STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215126	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berlin Nursing and Rehabilitation Center	9715 Healthway Drive Berlin, MD 21811

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, facility staff interview and surveyor record review it was determined that the facility staff failed to ensure the dignity of a Resident. This finding was found to be evident for 1 (Resident #68) out of 1 Resident reviewed for Resident Rights.The findings include:An indwelling Foley catheter is a flexible tube inserted through the urethra (the tube that carries urine from the urinary bladder to the outside of the body) into the bladder to drain urine. A small balloon inflated with sterile water secures it in place. The indwelling Foley catheter is connected to a drainage bag for urine collection.On the initial tour of the facility at 8:25 AM on 7/15/2025 the surveyor observed Resident #68 in bed. It was observed that a Foley catheter drainage bag was attached to the Resident's bed frame. The Foley catheter drainage bag was not covered with a privacy barrier and urine was visible in the Foley catheter drainage bag.The surveyor conducted a record review of Resident #68's electronic medical record on 7/17/2025 at 7:35 AM and the review revealed that Resident #68 had a physician order dated 7/9/2025 for an indwelling Foley catheter. Additionally, there was a physician order for a privacy bag in place every shift for Resident #68.In an interview with the Director of Nursing (DON) on 7/22/2025 at 11:00 AM that surveyor asked what the expectation was for Foley catheter drainage bags to be covered with a privacy barrier. The DON stated that the facility had Foley catheter drainage bags that had a grayish-blue color privacy barrier that covered the Foley catheter drainage bag. The surveyor conveyed to the DON that Resident #68 (who was admitted to the facility on [DATE]) did not have a privacy barrier cover on the Foley catheter drainage bag on the initial tour of the facility. The DON stated that it was the responsibility of the nursing staff to change the Foley catheter drainage bags to the bags that the facility provided when Residents were admitted to the facility. Additionally, the surveyor conveyed that Resident #68 was observed earlier today and had a privacy barrier cover on the Foley catheter drainage bag.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews and record reviews it was determined that the facility failed to ensure showers were provided to a Resident as scheduled. This was found to be evident for 1 (Resident #65) out of 1 Resident reviewed for self-determination during the recertification survey.The findings include:During an in-person interview with Resident #65's Power of Attorney (POA) conducted on 07/15/25 at 2:51 PM, the POA expressed concern that the Resident had not received routine showers.On 07/17/25 at 3:12 PM, a review of Resident #65's physician orders revealed an order for Bathing (Bath/Shower/Days/Shift): Tues./Fri. 7-3 Shift. During a review of Resident #65's POC (Point of Care) conducted on 07/17/25 at 3:19 PM, it was discovered that the Resident had not received a shower from 04/01/25 - 07/17/25 with the exception of 1 day on 04/14/25.On 07/18/2025 at 5:50 AM a review was conducted of Resident #65's care plan. The review did not reveal that the Resident refused care or showers. During an interview conducted on 07/18/2025 at 7:08 am, the DON stated that showers are documented in the POC as well as refusals. The DON reviewed the Resident #65's POC with this Surveyor and confirmed that the Resident had 1 shower during the period of 04/01/25 through 07/17/25 and that there was no documentation that the Resident had refused showers. The DON also reviewed the Resident's care pan with this Surveyor and confirmed that the Resident did not have a care plan for refusal of care or showers.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on record reviews and interviews it was determined that the facility failed to ensure complete medical records were provided in a timely manner. This was found to be evident for 1 (Resident # 107) out of 1 Resident reviewed for medical records during the re-certification survey. The findings include: A review of complaint #348368 reported to the Office of Health Care Quality (OHCQ) was conducted on 07/21/25 at 11:22 AM. The complainant reported that we have attempted on many occasions to obtain the medical records for Resident #107. We received 8 pages not including the cover page on 01/17/23 and 13 pages on 09/20/23 not including the cover page. We have requested to receive the complete medical records for Resident #107 multiple times since 12/22.On 07/21/25 at 11:30 AM a review of the medical records request confirmed that on 1/17/23 the facility faxed 9 pages that included the cover page and faxed 14 pages on 09/20/23 that included the cover page. These dates and number of pages faxed confirmed the complainant's concerns. No other fax confirmations were present that showed the complete medical records packet had been provided to the complainant. A further review of the medical record requests revealed a letter from the complainant that requested all medical records from the patient chart on 10/08/23 which was 10 months after the initial request. During an interview conducted on 07/21/25 at 11:33 AM, the medical record staff #7 provided this Surveyor with a complete packet of Resident #107's medical records. This Surveyor asked Medical Record staff #7 when the packet was sent to the complainant. The Medical Records Staff member stated that she was unsure, but she thought she emailed the complete packet of medical records. She stated that she would reach out to her IT department to retrieve her emails to show when she emailed the Resident's complete medical records to the complainant. The Medical Records Staff #7 stated that it would take a couple of days for IT to retrieve her emails. During an interview with the Nursing Home Administrator (NHA) conducted on 07/21/25 at 11:37 AM, the NHA stated that she would work on getting IT to retrieve the Medical Record Staff #7 emails. During an interview conducted on 07/22/25 and 07/23/25, the Director of Nursing (DON) stated that IT retrieved Medical Records Staff #7's incoming emails but had not retrieved the outgoing emails and therefore was unable to provide confirmation that complete medical records were provided to the complainant. This Surveyor expressed concern based on what was provided that the facility failed to provide a complete medical record for the complainant.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews it was determined that the facility failed to ensure Residents received accurate comprehensive assessments. This was found to be evident for 4 (Resident #74, #83,#100 & #11) out of 19 Residents reviewed for accuracy of assessment during the re-certification survey.The findings include: 1) During the interview conducted on 07/15/2025 at 2:19 PM, it was discovered that Resident #74 was hard of hearing and could communicate only using a whiteboard. The Resident stated that he/she could not hear and did not have hearing aids. On 07/18/2025 at 6:16 AM a review of Resident #74’s medical records revealed a diagnosis for unspecified hearing loss, bilateral. The Care Plan is a document that outlines the care and support a Resident needs, often created for individuals receiving healthcare, personal care or other types of support. It’s a personalized roadmap for managing a Resident’s health and well-being, ensuring consistent and coordinated care. Care Plans are not just for nurses; they can be used by various healthcare professionals, caregivers and even the individuals receiving care themselves. Care plans are tailored to the individual’s specific needs, goals and preferences. During a continued review of the resident's medical records, it was discovered that the Resident had a care plan for hearing loss. The care plan stated that Resident #74 will “compensate for hearing loss by utilizing a whiteboard with marker to communicate with staff.” According to the Centers of Medicare and Medicaid Services (CMS) the Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. During an interview conducted on 07/18/23 at 6:49 AM, the Director of Nursing (DON) stated that the Resident hearing was severely impaired and required the use of a white board to communicate with the Resident. This Surveyor questioned why Resident #74’s MDS assessment for hearing assessed the Resident with moderate hearing loss. The DON reviewed the MDS assessment dated [DATE] and confirmed the assessment was not accurate. During an interview conducted on 07/18/25 at 8:42 AM, the DON advised that Resident #74’s MDS hearing assessment was corrected and now showed that the resident’s hearing was highly impaired. 