STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215128	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland, LLC	7920 Scotts Level Road Baltimore, MD 21208

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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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews, it was determined that the facility failed to provide a safe sanitary environment related to sewage water backup. This was found on 1 of 8 days of the survey.The Maryland Office of Health Care Quality (OHCQ) determined that concern met the Federal definition of Immediate Jeopardy and the facility was notified in writing of this determination at 3:25 PM on 7/15/25. The findings include:On 7/15/25 at 8:44 AM, at the entrance conference the Nursing Home Administrator (NHA) confirmed that the facility was having a problem with a drainage pipe and that they were dealing with a sewage issue.On 7/15/25 at 9:36 AM, the surveyor observed the kitchen. A pooling of sewer water was noted over a circular drain in the floor. Four other square drains throughout the kitchen were filled with liquid, 3 were noted with a brown color with a foul odor. One of the drains had a bleach smell as if it had just been cleaned.On 7/15/25 at 9:36 AM, the surveyor interviewed the kitchen manager. During the interview the Kitchen Manager stated that yesterday after lunch (7/14/25) the drain by the three-compartment sink started backing up and water started to accumulate in the kitchen. She further stated that the plan implemented was to continuously have the water evacuated by the floor cleaning machines. She stated that the backup was contained in this area and confirmed they continue to utilize the kitchen. On 7/15/25 at 10:32 AM, the surveyor observed the dishwashing area. The drain below the dishwasher was overflowing with discharged water from the dishwasher. The surveyor asked the kitchen staff if this was normal for the water not to drain. Kitchen staff #32 stated that sometimes when the drains are clogged the water accumulates but once the clog is removed it will drain again. The kitchen staff stated that the current blockage was affecting the draining of the discharged water from the dishwasher. The surveyor observed a portable rack to dry dishes parallel to the dishwasher and just behind the portable rack was another rack where clean dishes were placed to dry. The surveyor asked how the facility was ensuring that the backup and accumulated water from the drains were not contaminating clean surfaces used for food preparation. The kitchen manager stated that she now would be covering the clean dishes with plastic. The surveyor observed dishes on the lower rack were less than 6 inches off of the floor.The surveyor observed the utility hallway adjacent to the kitchen where it was noted that sewage was flowing from the drain. Fecal matter was next to the drain on the floor. The surveyor relayed the concern that sewage drainage was backing up from this drain and that a drain in the kitchen was also backing up, potentially containing the identified fecal matter.Also noted in the utility hallway were two mattresses on the floor in at least one inch of sewage water. A food storage room connected to the utility hallway was noted to have the carpet saturated by sewage water. All food items were up on shelves. On 7/15/25 at 10:48 AM, Regional Director of Operations Staff #1 stated that out of an abundance of precaution that they would be running the tray line out of the dining room, switch to plastic wear and terminally clean the kitchen.On 7/15/25 at 10:51 AM, the surveyor observed what was identified as sewage water by Staff #1 on the floor of the clean linen room. Laundry was circulating in the dryer and two staff members were folding laundry. During the observation Staff #3 stated that laundry was currently not being done in the building and that it was being sent out to be (continued on next page)

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

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

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	laundered. The surveyor asked about the laundry that was currently being dried and folded. The Nursing Home Administrator stated a few loads of laundry were brought back wet. On further observation, a closet-like area that contained two shelves of folded linen were noted with pooling water on the floor. The linen was not covered. Additionally, two carts in the clean laundry, in which the staff had just folded and placed laundry, were left uncovered and exposed to the sewer water on the floor. Staff #1 stated that all the linens would be re-washed and the room terminally cleaned after this was brought to his attention. On 7/15/25 at 11:21 AM, the surveyor observed a floor drain that had the cover removed in the hallway just outside room [ROOM NUMBER]. A foul odor was noted coming from the drain. The surveyor asked Environmental Service Staff EVS #8 is they could smell the odor. She stated she could. When asked how long the cover had been off EVS #8 Stated she was not aware. On further observation it was noted brown substance was being tracked down the hallway from the drain that was overflowing in the front entrance way and into the residential hallway.Interview on 7/15/25 at 2:20 PM with Maintenance Director staff #7 revealed that the concern was identified on Saturday 7/12/25 at 3:05 PM when he was contacted by the supervisor on duty that there was a backup in the kitchen where the water was not draining. A call was made to a plumbing company at that time and they were successful in clearing the identified clogged drains in the kitchen. On 7/14/25 the identified concerns from Saturday were found again, however, he stated that he came in at 9:00 AM to his assistant, Staff #6 trying to clear another drain in the front of the facility by the lobby. He further stated that at that time (7/14/25 at 9am) multiple drains were backing up throughout the facility including the laundry rooms.The facility provided a plan to remove the immediacy while the surveyors were onsite. The removal plan was accepted by the OHCQ at 8:15 PM on 7/15/25, after 2 initial plans were submitted at 6:09 PM and 