #28 on 3/03/26 at 8:50 AM she reported pressure ulcer treatment should have an order to be completed. She advised if there was a time frame for the order and it ended; there should be an updated order to continue treatment for the pressure ulcer. During an interview with the 3rd floor Nurse Manager on 3/03/2026 at 9:57 AM she reported that when a wound order ends after a set time frame, the wound should have a reassessment completed and the order renewed. She confirmed that the order for Resident #7 was not reinstated until 2/09/2026 and there was no documentation of that wound care order being completed on 2/07/2026 and 2/08/2026.During an interview with the Director of Nursing on 3/03/2026 at 11:10 AM she reported nurses have to put an order in after assessing the wound and calling the doctor for the orders. She confirmed the order should have been renewed and the order continued on 2/07/2026 and not on 2/09/2026 for Resident #7.2. During a review of the TAR for Resident #122 on 3/03/26 at 11:27 AM it was revealed that the Resident was being treated for a Stage II pressure ulcer. He/she had an order that stated, Cleanse left buttock with Normal Saline Solution, pat dry and apply xeroform and cover with optiform one time a day for three weeks and the order ended on 2/18/2025. The order was not renewed until 2/28/2025. There was no documentation of this wound treatment being completed on 2/19/2026 through 2/27/2025.During additional medical record review, a Skin: Pressure Ulcer Assessment form dated 2/19/25 was discovered which reported the left buttock wound was a stage II pressure ulcer and would be treated with Xeroform. This order was not found in the TAR and was not shown as being completed from 2/19/25 through 2/27/25. During an interview with Licensed Practical Nurse (LPN) #29 on 3/03/26 at 1:29 PM she reported that when the pressure ulcer assessment is completed, the doctor is notified and treatment orders would be obtained. She advised the order would be listed in the treatment section on the Skin: Pressure Ulcer Assessment form. She confirmed that the Treatment section on the Skin: Pressure Ulcer Assessment form date 2/19/2025 showed the wound would be treated with Xeroform. She confirmed the treatment section would be completed after getting orders from the doctor. She was not aware of a reason the order wasn't continued on 2/19/2025 for Resident #122.During an additional interview with the DON on 3/03/2026 at 1:40 PM she confirmed the nurses have to put the order in after assessing the wound and calling the doctor for the orders. She agreed the treatment listed on<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the Skin: Pressure Ulcer Assessment form would be what the doctor wanted to treat the wound and would be the treatment for Resident #122. She agreed the xeroform treatment order was not continued as ordered for Resident #122 on 2/19/2025. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, record reviews and interviews it was determined that the facility failed to keep residents free from injury. This was evident for 1 (Resident #10) of 1 resident reviewed for injuries during the annual recertification survey. The findings include:02/25/2026 at 9:10 AM, Resident #10 was observed to have a dressing in place on their left lower leg that was clean, dry, and intact. The Minimum Data Set (MDS) is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified and care is planned based on these individualized needs.Brief Interview for Mental Status (BIMS): A screen used to assist with identifying a resident's current cognition. The BIMS score ranges from 00 to 15. A score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 00-07 indicates severe cognitive impact. Care plans provide direction for individualized care of the resident. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 2/26/2026 8:36 AM, a review of Resident #10 medical records revealed an MDS assessment completed on 12/17/25 with a BIMS of 07 indicating severe cognitive impairment and was assessed to require substantial / maximal assistance with transfers. A review of Resident #10 care plans showed they were care planned for risk for falls related to weakness, poor safety awareness, attempted self-transfers, and confusion.On 03/02/2026 at 12:04 PM review of Resident #10 medical records confirmed they sustained an injury during a transfer from the bed to the wheelchair on 1/29/26. The progress note documented the laceration to be 6cm x 5cm with a depth of 2cm requiring a transfer to the hospital