2) The surveyor conducted a record review of Resident #83 electronic medical record on 7/18/2025 at 11:45 AM. Review of the medical record revealed documentation in the progress notes that Resident #83 had a fall (observed sitting on the floor in room on buttock) on 9/29/2024 at 1:03 PM. Further review of the medical record revealed that Resident had a care plan for history of falling related to decreased strength and mobility, but the quarterly MDS assessment dated [DATE] was coded that Resident #83 had no falls. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON) at 12:50 PM on 7/18/2025 the surveyor conveyed to DON that Resident #83 had an unwitnessed fall (found on the floor in room on buttock) on 9/29/2024 at 1:03 PM, but the quarterly MDS assessment dated [DATE] indicated that Resident #83 did not have any falls. The DON acknowledged the surveyor and confirmed that Resident had a fall, and it was not coded accurately on the quarterly MDS assessment. DON stated that she would review with the MDS Coordinator. An indwelling Foley catheter is a flexible tube inserted through the urethra (the tube that carries urine from the urinary bladder to the outside of the body) into the bladder to drain urine. A small balloon inflated with sterile water secures it in place. The indwelling Foley catheter is connected to a drainage bag for urine collection. 3) On 7/21/2025 at 3:15 PM the surveyor conducted a record review of Resident #100’s electronic medical record. The medical record review revealed that Resident #100 had a physician order for an indwelling Foley catheter dated 10/9/2023 and a care plan for an indwelling urinary catheter. Further review of the medical record revealed that Resident #100’s discharge MDS dated [DATE] was coded that Resident had an indwelling catheter, but urinary continence was coded as “occasionally incontinent”. The surveyor conveyed to the Licensed Nursing Home Administrator (LNHA) at 8:10 AM on 7/22/2025 that Resident #100 had a Foley catheter on discharge to the hospital on [DATE], but the discharge MDS assessment dated [DATE] was coded that Resident had an indwelling catheter and coded that Resident was “occasionally incontinent”. The surveyor stated that if the MDS assessment was coded that the Resident had an indwelling catheter then urinary continence should be coded as “Not rated” on the MDS assessment. The LNHA acknowledged the surveyor. In an interview with the Director of Nursing (DON) at 9:00 AM on 7/22/2025 the surveyor conveyed that Resident #100 had an indwelling Foley catheter on discharge11/12/2023 to the hospital, and the discharge MDS assessment dated [DATE] was coded that Resident #100 had an indwelling catheter, but urinary continence was coded as “occasionally incontinent”. Urinary continence should have been coded as “Not rated”. The DON acknowledged and confirmed that Resident #100 had a Foley catheter on discharge and that the discharge MDS dated [DATE] was coded inaccurately for urinary continence and should have been coded as “Not rated”. DON stated that she would review with the MDS Coordinator. No additional information was provided by the facility at the time of exit. 4) Resident #11 was admitted to the facility with diagnoses which included Dementia and Diabetes Mellitus. On 07/16/25 at 8:00 AM the surveyor reviewed Resident #11’s clinical record. The review revealed that the resident fell on [DATE] and complained of pain at the back of the head. Resident #11 was sent to the Hospital emergency room and returned to the facility on [DATE]. Further review of the resident’s clinical record revealed that a quarterly MDS was completed on 09/13/24. The MDS coded the resident under Section J1800 (Falls) as not having any falls since re-entry or the prior assessment. The prior MDS assessment was completed on 06/13/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/25 at 9:20 AM the surveyor interviewed the MDS Coordinator and enquired about the fall which occurred on 07/03/24 not being coded on the quarterly MDS dated [DATE]. The MDS coordinator reviewed the clinical records during the interview, confirmed the surveyor’s findings and stated that the fall should have been coded. “I will speak with my supervisor and make a correction if that is possible” On 07/17/2025 at 9:05 AM the DON was notified of the surveyor's findings and stated that she was already aware of them.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record reviews, and interview, it was determined that the facility failed to develop and implement a Baseline care plan for a resident requiring hemodialysis treatments. This was evident for 1 (Resident #69) out of 2 residents requiring hemodialysis treatments reviewed during the annual recertification survey.The findings include:A Baseline care plan must be completed within 48 hours of a resident's admission to the facility and must include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the baseline care plan as well as a list of the resident's current medications must be provided to the resident and their responsible party.On 07/17/25 at 8:55 AM the surveyor conducted a review of Resident #69' s clinical records. The records revealed that Resident # 69 was admitted to the facility in February 2024 with Diagnoses which included Atherosclerotic Heart Disease, Dementia and End Stage Renal Disease. The resident receives hemodialysis treatments three days a week. Further review of Resident #69's clinical record failed to reveal any evidence that a Baseline care plan was completed and provided to the resident and their responsible party. During an interview on 07/22/25 at 10:35 AM the Director of Nursing (DON) stated that Baseline care plans are created by the Admitting Nurse within 48 hours of a resident's admission to the facility and that residents and /or their responsible parties are given copies of the care plan after signing them. The DON reviewed the clinical record of Resident #69 and confirmed that a Baseline care plan was not completed for that resident. The DON stated, I do not know why a Baseline care plan was not completed, I will provide education to the nurses and do chart audits on new admissions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to develop and implement comprehensive care plans. This was found to be evident for 3 (Resident #6, #8, & #44) out of 19 Residents reviewed for Care Plans during the re-certification survey.The findings include: 1) During an interview with Resident #6 on 7/15/25 at 3:09 PM it was revealed that the Resident was on dialysis, and he/she also reported having concerns with continuous constipation. During a review of Resident #6’s medical records conducted on 7/16/25 at 11:30 AM it was discovered that the Resident had a history of constipation and was receiving dialysis three days a week. A review of a progress note dated 5/22/25 at 5:37 PM reported that the Resident had complained of constipation and Lactulose was given. The note also stated that the Resident was scheduled for “hemodialysis in the morning.” A review of the Medication Administration Record (MAR) for Resident #6 revealed a physician’s order for Senna and Bisacodyl tablets for constipation which had been administered daily. There was an additional order for a Dulcolax suppository to be taken when needed. A Care Plan is used in nursing facilities to summarize a resident’s health conditions and care needs. It is used to ensure resident’s needs are met and consistent care is provided to the resident based on those needs. During a continued review of medical records for Resident #6 it was determined that constipation and dialysis was not included in the Care Plan. During an interview with the Director of Nursing (DON) on 7/17/25 at 11:04 AM, she reported she would have expected constipation and dialysis to have been included in Resident #6’s Care plan. She reported his/her Care Plan was audited yesterday after discussing other Care Plan issues with another Surveyor. An additional review of the Care Plan on for Resident #6 on 7/17/25 at 11:12 AM revealed the Care Plan was updated on 7/16/25 to include; Resident is receiving Hemodialysis, Due to End Stage Renal Disease” and “Bowel and Bladder – Ensure adequate bowel elimination”. 