7:23 PM, respectively. The plan included the assurance that a plumbing contractor unclogged the drain pipe and that the drain contents were no longer overflowing into the facility; All areas of the kitchen, laundry, to including clean linen room, and utility hallway, adjacent to the kitchen, have sewage water removed and the area sanitized; Any food items that had the potential to be contaminated were discarded and kitchen equipment that had the potential to be contaminated were sanitized; Linens in both clean and soiled that had the potential to be contaminated were re-washed. All floor drains that were open are now covered; And all current residents would be monitored for gastrointestinal symptoms for the next 72 hours.The facility plans for removal included the following: Education provided to the Environmental Staff, Kitchen Staff, and Maintenance Staff on infection control practices and cross contamination concern in regard to sewage exposure performed by the facility Educator and Nursing Supervisors. The education included training staff to pulse operations and immediately notify a supervisor to ensure a plan will be created and implemented to mitigate cross contamination. Education completed by 7/17/25. The Maintenance Director or Maintenance Assistant will snake line weekly to prevent drains from being clogged. A contracting plumbing vendor ran a camera to assess if there are further corrective actions needed to prevent drains from clogging. The reports will be reviewed for further action needed. Nursing Supervisors will perform rounds every shift for 2 weeks and then daily for 3 months to ensure drain lines are not overflowing. Any issue identified will immediately be communicated to the Maintenance Director and the Executive Director for appropriate actions. The Infection Control Coordinator or Food Service Director will observe the kitchen staff weekly for 3 months to ensure that there is no cross contamination of clean items. The Infection Control Coordinator or Environmental Service Director will observe laundry staff weekly for 3 months to ensure there is no cross contamination of clean linens. The results of the rounds and audits will be submitted to the Performance Improvement Committee for review and corrective action if needed. After determination of Immediate Jeopardy concerns, the Immediate Jeopardy was removed on 7/17/25 after validation that the plan had been implemented. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review, and interview it was determined that the facility failed to provide a Resident's Representative the right to be involved in the vaccination consent process. This was found evident in 1 (Resident #73) of 5 residents reviewed for vaccinations. The findings include: On 7/24/25 at 9:02 AM, the surveyor reviewed Resident #73's medical record. The review revealed an evaluation titled, Physician's Certification of Incapacity to Make an Informed Decision completed by two providers dated 7/21/22 and 8/4/22. Both providers indicated the Resident #73 was unable to make a rational evaluation of the burdens, risks, and benefits of the treatment, or course of treatment. On further review it was noted that Resident #73's spouse was indicated on the Surrogate Identification Form. The surveyor reviewed the consent forms for the administration of the influenza (flu) vaccinations. In the 2022 flu season a telephone consent was obtained and documented by Resident #73's spouse. However, in the 2023 flu season, the consent form indicated the Resident had given consent and the form had Resident #73's signature, even though he/she was unable to give consent per the physician's evaluations. On 7/24/25 at 9:30 AM, the surveyor conducted an interview with the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that Resident #73's spouse should have been contacted to give consent for the 2023 flu vaccination and not the Resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews it was determined that the facility failed to provide a resident with a reasonable accommodation of need. This was found evident during one random observation on the survey for Resident #77. The findings include: On 7/16/25 at 8:56 AM, the surveyor observed that Resident was laying in bed awake and noted that his/her food tray was on the over-the-bed table next to Resident #77's bed. Resident #77 stated that his/her bed stopped working yesterday evening and that he/she was unable to raise the head of the bed up to eat. Resident #77 stated the bed has been fixed before but occasionally stops working. Resident #77 stated that he/she was told to hold off on eating until he/she could be set upright to eat. On 7/16/25 at 8:08 AM, the surveyor interviewed Resident #77's Geriatric Nursing Assistant (GNA) #13. GNA #13 stated that she was aware the Resident #77's bed was not working and she informed her Unit Manager. She confirmed that she instructed the Resident to wait to eat because he/she needed to be upright for safety concerns. On 7/16/25 at 8:29 AM, the surveyor conducted a follow up interview the GNA #13. She stated the plan was to get Resident #77 up to a chair for breakfast and that she was going to find another staff member to help. The surveyor observed Resident #77 still laying in bed and food not eaten. On 7/16/25 at 8:35 AM, the surveyor observed Resident #77 up in a wheelchair being wheeled into the activities room where his/her food was delivered after being re-heated. On 7/16/25 at 1:32 PM, the surveyor conducted an interview with the Regional Clinical Director of Operations Staff #5. During the interview the surveyor informed Staff #5 of the observation where Resident #77 had to wait over 35 minutes to eat his/her breakfast due to the controls on the bed not working from the night before.