emergency room (ER) for acute care of the laceration.A skin assessment note dated 2/7/26 documented the presence of 7 superficial stitches and 3 deep sutures for treatment of the laceration. On 03/03/2026 at 8:40 AM, an Interview with Licensed Practical Nurse (LPN #5) confirmed that Geriatric Nurse Aide (GNA #20) came to her and asked her to come to the Resident #10 room to look at a cut. LPN #5 looked at the cut and called her Nurse Manager to come look at the laceration. She reported the Nurse Manger called the Nurse Practitioner (NP) to come and assess resident #10 injury. LPN #5 stated that GNA #20 reported to them it must have happened when she was transferring the resident from the bed to the wheelchair. LPN #5 stated the Nurse Manager completed an in-service for transfers with the nursing staff after the incident. On 03/03/2026 at 8:45 AM, an interview with GNA #20 confirmed the cut to Resident#10 leg happened when she stood the resident up to transfer them. GNA #20 stated that when she stood the resident up from the bed, they immediately complained to her about becoming dizzy but at that point she decided it was safer to sit the resident in the wheelchair since Resident #10 had already started to pivot. GNA #20 looked down at Resident #10 leg as they sat down in the wheelchair, and she could see a cut. Once they were seated in the wheelchair, GNA #20 went and called LPN #5 to the room to assess the cut. GNA #20 confirmed she received education and training for proper transferring from the Nurse Manager.A Power of Attorney (POA) is a legal document granting authority to a trusted person (the agent or attorney-in-fact) to act on behalf of another (the principal) regarding financial, legal, or medical matters. It is essential for incapacity planning, allowing decisions to be made without court intervention On 03/03/2026 at 8:49 AM, an interview with the Nurse Manager confirmed Resident #10 sustained an injury to the left leg that resulted in a laceration to their left shin. She reported that LPN #5 called her to assess Resident #10 leg and she determined it was going to need further care than they could provide in-house. The Nurse Manager called the on-call NP to come and assess Resident #10 injury. When the NP arrived, they agreed Resident #10 should be sent to the ER for further treatment. The Nurse Manager stated they cleaned and wrapped the leg and administered pain medication while waiting for the transfer. She also stated they called the Power of Attorney (POA) to let them know of the incident and transfer to the ER as well as completed a change of condition<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assessment. The Nurse Manager confirmed she provided education and training for her nursing staff on proper transfers after the incident. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, record review and interview it was determined that the facility failed to ensure a Resident's enteral feeding was labeled. This was found to be evident for 1 (Resident #34) out of 1 Resident observed for tube feeding during the recertification and complaint survey. The findings include: Enteral feeding, or tube feeding, delivers liquid nutrition directly into the stomach or small intestine via a tube for individuals with a functioning gut who cannot consume enough calories orally. It is used for short-term (<4-6 weeks, e.g., nasogastric) or long-term support (e.g., G-tube/PEG) to treat malnutrition, swallowing difficulties, or critical illness.A gastrostomy tube (G-tube) is a medical device inserted through the abdomen into the stomach to deliver nutrition, fluids, and medication directly, bypassing the mouth and esophagus. It is used for individuals, often children, with swallowing difficulties, chronic illness, or failure to gain weight.During an observation conducted on 02/25/2026 at 9:45 AM, the Surveyor observed Resident #34 in bed asleep, head of the bed (HOB) raised at 45 degrees, and an enteral feeding infusing from an electronic feeding pump through the Resident's PEG tube. The Surveyor observed the enteral feeding bottle of Glucerna 1.5 without a date and time when the enteral feeding began infusing. A photo was taken of the Glucerna enteral bottle unlabeled by the Surveyor. Dysphagia is the medical term for difficulty swallowing, causing pain, coughing, or food to feel stuck in the throat or chest. It is caused by neurological damage (stroke, dementia), muscular disorders, or obstructions like tumors. Diagnosed via imaging (barium swallow), endoscopy, or