2) During an interview with Resident #8 on 7/15/25 at 11:30 AM he/she reported having concerns with constipation and reported that it has not improved with treatment. The Resident also reported “I’m always in pain, they say it’s arthritis.” During a review of Resident #8’s medical records conducted on 7/17/25 at 8:23 AM it was discovered that he/she was admitted [DATE] and had a history of Type II Diabetes, Constipation, Major Depressive Disorder and Chronic Pain Syndrome. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Medication Administration Record (MAR) for Resident #8 it was discovered that the Resident had an order for Lactulose and Sennosides-docusate sodium for constipation which had been administered daily, Eliquis an anticoagulant which had been administered daily, Venlafaxine for Major Depressive Disorder and an order for Humalog KwikPen Insulin for Diabetes when needed for a blood sugar of 200. During a continued review of Resident #8’s medical records it was determined Constipation, Anticoagulant medication, Depression, Diabetes and Chronic Pain were not included in the Care Plan. During an interview with the DON on 7/18/25 at 9:51 AM she reported Constipation, Anticoagulant due to Eliquis, Depression, Diabetes and pain would be expected to be included in Resident #8’s Care Plan. During an additional review of Resident #8’s Care plan on 7/22/25 at 7:11 AM it was revealed it had been updated on 7/21/25 and the following was added, “constipation related to mobility.” Diabetes, Anticoagulant and pain were not included in the Care Plan update. 3) According to the Mayo Clinic, a contracture is a condition where muscles, tendons ligaments, or skin tighten, restricting the normal movement of the body part. This can lead to a joint being stuck in a bent or flexed position. A splint is a device that supports or immobilizes a joint to prevent or correct the tightening and shortening of soft tissues (like muscles, tendons and ligaments) that restricts movements. On 7/15/2025 at 9:50 AM, during the initial facility tour, Resident #44 was observed in bed with contractures of the left elbow, left hand and right hand and was not wearing any splints on either hand. On 7/21/2025 at 8:19 AM, a review of the Resident #44’s medical records confirmed an admission on [DATE], with diagnoses including but not limited to: · Contracture, left elbow; Contracture, right hand; Contracture, left hand. A Minimum Data Set (MDS) is a standardized set of data elements used in healthcare to ensure consistent and comprehensive assessment of individuals, particularly in nursing homes. It provides a foundation for care planning and quality improvement by capturing key information about a resident's functional status, health conditions, and other relevant factors. · The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/15/2025 also confirmed upper extremity impairment on both sides. A review of the Evaluation & Plan of Treatment notes signed by Occupational Therapist (OT #18) signed on 3/14/2025 revealed: contractures of left hand and left elbow, recommending “Orthotics Splint/ Orthotic recommendation: towel rolls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #44’s care plan revealed no evidence that a care plan was formulated to address contractures since the resident’s admission. A care plan meeting note written by the Social Worker on 4/10/2025 indicated “Resident is seen by occupational therapy for bracing and splinting of hand.” On 7/21/2025 at 9:26 AM, the Director of Nursing (DON) confirmed the absence of a care plan to address contractures. The DON stated that it was expected that if the Therapy department had recommendations, they were supposed to discuss it in our meetings. The DON acknowledged the concern.

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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 record reviews and interviews, it was determined that the facility failed to review and revise the Interdisciplinary Care Plans to reveal accurate interventions for Residents. This was evident for 2 (Resident #69 & #5) out of 19 Residents reviewed for care plan timing and revision.The findings include: 1) On 07/15/2025 at 11:19 AM Resident #69 informed the surveyor that he /she had a wound on their bottom. On 07/18/25 at 11:30 AM a review of Resident #69’s clinical record revealed that the resident had been receiving daily dressing changes to the Right Thigh from 05/09/25. The physician’s order stated Cleanse Posterior Right Thigh with Soap and water, pat dry apply border gauze daily - Order Date 05/09/25. According to CMS (Centers for Medicare and Medicaid Services), a care plan meeting is a structured, interdisciplinary conference where staff, residents, and families discuss and review the resident's care plan, ensuring needs are met and goals are achieved. In long-term care facilities, a care plan meeting should occur within 7 days of completing the comprehensive assessment. Further review of Resident #69’s clinical record failed to reveal a care plan related to the resident’s actual skin impairment with specific interventions and approaches to manage the affected area on the Right Thigh. A review of the documentation dated 6/20/25 written by a Licensed Nurse who performed a skin check on that date, stated “(Resident’s Name) has a wound on inner R thigh that has a treatment ordered. (Resident’s Name) has no new alteration of skin integrity.” The clinical records also failed to reveal the measurements or description of the wound. On 07/20/25 at 07:35AM in an interview with the surveyor, the Director of Nursing confirmed, the resident’s care plan was not revised to include Resident #69’s actual skin impairment. She also confirmed that there was no description in the clinical record of the affected area at the Right Thigh. The DON stated that she would do an in-service on wound documentation with the nurses and would ask the wound team to do an assessment of the resident’s wound. On 07/21/2025 at 02:15 PM the surveyor was informed by Director of Nursing that Resident #69 was assessed by the wound team and that the area affected on the Right Thigh was diagnosed as Dermatitis. Further, the care plan and clinical records were updated in keeping with the resident’s condition. 2) On 7/21/2025 at 12:00 PM, Resident #5's significant other expressed frustration about not being invited to a care plan meeting. He/she stated that Resident #5 was admitted on [DATE], and he/she had not received any calls or notices from the Social Worker regarding a meeting. On 7/21/2025 at 2:18 PM, in an interview with the Social Worker, she confirmed that no care plan meeting had been scheduled for Resident #5. She stated that while she typically scheduled meetings within 2 weeks of admission, she would schedule one sooner if requested by the family. He/she added that invitations were sent via email, phone calls, or notices. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/25 at 3:05 PM, the Social Worker provided a copy of a care plan meeting invitation dated June 22, 2025, at 3:00 PM. However, there was no documentation in the medical record to indicate that the Responsible Party declined the invitation or a meeting occurred. On 7/22/2025 at 7:50 AM, the Director of Nursing (DON) was informed and acknowledged the concern, stating that a care plan meeting was scheduled for that day. On 7/23/2025 at 7:44 AM, following surveyor intervention, the Social Worker confirmed that a care plan meeting was held on 7/22/25 at 3:00 PM, attended by the Interdisciplinary Team (IDT). A sign in sheet for this meeting was also provided to the surveyor.