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on review of facility investigation, resident medical records, and interviews, it was determined that the facility failed to ensure that a resident remained free from abuse. This was true for 1 (Residents #2) of 16 residents reviewed for abuse during the annual re-certification survey. The findings include:Nursing Practice Act: 10.27.19.02:D. A nurse may not engage in sexual misconduct. Sexual misconduct includes but is not limited to: (3) Solicitation of a sexual relationship, whether consensual or nonconsensual, with a client.On 7/16/2025 at 8:15 AM the facility reported incident (FRI) was reviewed. Staff #37, GNA (Geriatric Nursing Assistant) and Staff #38, RN (Registered Nurse) walked into the room on 10/6/2024 on evening shift and witnessed Staff#39, GNA touching Resident #2 in their vaginal area and kissing Resident #2's breast. Later the Administrator interviewed Staff #39, the GNA accused of the allegations. Staff #39, GNA stated that they cleaned Resident #2, and the Resident asked them to put barrier cream on their virginal area due to itching, which they did. Staff #39 also denied kissing Resident #2's breast. Staff # 39 did admit to giving Resident #2 a kiss on the lips.On 7/16/2025 at 9:29 AM, Resident #2 was interviewed about the October 2024 incident with Staff #39, GNA. Resident #2 stated that they initiated physical contact and consented to everything, specifically asking Staff #39 to apply cream to their vagina. Resident #2 denied Staff #39 kissing her breast but admitted Staff #39 kissed her on the lips.On 7/18/2025 at 8:30 AM, the facility policy was reviewed. The policy states, Employees shall not become romantically or sexually involved with a resident or a co-worker with whom he/she is in a supervisory position. Further record review revealed that Staff #39 was terminated on 10/11/2024 for violating the company's Standard of Conduct Policy.On 7/18/2025 at 10:05 AM the Administrator was asked about the FRI between Resident #2 and Staff #39. The Administrator recalled that Staff #39 was accused of inappropriate touching Resident #2, which Staff #39 denied, but admitted to kissing Resident #2 on the lips.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on medical record review, interview and policy review it was determined that the facility failed to acquire and document the appropriate consents and procedures prior to the implementation of a restraint. This was evident during the review of 1 of 3 residents (R-165) reviewed for restraints. The findings include:Review of the medical record for Resident #165 on 7/22/25 at 12:06 PM revealed this resident was admitted to the facility for rehabilitation post-acute hospital stay where a gastrostomy tube was placed secondary to the resident developing dysphasia (difficulty swallowing) after a stroke. An abdominal binder was placed on resident as well as a care plan was developed on 9/13/23. However, further record review revealed that the abdominal binder was placed on Resident #165 as early as 9/1/23.Further review of the consents form 'Physical restraint/Siderail consent Form' for the use of restraints revealed that consent for the use of the abdominal binder was not acquired from the family until 9/18/23. Additionally, according to the consent, the facility is to document what treatment /symptom the restraint device is being placed for and the healthcare provider that ordered the device. The potential benefits and risks are to be reviewed and identified prior to the implementation of the restraint as well. Regarding this abdominal binder, the medical condition, alternatives attempted and the potential risks and benefits were not identified related to Resident #165. Registered Nurse (RN), Unit Manager (UM) #43, was interviewed with the Director of Nursing (DON) on 7/23/25 at 10:54 AM. She was asked about the consent, the care plans and specifically Resident #165. She acknowledged at that time that the consent was not completed timely and that it was not filled out appropriately. The concern that a restraint was placed without the proper documentation and evaluations was reviewed at this time with the facility DON.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews it was determined the facility staff failed to conduct a thorough investigation for an incident of abuse. This was evident for 1 (#176) resident reviewed for 1 of 16 reports of abuse.The findings include:A facility reported incident of resident-to-resident abuse was reviewed on 7/17/25 at 12:31 PM.The report revealed that on 3/12/23 at 11:00 PM Resident #176 assaulted Resident #175. The facility Executive Director (ED) reported the incident and investigated. The investigation consisted of interviews that the ED conducted with staff.Staff #29 the Housekeeping Supervisor indicated she overheard screaming from a resident's room. She went to the room and observed Resident #175 who was standing next to the bed, struck Resident 176, who was lying in the bed. She sent Resident #175 out of the room, 2 nurses came to the room, and she informed them of what she observed. They walked Resident #175 to his/her room down the hall. The 2 nurses were not identified by Staff #29. -There were no interviews/statements from Staff #22 the RN (Registered Nurse) who was assigned to both residents at the time of the incident.-There was no statement from Staff #23 the nursing shift supervisor, to whom the incident was immediately reported as indicated on the incident investigation form.-Staff #33 the Geriatric Nursing Assistant (GNA) who was assigned to provide care to Resident #176 indicated only that she did not witness the incident.-Staff #36 the GNA who was assigned to provide care to Resident #175 indicated only that she did not witness the incident.