motility studies, it is classified as oropharyngeal or esophageal.During a record review conducted on 02/25/26 at 10:39 AM, Resident #34 had the following order: Enteral Feed Order one time a day for dysphagia Glucerna 1.5 cal via PEG tube using pump at 50 ml (milliliter) /hr. (hour) x 20 hrs. (Start at 2pm). This provides 1000ml total volume of enteral formula. Pump to flush 50 ml water q (every) 1 hr. while running (1000ml). Provides 1500kcal (kilocalorie), 82g prot (protein), 1759 ml free water. Order Date 02/24/2026.During an interview conducted on 2/25/2026 at 11:19 AM the Director of Nursing (DON) advised that the expectation was that the staff labeled the enteral feeding bottle with the date and time of when the enteral feeding began infusing. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation and interviews it was determined that the facility failed to ensure staff practiced infection control. This was evident for 4 (Residents #138, #3, #65 and #131) out of 6 Residents observed for infection control during the recertification survey.The findings include:<br><br>1) Enhanced Barrier Precautions (EBP) are infection control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents at high risk of spreading multi-drug-resistant organisms (MDROs). They prevent transmission of resistant bacteria like C. auris or MRSA, especially for those with wounds or medical devices.<br><br>On 02/25/2026 at 9:32 AM The Surveyor observed a sign on the Resident's entry door for Enhance Barrier Precaution (EBP). The Surveyor entered the Resident's room and observed GNA/PDA #30 cleaning Resident #138's face with a white cloth. The GNA/PDA was not wearing gloves and a gown while she provided high contact care.<br><br>During an interview GNA/PDA #30 stated that she was familiar with EBP that was why she washed her hands before and after providing care. The Surveyor and the GNA/PDA reviewed the sign posted on the entry door, the GNA/PDA stated that she should have worn gloves and a gown when she provided care.<br><br>During an interview conducted on 02/25/2026 at approximately 12:30 PM, the Director of Nursing (DON) reported that GNA/PDA was not an employee of the facility she was hired by the Resident or the Resident Representative. The DON reported that she personally educated the PDA on EBP right after the Surveyor expressed concern of the observation.<br><br>The DON further explained that when the facility was made aware that a PDA had been hired, the facility would provide the PDA education and expectation of facilities policies and procedures. The Surveyor requested the records for the education that was provided to GNA/PDA #30. The DON stated that she would obtain the records however the records were never provided to the Surveyor.<br><br>2) During an observation on 2/27/2026 at 8:47 AM Licensed Practical Nurse (LPN) #21 was observed using a rolling blood pressure machine on Resident #3. After using the device to obtain a blood pressure and heart rate, she returned the machine to the hallway beside her medication cart. She then returned to Resident #3 to administer medications. The blood pressure machine was not cleaned.<br><br>During an observation on 2/27/2026 at 9:06 AM LPN #21 was observed taking the rolling blood pressure machine that was used on Resident #3 to Resident #65, the device was not cleaned prior to taking to the Resident. After she obtained a blood pressure and heart rate she returned the machine to the hallway beside her medication cart. She then returned to Resident #65 to administer medications. The blood pressure machine was not cleaned.<br><br>During an observation on 2/27/2026 at 9:28 AM LPN #21 was observed taking the rolling blood pressure machine that was used on Resident #65 to Resident #131, the device was not cleaned prior to taking to the Resident. After she obtained a blood pressure and heart rate she returned the machine to the hallway beside her medication cart. The blood pressure machine was not cleaned.<br><br>During an interview with LPN #21 on 2/27/26 at 9:32 AM she advised the blood pressure machine was supposed to be cleaned after use and prior to taking it to a new room. She confirmed that she did not<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | clean the machine between the Residents.<br><br>During an interview with the Director of Nursing on 2/27/2026 at 12:51 PM she reported that the blood pressure cuffs should be cleaned between residents and advised she would do training to reinforce the cleaning of the machines between Residents. |