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews it was determined that the facility failed to ensure care provided to a Resident met the professional standards of practice. This was found to be evident for 2 (Resident #65 & #55) out of 2 Residents reviewed for Services Provided Meet Professional Standards during the re-certification survey.The findings include: 1) The Surveyor observed Resident #55 in bed on 7/15/2025 at 9:00 AM during the initial tour of the facility. Resident #55 was observed with a soft cast to his/her left arm and dried blood and sutures to left forehead laceration. On 7/17/2025 at 12:30 PM the surveyor reviewed the facility’s investigation file for the facility reported incident (FRI) MD#00219326/348447 dated 7/1/2025 that the facility submitted to the Office of Healthcare Quality (OHCQ) for an unwitnessed fall with injury. Additionally, the surveyor conducted a record review of Resident #55’s electronic medical record. Review of these records revealed that Resident #55 had an unwitnessed fall (found lying on the floor in room) on 7/1/2025 resulting in an emergent 911 transfer to the local hospital for evaluation of forehead laceration and open area on left wrist. Resident #55 returned from the hospital emergency room (ER) on 7/2/2025 with a fracture of the left wrist and dissolvable sutures to the left forehead. Further review of Resident #55’s medical record revealed that there was lack of evidence of follow-up documentation of nursing care for Resident. Resident #55’s medical record lacked documentation that neurological checks for the forehead laceration and circulation checks for the left arm fracture were performed by nursing staff and lacked documentation of follow-up progress notes for the Resident’s condition related to the fall and injuries. In an interview with the Director of Nursing (DON) at 3:00 PM on 7/17/2025 the surveyor conveyed to DON that there was lack of documentation of follow-up nursing care in the medical record for Resident #55 related to the unwitnessed fall, forehead laceration and fracture of left wrist. The DON acknowledged the surveyor and confirmed that there was lack of documentation of the nursing care related to the Resident #55’s fall which included lack of neurological checks, circulation checks and follow-up progress notes on Resident’s condition after a fall with major injury. No additional information was provided by the facility at the time of exit. 2) During a random observation conducted on 07/18/2025 at 10:00 AM, this surveyor observed Resident #65 lying in a bed in a high position from the floor. The Resident was yelling, please help me. The Resident was completely naked lying on his/her right side and holding on to the right bed side rail. This Surveyor observed a soiled disposable diaper on the floor next to the Resident's bed. In the bathroom the water was running on feces soiled wash cloth that laid at the bottom of the sink. At the time of the observation the privacy curtain had not been pulled and there were no staff in the room. A continued observation of the unattended Resident was conducted from 10:00 AM to 10:10 AM. During this time no staff returned to Resident #65’s room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/25 at 10:11 AM, this Surveyor observed the assignment board and learned that Geriatric Nursing Assistant (GNA) #15 was assigned to care for Resident #65. During an interview conducted on 07/18/26 at 10:12 AM, Unit Manager (UM) #14 confirmed that GNA #15 was assigned to Resident #65. When asked where the GNA was at the time the Unit Manager stated that the GNA was assisting another GNA in Resident room [ROOM NUMBER]. This Surveyor expressed concern for the condition Resident #65 was left in. On 07/18/2025 at 10:13 AM both this Surveyor and the Unit Manager returned to Resident #65’s room. The Unit Manager was visibly upset and immediately assisted the Resident. The UM lowered the bed, covered the resident and attempted to calm him/her. The UM observed the soiled disposable diaper on the floor and the water running on the feces soiled wash cloth in the Resident’s bathroom sink. On 07/18/2025 at 10:16 AM this Surveyor asked the Regional Clinical Services Director to come and observe the condition Resident #65 was left in. When the Surveyor and Regional Clinical Service Director returned to the room GNA #15 and the Unit Manager were in the room. The GNA explained that the Resident had refused care and became combative, so she left the Resident. Both the Unit Manager and Regional Clinical Service Director provided education to the GNA for safety, privacy, dignity, infection control, and proper handling of a resident who refused care or was combative. On 07/20/25 at 7:32 PM the Director of Nursing (DON) reported that an in-service was in progress for all nursing staff on safety, privacy, dignity, infection control, and caring for a resident who refused care or combative. She also stated that GNA #15 had been suspended for the lack of care provided to Resident #65.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and interviews, it was determined that the facility failed to ensure that dependent residents' grooming needs were met in accordance with the residents' plan of care. This was evident in 1 (Resident# 69) of 1 resident reviewed for Activities of Daily Living (ADL).The findings include: Resident # 69 was admitted to the facility in February 2024 with Diagnoses which included Atherosclerotic Heart Disease, Dementia and End Stage Renal Disease. On 07/15/2025 at 10:25 AM and on 07/18/25 at 7:40 AM the surveyor observed Resident #69 lying in bed with unshaven facial hair. On 07/20/25 at 06:30 PM the surveyor again observed the resident with unshaven facial hair approximately I/8 inch long sitting in a wheelchair in his/her room. During an interview on 07/20/2025 at 06:30 PM the Resident #69 stated I need assistance with shaving because I cannot do it myselfOn 07/17/25 at 08:55 AM a review of Resident 69's clinical record revealed a care plan initiated on 08/06/24 which stated Resident #69 had limited ability to maintain grooming/personal hygiene. The Goal was that the resident would be well groomed, and the approach was Provide (assistance/full staff performance) for facial hair.On 07/20/25 at 5:21PM in an interview, GNA Staff #22 was asked if she helps Resident #69 with shaving. GNA Staff#22 seemed unaware of the resident's needs and stated that the resident was independent, and assistance would be provided when requested by the resident.During an interview on 07/21/2025 at 8:22 AM Staff Infection Preventionist/Staff Educator (IP/SE) confirmed Resident # 69 had a care plan for grooming with an intervention for assistance with facial hair. The surveyor informed Staff IP/SE that in an interview, the Geriatric Nursing Assistant (GNA) seemed unaware of the needs of the resident as regards shaving. Upon reviewing the clinical record, Staff IP/SE stated that the person who created the care plan did not check the box to transfer the data to the resident's profile. As such, the GNA was unaware of the resident's grooming needs. Staff # IP/SE immediately checked the box and provided the surveyor with a copy of the updated record. On 07/21/2025 at 9:07 AM in an interview, the Director of Nursing was notified of the surveyor's findings. The DON reviewed the clinical record and confirmed the findings.On 07/23/25 the surveyor observed Resident #69 in a wheelchair sitting at the receptionist's desk clean shaven with no facial hair.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined that the facility failed to 1) obtain an order for the use of a splint and 2) properly assess and address the resident's condition prior to hospital transfer. This was evident for 2 (Resident #44 and #96) of 2 resident reviewed for position and mobility and 1 resident reviewed for hospitalization during the recertification survey.The findings include:1) According to the Mayo Clinic, a contracture is a condition where muscles, tendons ligaments, or skin tighten, restricting the normal movement of the body part. This can lead to a joint being stuck in a bent or flexed position.A splint is a device that supports or immobilizes a joint to prevent or correct the tightening and shortening of soft tissues (like muscles, tendons and ligaments) that restricts movements.On 7/15/2025 at 9:50 AM, during the initial facility tour, Resident #44 was observed in bed with contractures of the left elbow, left hand and right hand and was not wearing any splints on either hand.On 7/21/2025 at 8:19 AM, a review of the Resident #44's medical records confirmed an admission on [DATE], with diagnoses including but not limited to: Contracture, left elbow Contracture, right hand Contracture, left handThe Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/15/2025 also confirmed upper extremity impairment on both sides.A review of the Evaluation & Plan of Treatment notes signed by Occupational Therapist (OT #18) on 3/14/2025 revealed: contractures of left hand and left elbow, recommending Orthotics Splint/ Orthotic recommendation: towel rolls. However, no splint order was written on the Physician orders.On 7/21/2025 at 8:45 AM, a follow-up observation of Resident #44 showed no splints or braces on his/her bilateral hands. On 7/21/2025 at 9:26 AM, in an interview with the Director of Nursing (DON), she confirmed the absence splint orders to address contractures. The DON stated that the Therapy department was expected to share their recommendations in their meetings. The DON acknowledged the concern.On 7/21/2025 at 12:50 PM, during an interview with OT #18, he/she confirmed recommending the continued use of towel rolls for Resident #44's right and left hand in her OT discharge summary (dates of service 2/26/24- 4/26/24, with the note was signed on 4/26/2024 at 9:20 AM. He/she indicated that he/she verbally educated the Geriatric Nurse Assistants (GNAs) and notified the charge nurse of the recommendation. 