-5 other staff working at the time of the incident all indicated only that they did not witness the incident. The investigation did not attempt to identify how the incident occurred including who last saw Resident #176, what s/he was doing, where s/he was, his/her behavior and mood, any warning signs or staff interaction with him/her and his/her response. The 2 nurses Staff #29 indicated came to the room and escorted Resident #176 to his/her room, were not identified and did not provide statements as to any pre or post incident behaviors and interventions they implemented including the residents' responses. In an interview on 7/18/25 at 9:43 AM Staff #29 was not able to recall the incident. She was reminded of the date and time of day and was provided with her interview witness statement but was still unable to recall the incident. Staff #23 was interviewed on 7/21/25 at 7:30 AM. She was provided with the residents' names, the date and time of the incident and a brief description of the events and asked to explain what had occurred that night. She shook her head and indicated that she did not remember the incident, nor the residents involved. She was asked what she would do as a supervisor, if a resident-to-resident assault occurred. She indicated that she would separate the residents, move one to another unit if possible, try to determine if 1:1 supervision is needed and call the Director of Nursing to report the incident. Staff #22 was interviewed on 7/21/25 at 3:32 PM. She recalled the incident but was unable to recall when asked if Resident #176 wandered much on the unit. She did remember she called the supervisor and the resident's family. When asked if she could recall when or where Resident #176 was seen by staff prior to the incident she stated, That's a long time ago, I'm not sure. When asked if she knew who walked with Resident #176 back to his/her room she indicated she wasn't sure, it could have been her and a GNA. On 7/21/25 at 4:03 PM - Interview with Staff #5 a Regional Director of Clinical Operations was asked if the facility conducted an RCA (Root Cause Analysis) regarding the incident. He was made aware that the surveyor was unable to find any documentation indicating what Resident #176 was doing prior to the incident - that there was no behavior documentation for night shift, and evening shift indicated no behaviors. It was unknown if the resident was wandering, or was asleep, or the circumstances leading up to the incident. He indicated that he was aware of that and that unfortunately there was no RCA conducted. In an interview on 7/23/25 at 9:42 AM the ED was made aware of the above concerns.Cross reference F 842.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, it was determined the facility failed to 1) notify the Ombudsman of resident's transfers, 2) provide the Resident and/or Representative with a written notice of the facility's bed hold policy upon transfer. This was found evident of 2 (Resident #10 & #141) of 4 residents reviewed for hospitalization 3. Failed to provide the resident/family/RP with discharge instructions. (#161) This was evident for 1 of 3 discharge records reviewed during the survey. The findings include: 1a) On 7/16/25 at 9:29 AM, the surveyor reviewed Resident #10’s medical record. The review revealed that Resident #10 was sent to the hospital on 4/25/25 and returned to the facility on 5/2/25. On 7/21/25 at 1:18 PM, the surveyor requested documentation to demonstrate that the Ombudsman was made aware of the hospitalization. On 7/21/25 at 1:42 PM, the surveyor conducted an interview with the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that during that time period no one at the facility was providing notices to the Ombudsman of transfers and discharges. 1b) On 7/22/25 at 7:03 AM, the surveyor reviewed Resident #141’s medical record. The review revealed that Resident #141 was hospitalized on [DATE]. On 7/22/25 at 7:56 AM, the surveyor requested documentation to demonstrate that the Ombudsman was made aware of the hospitalization. On 7/22/25 at 8:45 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that during that time period no one at the facility was providing notices to the Ombudsman of transfers and discharges. 2a) On 7/16/25 at 9:29 AM, the surveyor reviewed Resident #10’s medical record. The review revealed that Resident #10 was sent to the hospital on 4/25/25 and returned to the facility on 5/2/25. On 7/21/25 at 1:18 PM, the surveyor requested documentation to demonstrate that the Bed Hold policy was given to Resident #10’s Responsible Party (RP). On 7/21/25 at 1:46 PM, the Regional Clinical Director of Operations Staff #5 stated he was unable to find documentation that the written notice was sent to Resident #10’s Responsible Party (RP). 2b) On 7/22/25 at 7:03 AM, the surveyor reviewed Resident #141’s medical record. The review revealed that Resident #141 was hospitalized on [DATE]. On 7/22/25 at 7:56 AM, the surveyor requested documentation to demonstrate that that the Bed hold policy was given to Resident #141’s Responsible Party (RP). On 7/22/25 at 8:45 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 stated that he found documentation that stated the bed hold policy sent with the Resident to the hospital. Staff #5 was not able to provide evidence that a written notice was given to Resident #141’s RP. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Next the survey reviewed the facility’s bed hold policy. The policy states, The resident and his/her surrogate decision-maker or court appointed legal representative will be provide written and/or verbal information regarding the bed-hold policy at the facility: Upon admission, At the time of transfer to the hospital, at the time of any therapeutic leave and if the bed-hold regulation were to change. 3. During the review of Resident #161’s medical record on 7/21/25 at 8:28 AM discharge planning revealed that there was no documentation of what was provided to the family/resident/representative (RP) at the time of discharge regarding planning, preparation and medications. Resident #161 was being discharged from the facility after rehabilitation from deconditioning and medication management after a kidney transplant. On 7/21/25 this surveyor requested any discharge planning and paperwork that was provided to the family/resident at discharge. On 7/22/25 at 6:42 AM the Regional Clinical Director notified this surveyor that there was no discharge paperwork in the record. The concern was reviewed with him at this time that there was no discharge planning and directions provided to the family of a resident with complex diagnosis' including gastrostomy tube feeding, wound care and anti-rejection medications needed for kidney transplant.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, it was determined that the facility failed to develop/revise a comprehensive person-centered care plan specifically including measurable objectives-ideal healthy weight and timeframes to meet residents' significant weigh change concern. This was evident for 1 (Resident #64) out of 132 residents reviewed for care plan development to meet medical and psychosocial needs during an annual survey.The findings include: During a rounding on 07/15/2025 at 9:45 AM, Resident #64 stated I like to lose some weight. Observed the resident was wearing oversize clothes and seemed too small. Interview, on 7/16/25 at 1:50 pm, Resident #64 revealed that she came back from an emergency room visit due to a mental melt-down episode; feeling depressed and wanted to kill herself. The resident stated that I felt bad and looked at me I can not do anything for myself but getting big.Record Review, on 07/18/2025 at 11:00 AM, of Resident #64's record indicated 8/23/2024 the resident was admitted to this facility with diagnoses of mitochondrial metabolism disorders, seizures disorder, anxiety and depression disorders. The admission weight record showed 205lbs then her weight was sharply gained to 229lbs by November 2024. From the last weight measured 6/22/25 it increased to 257.3lbs/ BMI 41 as severe obesity.Mitochondrial Metabolism Disorders -A group of conditions that affect how mitochondria work in one's body. Mitochondria make energy in cells. When mitochondria can't produce enough energy that the body needs, it affects how a person's organs function. Specific Health Risks:Neurological: Developmental delays, seizures, encephalopathy, cognitive decline, and stroke-like episodes (MELAS). Metabolic: Lactic acidosis, diabetes mellitus, and other metabolic disturbances. Musculoskeletal: Muscle weakness, hypotonia, and exercise intolerance. Cardiovascular: Cardiomyopathy and arrhythmias. Organ Failure: Liver, kidney, and gastrointestinal dysfunction. Vision and Hearing: Impairment of vision and hearing. *Growth: Stunted growth and poor weight gain. Increased Risk of Infections: Some mitochondrial disorders can weaken the immune system, increasing susceptibility to infections. Medication Sensitivity: Individuals with mitochondrial disorders may be more susceptible to adverse effects from certain medications, including some antibiotics and drugs that affect mitochondrial function. Body Mass Index (BMI) is a calculation used to estimate body fat percentage and assess weight status. Healthy Weight: BMI between 18.5 and 24.9.Overweight: BMI between 25 and 29.9.Obesity: BMI of 30 or higher.Obesity is further classified into:Class 1: BMI 30 to 34.9.Class 2: BMI 35 to 39.9.Class 3 (Severe Obesity): BMI 40 or higher. Further record review found that Nutrition/Dietary Staff #17 noted on 1/31/2025 that the diet order as regular texture diet; finding 12.1% unhealthy weight gain since 8/2/2024 as clinically significant weight gained. At that time care planned to avoid significant weight change through the next review period. On 3/24/25 Staff #17 had a discussion with the family which they agreed to limiting concentrated sweets (cakes, cookies, pie, soda, juice) and starchy. Again on 4/30/2025 [NAME] Staff #16 documented that weigh gain 11.2% in the last 180 days and no specific weight control plans.The initial care plan was ineffective as Resident #64 continued to gain weight and no specific measurable care plan was developed.Observation of dining, on 07/18/2025 at 12:16 PM, Resident #64 was finishing a 2 layers cake and had a cup of juice from her tray. Interview, on 07/18/2025 at 2:35 PM, Staff #17 stated that she recognized the significant weight gained and obtained family support to limited sweets. She could not explain no other assessment or weight control was done. Additionally, Staff #16 documented 11.2 % weight gain in 180 days, no specific assessment or weight control was done. Both confirmed that they did not report to the physician nor revised a personal centered care plan to address the concern that was devesting Resident #64. Further interview, with Educator Staff #27 who stated that any greater than 5% weight change would trigger a significant condition change in the system and it had to report it to the medical staff and prompt the interdisciplinary team to revise the care plan to promote residents' weight control and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well-being. During an interview, on 07/18/2025 at 4:33 PM, the administrator was made aware of the above findings, and he was expecting that the facility staff to follow-through to meet Resident #64's weight control & psychosocial needs instead of allowing significant weight gain.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to follow the facility's standard of oxygen care consistently. This was found evident of 1 out of (Resident #12) residents reviewed for respiratory care during an annual survey.Observation, on 07/15/2025 at 3:04 PM, Resident #12 was found on 2 liters of oxygen with nasal cannula in use and there was no label on the humidifier water bottle nor the oxygen nasal cannula tubing with a change date/time.Nasal cannula- a tubbing used to provide supplemental oxygen.Record review, on 07/16/2025 at 1:08 PM, of this resident's record indicated 1/18/25 the resident was admitted to this facility after a complicated hospitalization with diagnoses of new seizure disorder, heart attack, hypoxia, dysphagia and post medical diagnoses: intellectual disability, end of renal disease on hemodialysis MWF. The admission oxygen order was continuing oxygen 2-liter nasal canula and check every shift. Further review Futurecare Nursing Practice Manual/ Respirator Therapy of Oxygen Equipment Changing Schedule under procedure 2.- Replace equipment with newly labeled equipment displaying the date, time and the nurse's initials.Observation, on 07/22/2025 at 12:40 PM, Resident #12 resting in bed noted to have oxygen being delivered via nasal cannula, however, the oxygen nasal canula tubing was not labeled with a change date/time. Interview, on 07/23/2025 at 09:53 AM, Nursing Staff #18 reported that every time the oxygen tubing and oxygen humidifier pre-filled with sterile water change, both should have labeled. During the interview, on 07/23/2025 at 10:02 PM, met Unit Manager #19 at this resident's bedside, she witnessed and agreed that the oxygen tubing should have labeled the change date/time and the nurse's initials. The [NAME] Clinical Nurse Staff #5 was made aware of the above findings as a deficiency practice concern.