2) On 7/16/2025 at 8:41 AM, a review of Resident #96's medical records indicated that he/she was admitted on [DATE] and discharged to the hospital on 6/2/25. On 7/16/2025 at 10:39 AM, the Nursing Home Administrator (NHA) confirmed that only one progress note for Resident #96 was written between 6/1/25 and 6/2/25. On 7/16/2025 at 10:59 AM, the surveyor received a copy of the progress note from the Director of Nursing (DON) dated 6/2/2025 for Resident #114, Resident #96's spouse, who initiated the transfer to the hospital. Further review of documents provided by the Director of Nursing (DON) revealed the following: The Nurse's note written on 6/2/25 at 10:43 AM, indicated that Resident #114 called 911 for his/her spouse, whom he/she shared a room with. He/she reported that Resident #96 was having pain and experiencing trouble with breathing. The Nurse indicated that he/she assessed Resident #96's vital signs which were normal. However, no vital signs have been recorded from 6/1/ 25- 6/2/25. The DON confirmed the finding and stated that vital signs were expected to be obtained and documented in the medical record. The Medication Administration Record (MAR) indicated that Tylenol (Acetaminophen) 325 mg tablet, every 6 hours as needed was administered on 6/2/2025 at 6:12 AM for pain. However, there was no documentation to indicate that the complaint of trouble breathing was addressed. On 6/2/25 at 5:02 PM, Occupational Therapist (OT #18) conducted a Brief Interview of Mental Status (BIMS) assessment of Resident #96, who scored 14 out of 15, indicating intact cognition. Brief Interview for Mental Status (BIMS) is a screening tool used to assess basic cognitive function in patients in long-term care facilities. On 7/16/2025 at 1:15 PM, the Nursing Home Administrator (NHA) was informed of the concern.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews it was determined that the facility failed to ensure a Resident received audiology services. This was found to be evident for 1 (Resident #74) out of 1 Resident reviewed for treatment to maintain hearing during the annual recertification survey. The findings include: During an observation and interviews conducted on 07/15/2025 at 2:19 PM, it was discovered Resident # 74 was hard of hearing. When this Surveyor asked Resident #74 a question the Resident responded, you must use the whiteboard on the table because I cannot hear. When asked if the Resident had hearing aids by writing my question on the whiteboard, Resident #74 read the question and responded no. When asked if he/she had seen an Audiologist for the loss of hearing via the whiteboard, the Resident responded no, not since he/she had been at the facility. A review of Resident #74's medical records was conducted on 07/18/2025 at 6:16 AM. The medical records revealed a diagnosis for Unspecified Hearing Loss, bilateral. A review of Resident 74's care plan stated that the Resident had hearing loss and as the intervention the Resident would utilize a whiteboard with a marker to communicate with staff. According to the Centers of Medicare and Medicaid Services (CMS) the Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. A review of Resident 74's MDS quarterly assessment was conducted on 07/18/2025 at 6:23 AM. The MDS assessment dated [DATE] revealed that the Resident's hearing was assessed as having moderate difficulty. During a review of Resident #74's medical records conducted on 07/18/25 at 6:27 AM it was discovered that the Resident had not received an Audiology consultation since admission of 11/21/23. During an interview conducted on 07/18/25 at 9:22 AM, the Clinical Service Director stated that the facility had not ordered an audiology consult to have the Resident hearing assessed. The Clinical Service Director stated that an appointment would be scheduled for audiology.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure Residents received proper dialysis care. This was found to be evident for 2 (Resident #6 & #69) out of 2 Residents observed for dialysis care during the recertification survey. The findings include: 1) Hemodialysis is a treatment that filters waste and excess fluid from the blood when kidneys are not functioning properly. During an interview with Resident #6 on 7/15/25 at 3:09 PM it was discovered that the Resident has dialysis three times a week. During a review of the Treatment Administration Record (TAR) for Resident #6 on 07/21/2025 at 8:25 AM it was discovered that the Resident had several orders pertaining to dialysis care and monitoring. There was an order for “Dialysis three times per week”, “Once a Day on Monday, Wednesday, Friday.” Dialysis visits for July included 7/02/25, 7/04/25, 7/07/25, 7/09/25, 7/11/25, 7/14/25, 7/16/25, 7/18/25 and 7/21/25. There was an order for “Dialysis Communication Sheet Returned with Resident? Yes/No” and “Nurse must scan Dialysis Communication Sheet into matrix after Dialysis. If the Dialysis Communication sheet was not returned, notify Dialysis Center Supervisor sheet was not returned and to fax communication sheet to facility.” It was documented that the Dialysis Communication Sheet was not returned on 7/02/25, 7/04/25, 7/11/25, 7/14/25, 7/18/25 and 7/21/25. There were no Dialysis Communication Sheets found scanned into the matrix electronic medical record. There was an order for “Document Vital Signs post-dialysis treatment” and vital signs were not obtained on the following dates. On 7/2/25 - it was documented “Not Administered: Due to condition.” On 7/07/25 - it was documented as “Due to Condition, not taken.” On 7/18/25 - there were no vital signs documented, no note written. On 7/21/25 - it was documented, “Not Administered, Resident here when nurse came on, unable to find post dialysis papers.” There was an order for “Document Vital Signs pre-dialysis treatment” and vital signs were not obtained on the following dates. On 7/4/25 it was documented “Not Administered: Leave of absence – Dialysis” On 7/16/25 it was documented “Not Administered: Due to Condition” (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/25 it was documented “Not Administered: Due to Condition” On 7/21/25 it was documented “Not Administered: At Dialysis” There was an order for “Weight Pre/Post Dialysis Treatment” and weights were not documented on the following dates. On 7/02/25 it was documented “Not Administered: Due to condition”, “Await Dialysis weights” On 7/04/25 it was documented “Not Administered:”, “Leave of Absence Dialysis” On 7/07/25 it was documented “Not Administered:”, “Leave of Absence Dialysis” On 7/09/25 it was documented “Not Administered:”, “Await Dialysis Paperwork” On 7/11/25 it was documented “Not Administered:”, “Await Dialysis Paperwork” On 7/14/25 it was documented “Not Administered:”, “Await Dialysis Paperwork” On 7/16/25 it was documented “Not Administered:”, “Due to Condition” On 7/18/25 it was documented “Not Administered:”, “Discontinued” On 7/21/25 it was documented “Not Administered:”, “Discontinued” During a review of the Care Plan for Resident #6 on 07/21/25 at 8:32 AM it was revealed that the “Resident is receiving Hemodialysis” was added to the Care Plan on 7/16/25 and “Monitor vital signs as ordered’ and “Weigh Resident as ordered” was added to the approaches to be taken for care provided for the Resident. During an interview with Licensed Practical Nurse (LPN) #20 on 7/22/25 at 7:34 AM she reported the completed Dialysis Communication Logs would be sent with the Resident when he/she goes to dialysis. The completed Logs would be put into the “Provider Communication Book” when the Resident returns. After reviewed by the doctor the Dialysis Communication Log is placed into another file to be sent to Medical Records to be scanned into Matrix. During a search of the “Provider Communication Log” on 7/22/25 at 7:22 AM it was found to contain the following Dialysis Communication Logs for Resident #6. On 7/18/25 the Dialysis Communication Log had no pre or post dialysis weights or blood pressures documented. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/25 the Dialysis Communication Log had no pre or post dialysis weights or blood pressures documented. On 7/14/25 the Dialysis Communication Log had no post dialysis weights, or blood pressures documented. On 6/27/25 the Dialysis Communication Log had no pre dialysis weights or pre/post blood pressure documented. On 6/20/25 the Dialysis Communication Log had no pre or post dialysis weights or blood pressures documented. On 6/16/25 the Dialysis Communication Log had no post dialysis weights documented. During an interview with the Director of Nursing (DON) on 7/23/25 at 6:02 AM she reported that the facility should be getting vital signs and weights if not provided by dialysis. She confirmed there were missing Dialysis Communication Logs and that the nursing staff should attempt to obtain any missing logs from the dialysis center. She advised she would have to look into the order referring to nurses downloading the reports into the electronic chart because medical records would need to upload them into Matrix. 2) A dialysis shunt, also known as a dialysis fistula, is a surgically created connection between an artery and a vein, used to provide access for hemodialysis in patients with kidney failure. This connection allows for efficient blood flow to and from the dialysis machine during treatment. On 07/15/25 at 9:10: AM the surveyor conducted a review of Resident #69’ s clinical records. The records revealed that Resident # 69 was admitted to the facility in February 2024 with diagnoses which included Atherosclerotic Heart Disease, Dementia and End Stage Renal Disease. The resident receives hemodialysis treatments three days a week. Further review of Resident #69’s clinical record failed to reveal: 1. The type of Shunt and where the resident’s Shunt site was located 2. A physician’s order to monitor the Shunt site for signs and symptoms of infection 3. Documentation by the nursing staff regarding monitoring of the Shunt site and 4. A care plan with interventions and approaches relating to the Shunt site A review of the facility’s policy on “Shunt Care - Arteriovenous,” Complete Revision Date May 5, 2023, stated Routine Shunt Care - Item D “Inspect shunt sites every shift for color, warmth, redness and edema and drainage.” (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/25 at 01:25 PM the Staff Infection Preventionist/Staff Educator (IP/SE) stated that the resident’s Shunt site was monitored daily for redness, swelling and other signs of infection. Staff (IP/SE) reviewed the resident’s clinical record and was unable to identify where the resident’s Shunt was located. Staff (IP/SE) stated that there should have been a physician’s order to monitor the Shunt site but there was none on the record. The surveyor informed Staff (IP/SE) of the concerns regarding Resident #69’s Shunt care and reported the findings. Staff (IP/SE) reviewed the resident’s clinical record and confirmed the surveyor’s findings. On 07/17/2025 at 07:00 AM after the surveyor's intervention, a review of Resident #69’s clinical record revealed as follows: Physician Order: “Monitor R chest dialysis port for s/s (signs and symptoms) of infection or bleeding Every Shift: Order Date 07/16/2025 - Open Ended.” Care Plan: Dialysis Care Plan Goal: (Resident’s Name) will not develop complications from Dialysis. Approach - Monitor R chest port q shift per orders. Start Date: 07/16/25 On 07/17/2025 at 8:59 AM in an interview, the Director of Nursing (DON) was made aware of the surveyor's findings. The DON stated that she was already notified by Staff (IP/SE) and that physician’s orders were obtained. Later, around 01:00PM on 07/17/25 the DON stated that she received a document from [NAME] Dialysis Center which she provided to the surveyor. The document stated that the resident had a Central Venous Catheter to the Right Chest, and it was last used on 07/16/25. The document was printed on 07/17/25 at 09:49 AM

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance reviews at least every 12 months for 1 (Staff#21) of 5 staff members reviewed. The findings included:Performance reviews are to be completed at least every 12 months to identify what in-service education the geriatric nursing assistants need to address their competencies. On 07/16/25 at 2:30 PM the surveyor conducted a review of 5 Geriatric Nursing Assistants' personnel files. The records revealed that the facility failed to conduct a performance review for the calendar year 2023 for Staff #21 who had been employed by the facility for over 8 years.During an interview with the surveyor on 07/17/25 at 8:34 AM, the Director of Nursing (DON) stated that annual performance reviews for geriatric nursing assistants were conducted annually in keeping with the facility's policy. The DON reviewed the records and confirmed the surveyor's findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview and surveyor record review it was determined that the facility failed to act on recommendations from pharmacist drug regimen review reports. This finding was found to be evident in 1 (Resident #12) out of 1 Resident reviewed for unnecessary medication.The findings include:A pharmacist drug regimen review (DRR), also known as a medication regimen review (MRR), is a comprehensive evaluation of all medications a Resident is currently using. This includes prescribed medications, over the counter drugs, herbal products, dietary supplements, and even total parenteral ((intravenous) nutrition and oxygen therapy. The primary purpose of a DRR is to promote positive outcomes and minimize adverse consequences associated with medication use. A pain scale is a tool used to measure and describe the intensity of pain, which is a subjective experience. The pain scale helps individuals communicate their pain levels to healthcare professionals and can be used to track pain over time.The surveyor conducted a record review of Resident #12's electronic medical record on 7/16/2025 at 1:50 PM. The review of the medical record revealed that Resident #12 had a pharmacist drug regimen review (DRR) report dated 3/15/2025 that was not addressed by the Resident's physician. The pharmacist DRR report indicated that Tylenol and Tramadol (narcotic pain medication) were prescribed for pain PRN (as needed). Tylenol was ordered every 6 hours PRN for chronic pain and Tramadol was ordered three times a day PRN for chronic pain; however, the physician orders did not indicate what pain scale rating the nurses would use to administer Tylenol versus Tramadol. According to the pharmacist DRR report, the pharmacist made a recommendation for clarification of the physician orders to include the pain scale rating that nurses would use to administer Tylenol vs Tramadol.Further review of Resident #12's medical record on 7/16/2025 revealed that there was an additional pharmacist drug regimen review (DRR) report dated 6/14/2025 that was not addressed by the Resident's physician. The pharmacist DRR report indicated that Resident #12 was ordered Tramadol PRN for pain. According to the pharmacist DRR report, the medication had not been utilized in the past 60 days, and the pharmacist made a recommendation to discontinue the medication to save costs, reduce nursing time needed to maintain drug storage and decrease the possibility for outdated drugs being stored in the nursing facility.Review of Resident #12's physician orders on 7/17/2025 indicated that Resident still had orders for both Tylenol PRN and Tramadol PRN for pain without a pain scale rating.In an interview with the Director of Nursing (DON) on 7/17/2025 at 11:05 AM the surveyor conveyed that Resident #12 had a pharmacist DRR report dated 3/15/2025 that indicated that there were two physician orders for different PRN pain medications (Tylenol and Tramadol), but neither physician order included the pain scale rating. The pharmacist recommended a clarification of these physician orders to include the pain scale rating that nurses would use to administer Tylenol PRN vs Tramadol PRN. The DON acknowledged the surveyor. Additionally, the surveyor conveyed to the DON that Resident #12 had another pharmacist DRR report dated 6/14/2025 that indicated that the pharmacist recommended that Tramadol PRN be discontinued as the medication had not been utilized in