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on the review of a complaint, medical record review and interview with facility staff, it was determined that the attending physician failed to review the full program of care at each visit, ensuring the medication ordered and documented in the progress notes were accurate. This was evident for 1 of 3 residents (161) reviewed for physician services. The findings include:Review on 7/21/25 at 8:28 AM revealed that Resident #161 was initially admitted to the facility for rehabilitation post hospitalization and needed medication management. Resident #161 was admitted on Cellcept and Tacrolimus, they are immunosuppressant medications used in organ transplant recipients to prevent rejection. Secondary to abnormal labs, Resident #161 was sent to the hospital on 7/8/24. On 7/18/24, Resident #161 was re-admitted to the facility. However, the record review revealed that although Attending staff #20 wrote in his notes that Resident #161 was receiving the Tacrolimus on readmission, the medication was never reordered and therefore, Resident #161, did not receive the medication from readmission to discharge.Interview on 7/21/25 at 11:20 AM with attending staff #20 regarding his progress notes addressing the medication and the physician orders. Physician Staff #20 stated that ?yes' Resident #161 should have been on the medication at readmission, and it was missed on the readmission orders. These findings were reviewed with the facility NHA, DON and Regional Clinical Director throughout the survey and again on 7/24/25.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication without adequate monitoring. This was evident for 1 (Resident #14) of 5 Residents reviewed for unnecessary medications.The findings include:On 7/21/25 at 8 AM, the surveyor reviewed Resident #14's medical record. The review revealed that Resident #14 had three cardiovascular medications ordered in which administration instructions were based off of Resident #14's blood pressure and/or heart rate. The medication instructions were as follows:Amlodipine Besylate 10 mg, give one tablet by mouth one time a day for hypertension (high blood pressure), hold for systolic blood pressure (SBP) less than 110.Metoprolol Succinate Extended Release (ER) 25 mg, give one tablet by mouth one time per day for chronic heart failure (CHF), hold for heart rate less than 60.Hydralazine HCL 25mg give one table by mouth two times a day for hypertension, hold for blood pressure less than 110 or heart rate less than 60. Next the surveyor reviewed Resident #14's blood pressure and heart rate (pulse) documentation for the month of July.7/5/25- BP 163/80 HR 83 at 3:46 PM7/10/25- BP 130/67 HR 88 at 8:54 AM7/11/25 BP 126/64 HR 77 at 10AM7/11/25 BP 128/64 HR 74 at 8:07 PM7/19/25 BP 134/66 HR78 at 10:13 AM7/20/25 BP 112/58 HR 97 at 10:29 [NAME] 7/21/25 at 8:59 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the blood pressure and heart rates along with the cardiovascular medications. The DON stated that Resident #14 had an order for vitals (to include BP and HR) to be taken monthly. When asked if the blood pressure and heart rate are not taken prior to the administration of medications how would the staff know if they should administer per instructions. The DON explained that if there are parameters, then the PB and HR should be taken and when the order is written with parameters then there is an extra box that is checked to allow staff to enter the vitals. He further stated that if they are not marked on the Medication Administration Record (MAR) or vital sign documentation then the next place to look would be in the progress notes.The surveyor reviewed the July MAR with the DON. The review revealed that the medications were given 7 days in a row, from 7/12/25-7/18/25, without BP or HR documented in the medical record. The DON stated that any vitals taken to evaluate if the medications should have been given should have been documented at the time of administration.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review, it was determined that the facility's staff failed to track proper diet orders, to process the repeat insufficient proportion requests from residents and to honor residents' right to meet personal dietary proportion needs. This was evident for 1 (Resident #12) out of 2 residents reviewed for food during an annual survey.The findings include:Observation, on 07/15/2025 at 1:30 PM, Resident #12 finished everything on the lunch tray and yelled, I'm hungry and they did not bring enough food, Geriatric Nursing Assistant Staff #34 in the hallway stated that she notified the kitchen for additional food which it has been on-going for a while.Observation, on 07/16/2025 at 8:30 AM, this resident's main dish consisted of 3 parts of thin watery pureed food on a plate. Overheard this resident yelling out later, I'm hungry and need food. Observed the breakfast tray meal was completely finished by this resident. Record review, on 07/16/2025 at 01:08 PM, of this resident's record indicated that on 01/18/25 the resident was admitted to this facility after a complicated hospitalization with new diagnoses of seizure disorder, heart attack, hypoxia, dysphagia and post medical history included intellectual disability, end of renal disease on hemodialysis MWF. The admission diet order was pureed renal texture which was new to this resident at that time. The nutritional assessment was completed on 1/25/2025 and indicated that this resident's weight was 160.6 lbs; had 9.2% weight loss compared prior to hospitalization.Record review, on 07/17/2025 at 10:00 AM, of Resident #12's weight log: 01/23/2025 was167.42 lbs. then on 06/09/2025 was 163.79 lbs. The large portion meal and Renal product drink & before sleep snack were ordered on 04/29/25 and they were discontinued on 06/05/25 when this resident was hospitalized . After this surveyor's interventions, the large portion meal was finally re-ordered on 07/17/25 but not the Renal product drink and before sleep snack.