the last 60 days. The DON acknowledged the surveyor. During the interview the DON confirmed that both pharmacist DRR reports dated 3/15/2025 and 6/14/2025 had not been acted on by the physician for Resident #12. The DON provided the surveyor with a copy of the pharmacist DRR reports dated 3/15/2025 and 6/14/2025, but there was no response or signature from Resident #12's physician indicating whether he/she agreed or disagreed with the pharmacist recommendations. No additional information was provided by the facility at the time of exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and facility staff interview it was determined that the facility failed to 1) label/store drugs and biologicals appropriately and 2) properly secure medications. This finding was found to be evident during the review of medication administration and storage during the annual recertification survey.The findings include: 1) A Certified Medication Aide (CMA) is a healthcare professional who has completed additional training to administer medications in specific settings. They are responsible for ensuring Residents receive the correct medications at the right time and dosage, while also documenting the administration and reporting any adverse reactions or changes in Resident condition. CMAs complete a state-approved training program which included classroom instruction and practical experience in medication administration. After completing the training, CMAs must pass a certification exam. Senna Plus (sennosides-docusate sodium) is in the drug classification of a laxative. The medication is used for constipation and is administered by mouth usually at bedtime. On 7/16/2025 at 7:58 AM the surveyor observed the Certified Medication Aide (CMA) administer medications to Residents on the 300 unit of the facility. During this observation, it was revealed that the bottle of the medication Senna Plus (sennosides-docusate sodium) tablet 8.6-50 mg was not labeled with the date when the medication bottle was opened. The seal of the bottle was observed broken and the bottle was approximately ½ empty. In an interview with the CMA at 8:55 AM on 7/16/2025 the surveyor asked what the expectation was for dating bottles of medication when the bottles were opened. The CMA stated that the practice at the facility was that the medication bottles should be dated when the bottles were opened. The CMA proceeded to date the Senna Plus medication bottle. At 2:30 PM on 7/16/2025 the surveyor conveyed to the Regional Nurse Consultant (RNC) that during the observation of the CMA during medication administration on the 300 unit, that a bottle of Senna Plus which was opened and ½ empty was observed not labeled with a date. The RNC acknowledged the surveyor. Additionally, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the finding at time of exit. No additional information was provided by the facility. 2) During an observation on 7/16/25 at 6:17 AM a medication cart was found unlocked in the hallway between rooms [ROOM NUMBERS], each drawer was able to be opened. There were no staff near the cart or in the hallway containing the cart. During a continued observation on 7/16/25 at 6:21 AM GNA #17 was seen coming from the locked unit, Station 3, and he locked the medication cart as he walked by the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with GNA #17 on 7/16/25 at 6:21 AM he reported the nurse responsible for the medication cart was “on the other side assessing a patient” and he pointed towards the pair of secured doors for Station 3. During an observation on 7/16/24 at 6:23 AM inside the locked unit, Station 3, Registered Nurse (RN) #19) was found sitting in front of a computer at the nursing station. During an interview with RN #19 on 7/16/25 at 6:23 AM she reported the med carts are supposed to be locked when not in use and stated, “I left that one unlocked because I was going right back.” During an interview with the Director of Nursing (DON) on 07/16/2025 at 8:09 AM she reported the med cart should be locked when not in the nurse’s view and confirmed the medication cart found should’ve been locked. During a review of the Medication Management Program Policy on 7/21/25 at 1:26 PM it was revealed that the medication cart should be “Locked when not in use and in direct line of sight.”

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store and label food items to maintain the integrity of the specific items. This was evident during the initial tour of the kitchen. This deficient practice has the potential to affect all residents. The findings include: On 7/17/2025, at 8:21 AM, during an initial kitchen tour with the Dietary Manager, the surveyor observed three opened, unlabeled bags of bread on a steel cart located in the corner of the room. The Dietary Manager confirmed that opened bags of bread were expected to be labeled. Further observations in the kitchen revealed three 14-ounce containers of Beef flavored base that were unlabeled and located on a cart with other seasonings. According to the Dietary Manager, two of these containers actually held Chicken flavored base, which had been transferred from a 24-pound container stored in the cooler. The Dietary Manager acknowledged these concerns and stated that she would address them immediately. On 7/17/2025 at 4:09 PM, the Nursing Home Administrator (NHA) was made aware of these findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews it was determined that the facility failed to ensure timely and accurate documentation of medical records. This was found to be evident for 3 (#42, #2, #6, & #96) out of 5 residents reviewed for record documentation during the annual survey.The findings include: 1) During an interview with Resident #42 on 7/21/25 at 08:46 AM he/she reported often receiving medications late at night and stated medications were received “sometimes almost at midnight”. During a review of the Medication Administration Record (MAR) for Resident #42 on 7/22/25 at 6:32 AM it was discovered that there were medication documentations past 11 PM. The documentation in the MAR revealed the following medication administration notes. On 7/03/25 - The following medications were due at 9 PM: Xarelto, Trazadone, Tamsulosin, Simvastatin, Senna, Remeron, Pregabalin and Guaifenesin. The medications were signed off as complete at 11:44 PM with a note stating “Charted late, administered on time” by LPN #26. On 7/04/25 – The following medications were due at 9 PM: Xarelto, Trazadone, Tamsulosin, Simvastatin, Senna, Remeron, Pregabalin and Guaifenesin. The medication were signed off as complete at 11:17 PM with a note stating “Charted late, administered on time” by LPN #26 On 7/12/25 - The following medications were due at 9 PM: Xarelto, Trazadone, Tamsulosin, Simvastatin, Senna, Remeron, Pregabalin and Guaifenesin. The medications were signed off as complete at 11:43 PM with a note stating “Charted late, administered on time” by LPN #26. On 7/13/25 - The following medications were due at 9 PM: Xarelto, Trazadone, Tamsulosin, Simvastatin, Senna, Remeron, Pregabalin and Guaifenesin. The medications were signed off as complete at 11:49 PM with a note stating “Charted late, administered on time” by LPN #26. During an interview with the Director of Nursing (DON) on 07/22/2025 at 6:58 AM she reported medications are supposed to be administered within the timeframe of one hour before to one hour after the scheduled administration times. Nighttime medications are expected to be administered between 8PM and 10PM. She reported medications should be documented immediately after being administered. She reviewed the MAR of Resident #42 and agreed that the medications were not being documented at the time they were administered. Additional reviews of MAR’s were completed on Residents #2 and #6 which showed additional documentations of late charting for administered medications. 2) During a review of the Medication Administration Record (MAR) for Resident #2 on 7/22/25 at 7:06 AM it was discovered that there were late documentations. The documentation in the MAR revealed the following medication administration notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/03/25 - The following medications were due at 4:30 PM: Humalog Kwik Pen Insulin and Lantus Solostar Insulin. The medications were signed off as complete at 11:35 PM with a note stating “Charted late, administered on time” by LPN #26. The following medications were due at 9 PM: Tamsulosin, Potassium Chloride, Famotidine, Carvedilol and Atorvastatin. The medications were signed off as complete at 11:35 PM with a note stating “Charted late, administered on time” by LPN #26. 7/04/25 - The following medications were due at 4:30 PM: Humalog KwikPen Insulin and Lantus Solostar Insulin. The medications were signed off as complete at 11:06 PM with a note stating “Charted late, administered on time” by LPN #26. The following medications were due at 9 PM: Tamsulosin capsule, Potassium Chloride, Famotidine, Carvedilol and Atorvastatin. The medications were signed off as complete at 11:06 PM with a note stating “Charted late, administered on time” by LPN #26. 7/12/25 – The following medications were due at 4:30 PM: Humalog KwikPen Insulin and Lantus Solostar Insulin. The medications were signed off as complete at 11:37 PM with a note stating “Charted late, administered on time” by LPN #26. The following medications were due at 9 PM: Tamsulosin, Potassium Chloride, Famotidine, Carvedilol and Atorvastatin. The medications were signed off as complete at 11:37 PM with a note stating “Charted late, administered on time” by LPN #26. 7/13/25 – The following medications were due at 4:30 PM: Humalog KwikPen Insulin and Lantus Solostar Insulin. The medications signed off as complete at 11:44 PM with a note stating “Charted late, administered on time” by LPN #26 – The following medications were due at 9 PM Tamsulosin, Potassium Chloride, Famotidine, Carvedilol and Atorvastatin, The medications were signed off as complete at 11:44 PM with a note stating “Charted late, administered on time” by LPN #26. 3) During a review of the Medication Administration Record (MAR) for Resident #6 on 7/22/25 at 7:06 AM it was discovered that there were delayed documentations. The documentation in the MAR revealed the following medication administration notes. 7/15/25 - The following medication was due at 6 PM: Cephalexin and it was signed off as complete at 10:12 PM with a note stating, “Charted late, given on time” by LPN #27. 7/21/25 - The following medication was due at 6 PM: Cephalexin and it was signed off as complete at 8:46 PM with a note stating “Charted late, given on time” by LPN #26. During a review of the Medication Management Program Policy, it was discovered that “Medications are administered no more than one hour before to one hour after the designated medication pass time” and “Immediately after administering the medication to the Resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR.” 4) On 7/16/2025 at 8:41 AM, a review of Resident #96's medical records indicated that he/she was admitted on [DATE] and discharged to the hospital on 6/2/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/2025 at 10:39 AM, the Nursing Home Administrator (NHA) confirmed that only one progress note was written for Resident #96 between 6/1/25 and 6/2/25. On 7/16/2025 at 10:59 AM, the Director of Nursing also confirmed that there was no nursing note for Resident #96. Instead, a note dated 6/2/2025 for Resident #114 was provided. The DON explained that Resident #114 is the spouse of Resident #96 and initiated the transfer to the hospital. The DON acknowledged this as a concern, stating that the nurse should have documented in the right resident’s medical record. The Nurse’s note indicated that on 6/2/25 at 10:43 AM, Resident #114 called 911 for his/her spouse, whom he/she shared a room with. He/she stated that Resident #96 reportedly was in pain and was experiencing trouble breathing. The Nurse indicated that he/she assessed Resident #96’s vital signs which were normal. On 7/16/2025 at 1:15 PM, the Nursing Home Administrator (NHA) was informed of the concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure policies and procedures were followed to reduce the risk of infection. This was evident for 2 (Resident #6, #2) out of 4 residents reviewed for infection control procedures. The findings include: A dialysis catheter in the chest is a type of access used for hemodialysis, a treatment that filters waste and excess fluid from the blood when kidneys are not functioning properly. The catheter, a flexible tube, is inserted into a large vein in the neck or chest and is used to connect the patient's blood to the dialysis machine. The dialysis catheter is also known as a Central Line or a Central Venous Catheter. During an interview with Resident #6 on 7/15/25 at 9:43 AM he/she reported having wounds and a lot of problems with his/her right foot. He/she also stated it is infected to a degree. I'm supposedly on an antibiotic. Resident #6 also reported having a catheter in his/her right chest for dialysis. During an observation of the entryway to the room for Resident #6 on 7/15/25 at 3:28 PM it was discovered that there were no signs for Enhanced Barrier Precautions (EBP) and there were no infection control supplies located near the doorway of the room. During a review of medical records for Resident #6 on 7/16/25 at 11:31 AM, it was discovered that the Resident had a wound to his/her right foot. He/she was diagnosed with cellulitis on 7/14/25 and was currently taking an antibiotic for treatment. It was also discovered that the Resident had several wounds to the right foot prior to 7/14/25, a progress note dated 06/26/2025 reported wounds to the right heel, top of the right foot, two wounds to the side of the foot, three toes with wounds and a surgical amputation to the middle toe. Further review of the medical records for Resident #6 revealed that the Resident had a catheter in his/her right chest to be used for dialysis and there was no order for EBP to be followed. During an interview with the Infection Control Preventionist on 7/17/2025 at 9:17 AM she advised anyone with wounds, urinary catheters and dialysis catheters should be on EBP. She reported Resident #6 does have a dialysis catheter and a wound and he/she should be on EBP. During an additional record review on 7/17/25 at 10:32 AM it was discovered that Resident #6 now had an order for Enhanced Barrier Precautions placed on 7/17/25 at 9:21 AM. During an interview with the Director of Nursing (DON) on 7/17/25 at 11:04 AM she agreed that Resident #6 should have been on EBP and reported it had been corrected, the Resident now has EBP in effect. During a review of the Infection Prevention and Control Policies and Procedures: Transmission Based/Standard Precautions, and Enhanced Barrier Precautions Policy on 07/18/2025 at 6:25 AM it was discovered that EBP would be implemented for all residents with the following: wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator). The Policy continued with, The facility will post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE (gowns and gloves) and The Facility will provide gowns and gloves immediately outside of the resident's room. 2. A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. An indwelling urinary catheter is one that is left in the bladder. An indwelling catheter collects urine in a drainage bag. A Foley catheter is a type of indwelling urinary catheter. During a review of medical records for Resident #2 on 7/17/25 at 11:04 AM it was discovered that the resident had a urinary catheter in place and had a history of Urinary Tract Infections. During an observation of Resident #2 lying in bed on 7/18/25 at 6:45 AM it was discovered that his/her urinary catheter drainage bag was lying flat, face down on the floor.During an observation with the Director of Nursing (DON) on 7/18/25 at 07:02 AM she observed the urinary catheter drainage bag lying on the floor and reported the bag should not be on the floor, it should be hanging on the bed.During an interview with the DON on 7/18/25 at 9:32 AM she reported she had changed out the drainage bag for Resident #2. She also reported she had created education for staff titled infection control and the objectives were Foley catheter bag must have a cover over the urine, Foley catheter drainage bag must be clipped to bed or chair below the height of the bladder and Foley catheter bags cannot be on the floor. She also reported the Lippincott Nursing Procedures book is used as a resource when there is not a specific policy and there is one on each unit.CAUTI stands for Catheter-Associated Urinary Tract Infection. During a review on 7/18/25 at 10:46 AM of the Indwelling Urinary Catheter Care and Removal section from Lippincott Nursing Procedures 9th Edition provided by the DON it was discovered that when caring for the catheter collection bag, Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent CAUTI.