(R) Renal product is a nutritionally complete and calorically dense formula that provides protein, vitamins and minerals specifically to meet the needs of people with chronic kidney disease (CKD) on dialysis, acute kidney injury (AKI), fluid restrictions due to CKD or AKI, or electrolyte restrictions.Interview, on 07/17/2025 at 10:22 AM, Dietitian Staff #17 stated that Resident #12 was not eating for a while, and she was not aware of the resident's complaints about the insufficient proportion of meal nor knowing that the large portions ordered was discontinued on 06/05/2025. Further interview with nursing Staff #18 who stated this resident was always hungry and asked for more food every meal since the resident was re-admitted on [DATE].On 07/17/2025 at 11:49 PM, an interview with the Regional Clinical Director of Operations, Staff #5, occurred. The discussion regarded the above findings which the facility's staff failed to track the resident's proper dietary orders. The inability to process the repeated insufficient proportions requested from the resident failed to honor the residents' right to meet their personal dietary needs.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on medical record, review of a complaint, and interview of facility staff, it was determined that the facility's Medical Director failed to ensure adequate implementation of resident care intervention and/or policy review. This was found evident for 1 (Resident #98) of 1 resident reviewed for insulin use. The findings include: On 7/16/25 at 12:32 PM, the surveyor interviewed Resident #98. During the interview Resident #98 described that when he/she was admitted to the facility he/she was prescribed a glucose monitoring device that was utilized to monitor blood glucose levels without the use of a finger stick. Resident #98 stated he/she was very happy with the use of the device but shortly after the device was ordered it was discontinued. On 7/23/25 at 11:35 AM, the surveyor reviewed Resident #98's medical record. The review revealed an order was placed for 3/27/24 for Resident 98 to have a continuous glucose monitoring device. On further review, Nurse Practitioner (NP) #42 documented, on 4/6/24 in a progress note, that the patient was seen for a follow-up. Patient and patient's daughter are upset that they cannot use the continuous glucose monitoring and now will need to utilize finger sticks. Resident #98 reports a lot of pain in his/her fingertips. On 7/24/25 at 6:06 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview the surveyor requested the facility's policy for continuous glucose monitoring devices. Staff #5 stated that the facility did not have a policy for the use of this device because it is typically utilized in home settings where patients can self manage the device. Staff #5 confirmed that Nurse Practitioner (NP) #42 wrote the order for Resident #98 to have the device due to the request of the family and that Resident #98 utilized the device for approximately 2.5 days. Staff #5 stated that the previous Director of Nursing (DON) did not request clinical oversight from the Regional Clinical Staff and the device was removed when it was made known to Regional Clinical Staff it sues. Staff #5 further stated that the Medical Director spoke to the provider and informed her the device could not be utilized in the building. The Surveyor asked Staff #5 for the education that was provided by the Medical Director. Staff #5 confirmed that the education was non-formal and there was no documentation. There was also no documentation that any education was provided to other providers. The surveyor reviewed the concern that the facility still did not have a policy or procedure written in regard to the use or non-use of continuous glucose monitoring devices and that there was no formal education to providers after the Medical Director was aware the device was implanted within the facility without a policy or procedure for use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interview with staff it was determined the facility staff failed to maintain complete and accurately documented medical records by:1) Failing to document the disposition of a discharged residents personal property. This was evident for 1 (#163) of 1 resident reviewed for Misappropriation of Property. 2) Failing to document resident behavior. This was evident for 1 (#176) resident reviewed for 1 of 16 abuse reports reviewed. The findings include:1) Resident #163's medical record was reviewed on 7/15/25 at 11:55 AM due to complaints which included but were not limited to an allegation that the resident's wheelchair was stolen and was replaced by the facility with a broken chair. The resident was admitted to the facility from an acute care hospital in Maryland. According to the hospital Discharge summary dated [DATE], he/she had resided in a Long Term Care facility in another state prior to the hospitalization. During an interview on 7/16/25 at 12:20 PM Staff #10 the Rehabilitation Supervisor was asked if Resident #163 came to the facility with his/her own wheelchair or if one was provided for his/her use while here. He indicated that rehab staff assess all new admissions to determine if and what type of assistive device the resident would need. He was unsure if Resident #163 came with their own wheelchair, but he would look into it.He returned at 1:30 PM and indicated that the resident likely did not come with a wheelchair and one was likely provided by the facility for his/her use.He also indicated that at some point the resident's wheelchair went missing and was replaced, that the resident did not like the replacement, and it was again replaced with a new wheelchair. He was unable to confirm if Resident #163 personally owned these wheelchair(s) or if they were owned by the facility. Review of Resident #163's medical record at approximately 1:45 PM revealed a Rehabilitation Treatment Encounter note was written on 12/3/24 regarding a replacement wheelchair. The note did not indicate if the wheelchair replaced a chair owned by the resident or the facility. Resident #163's census record revealed the resident was discharged from the facility on the same date the note was written. Further review of Resident #163's medical record on 7/16/25 at 1:45 PM revealed a personal inventory list dated 1/12/24 which included numerous clothing and personal items. Wheelchair was listed in the Acquired After Admission column and was dated 2/23/24. The inventory list was signed by Resident #163 and a staff member.Staff #5 a Regional Clinical Director of Operations was interviewed on 1/17/25 at 7:52 AM. He indicated that the wheelchair reflected in the Rehabilitation note on 12/3/24 was likely a facility wheelchair, that the resident was transferred to the hospital on [DATE] and a wheelchair would not have gone with him/her.He was made aware and confirmed that Resident #163's Inventory of Personal Items included but was not limited to a wheelchair which reflected the resident had their own personal wheelchair and that the inventory did not reflect the disposition of the resident's belongings when he/she was discharged from the facility.He indicated that he assumed someone came and picked up the resident's belongings after discharge but was not able to find documentation in the record of the disposition of Resident #163's personal items including the wheelchair, who the belongings were released to or when they were released. 2) A complaint and facility reported incident of a resident-to-resident abuse was reviewed on 7/17/25 at 12:31 PM.The report revealed that on 3/12/23 at 11:00 PM, during the change of shift from evening to night staff, Resident #176 went into Resident #175's room and struck Resident #175 who was lying in bed.Review of Resident #176's medical record on 7/18/25 at 10:47 AM revealed physician orders for Behavior Monitoring for: scratching and kicking, wandering on the unit, intermittent pacing, hitting/punching, and refusal of care.Resident #176's March 2023 Behavior Record revealed spaces for staff to document incidents of the resident Hitting/punching, Intermittent pacing, Kicking, Refusal of Care, Scratching, and wandering on the unit.In the spaces provided for 3/12/23 evening shift (3:00 PM - 11:00 PM) all behaviors were documented as 0 - the behavior did not occur, except for wandering which was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blank.In the record for 3/12/23 night shift (11:00 PM - 7:00 AM) the spaces were blank - there was no documentation for any of the behavior monitoring areas. Staff #23 a nursing shift supervisor was interviewed on 7/21/25 at 7:30 AM. She was asked to explain what had occurred that night. She shook her head and indicated that she did not remember the incident, nor the residents involved. Staff #22 the RN (Registered Nurse) caring for both residents was interviewed on 7/21/25 at 3:32 PM. She recalled the incident but was unable to recall where Resident #175 was prior to the incident or if Resident #176 wandered much on the unit. On 7/21/25 4:03 PM an interview was conducted with Staff #5 a Regional Director of Clinical Operations. He was made aware that there was no behavior documentation for night shift, and evening shift indicated no behaviors. He confirmed that he was aware. In an interview on 7/23/25 at 9:42 AM the ED (Executive Director) indicated if he recalled correctly, Resident #176 had been wandering in the hallway. He returned a few minutes later and indicated that the incident occurred out of the blue and Resident #176 was not wandering and didn't have any prior behaviors. He was made aware of the above concerns at that time. Cross Reference F 610.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, and interviews, it was determined that the facility failed to maintain practices to help prevent the transmission of infections. This was found evident on 2 out of 3 observations of the laundry area. The findings include: On 7/15/25 at 10:51 AM, the surveyor observed the clean laundry room. The door to a linen closet was opened and linens were not covered. Additionally, two carts in the clean laundry room, in which the staff had just folded and placed laundry, were left uncovered and exposed to the sewer water on the floor. Staff #1 stated that all the linens would be re-washed and the room terminally cleaned after this was brought to his attention. On 7/18/25 at 10:51 AM, the surveyor again observed the door to a linen closet was opened and linens were not covered. The surveyor interviewed the Laundry Staff #40. Staff #40 stated that currently the clean laundry bin in the closet was prohibiting the door from closing but that she would be folding them next and after the bin was removed the the door would be closed. Next the surveyor went into the hallway where a mobile laundry cart was located. The linen was exposed, and the cover was draped over the top of the cart. Staff #40 stated that the linen cart should be covered but sometimes staff come down to get linen and forget to cover the linens after obtaining their supplies.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Number of residents sampled: Number of residents cited: Based on record review, and interview it was determined that the facility failed to document the rationale for non-administration of the influenza and pneumococcal immunization. This was found evident of 1 (Resident #66) of 5 residents reviewed for vaccinations during an annual survey. Influenza (flu) immunizations are usually offered during the flu season, which is considered October 1 through March 31 annually. The findings include: On 7/22/25 at 1:50 PM, the surveyor reviewed Resident #66's medical record. The review revealed that Resident #66 refused all vaccinations offered to him/her on 4/4/25. On Resident #66's influenza vaccination form it was documented that Resident #66 declined to have the influenza vaccination administered. Further on the form no rationale was given for the refusal even though the form asks for the reason to be indicated. The form was signed by the resident, indicating it was offered, and did not state that the refusal was due to the recently ending flu season. On further review the pneumococcal conjugate vaccine (PCV 20) form indicated that Resident #66 declined the vaccination. Again, no rationale for the refusal was provided even though the form asks for the reason. On 7/22/25 at 2:19 PM, the surveyor conducted an interview with the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that the rationale for refusal should be documented in the Resident's medical record.