STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215129	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Parkville	8710 Emge Road Baltimore, MD 21234

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and staff interviews it was determined that the facility failed to maintain infection control practices in the laundry room. This was evident during the recertification/complaint survey.The findings include:On 7/24/25 at 9:30 AM an inspection of the laundry room was conducted by the surveyor to ensure compliance with infection control. In a pile on the folding table were resident clean linen in various stages of folding and packaging. Also noted on top of the folding table were:2 cups of ice water in 12 oz plastic water cups1 super Sani Disinfectant wipe #21 Super Sani Disinfectant wipe #41 8 oz bye-bye odor spray1 8oz Aloe soft lotion (Geri-Geri)I pkt of wash clothIn an interview with Staff #19 a laundry assistant on 7/24/25 at 9:50 AM , she was asked to explain the laundry process from collection to delivery to residents, She stated that she picks up laundry in the morning from the nursing units, sorts the dirty laundry with PPE in the dirty area, and loads them in the wash. Once the wash is done, she brings them to the clean side where they are dried and then to the clean folding table for folding and packaging to return to residents. She was asked if she got training on infection prevention control on hire and she said she did. She was asked if the above supplies should be on the clean table with the residents clean laundry and she said it should not. On 7/24/25 at 9:57 AM, the Environmental Services manager (EVS) was called in and was shown the supplies on the clean folding table and asked if the cleaning supplies and ice water should be on the folding table. She acknowledged that they should not, she was made aware that this was a concern.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interviews, it was determined that the facility failed to ensure that a resident's room was clean, comfortable and homelike. This was evident for 1 of 2 nursing units reviewed during the recertification/complaint survey.The findings include: On 7/16/25 at 9:20 AM during the initial tour of the building, the surveyor walked into Resident #106's room and perceived an overwhelming strong smell of urine. The pungent smell seemed to be coming from all over the room including the bathroom. Inside the room, at the bedside was a commode less than one quarter full of urine, it was uncovered. Also observed was a vent by the bedroom window, it had a brown rusty color all over it. The resident was lying in bed watching TV, their clothing and bedding did not look or feel wet. The surveyor tried talking to the resident, but their speech was impaired, and the resident was difficult to understand. The surveyor asked for the nurse to come to the resident's room. Staff # 7, a licensed Practical Nurse (LPN) came in and was asked about the strong urine odor, he said he was not sure where it was coming from and proceeded to empty the bedside commode.On 7/17/2025 at 2:20 PM in an Interview with Staff #4 the maintenance director, He was asked about the rusty colored vent in Resident #106's room including the foul smell of urine. He said that he had fixed the vent before, had it all cleaned up and painted. That it all came back because the resident pees on it and caused it to rust again. That he will probably need to replace it. He was asked if the resident was able to stand and walk, he said he did not know. He was asked if he had seen the resident peeing at the vent, he said he had not. He was asked how often they check the resident's room, and he said they do daily rounds.In another interview with Staff #16, a housekeeper on unit 2 on 7/17/2025 at 2:56 PM, She was asked how often they clean the residents' rooms. She stated that they clean it every day, sweep, mop, dust over bed, take out trash, and clean the bathrooms daily. She was asked if she was aware of the strong urine odor coming from Resident #106's room and what they are doing about it. She stated that the resident pees on the floor, pees in a cup and throws it on the floor, that every time she goes in there, there was pee on the floor. Staff #14, the Environmental Services (EVS) Manager who was with the housekeeper at the time of the interview said that she had ordered mattress covers for the resident's bed, deep clean the room and that they go back and forth in the room but still can't get rid of the pungent urine smell.On 7/17/2025 at 3:28 PM The Director of Nursing (DON) and the Nursing Home Administrator (NHA) were asked what the facility was doing about the Pungent smell of urine in Resident #106's room including the rusty vent. They said they have discussed the issue before and decided to do more frequent cleaning and also had a discussion about taking out the floor. The NHA said he will reach out to the regional office again to see what they can do. They were made aware that the resident's room was not clean or homelike and that this was a concern.

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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. Based on observation, record review and interview it was determined that the facility failed to develop and implement a person-centered comprehensive care plan as required. This was evident for 1 (Resident #82) of 33 care plans reviewed during the survey process.The findings include: Hemiplegia refers to paralysis on one side of the body, meaning a complete inability to move the affected limbs.Hemiparesis: refers to weakness on one side of the body, which may involve difficulty with movement or a reduced range of motion The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents.On 07/16/2025 at 9:35 AM, in an interview with Resident #82, the resident stated that he/she had a decline in function since admission, he/she was able to get to and from the wheelchair by themselves and now they need help with transfers. On 07/23/2025 at 9:10 AM, a review of the resident medical history revealed that the resident had a history of hemiplegia and hemiparesis. A June 10, 2025 MDS assessment showed that Resident #82 was dependent and required substantial/max assistance for all activities of daily living. The resident also had an order for physical therapy, occupational therapy and speech evaluation. On 07/23/2025 at 9:23 AM, a review of Resident #82's care plan revealed that there was no documentation to support that care plan was developed to address the resident's impaired mobility. On 7/23/2025 at approximately 11AM, in an interview with the Director of Nursing (DON), the DON was notified that the facility failed to developed a comprehensive person-centered care plan that reflect the mobility needs of the resident including appropriate interventions and services provided.

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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. Based on observation, medical record review, and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reflect accurate and current interventions for residents. This was evident for 1 (Resident #126) of 50 residents reviewed during a recertification/complaint survey.The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan are accurate and appropriate for the resident.On 7/16/2025 at 2:15 PM, during initial pool screening, surveyor observed Resident #126 in bed awake and alert but non-verbal. The resident's roommate confirmed that the resident did not talk. However, surveyor did not observe any communication systems (board, cards, note pad, tablet, etc.) at the resident's bedside.On 7/16/2025 at 2:20 PM in an interview with the resident's nurse, Licensed Practical Nurse (LPN #7), he stated that the resident hears but cannot respond verbally. When asked if there were any communication systems used by staff to enable the resident express himself/herself, LPN #7 said no. However, LPN #7 stated that the staff who work with Resident #126 knew how to communicate with him/her using cues, and added that the resident's spouse visited regularly.On 7/23/2025 at 9:25 AM, a follow up observation was made of Resident #126 in their room. Resident #126 was awake in bed and could nod and/or shake their head in response to simple yes or no questions. Surveyor did not observe any communication systems/devices at the resident's bedside.On 7/23/2025 at 9:30 AM, An interview was conducted with the Unit Manager (UM #5). When asked how staff were communicating with Resident #126, UM #5 stated that the resident shakes him/her head for yes or no questions and facial grimaces. UM #5 added that the resident was able to point out stuff that s/he needed like the TV remote control. When asked if staff used any communication devices, UM #5 stated that they had a Picture board kept in the resident's closet. On 7/23/2025 at 9:45 AM Surveyor accompanied UM #5 to Resident #126's room. UM #5 searched the resident's closet and drawers but did not find the Picture board. UM #5 then asked Resident #126 if their spouse took the picture board home, the resident shook their head to indicate no.On 7/23/2025 at 4:26 PM Review of Resident #126's care plan revealed a care plan focus for [Resident's name] has a communication problem r/t Expressive Aphasia, Stroke initiated on 8/26/2023 with revision on 8/26/2023. Goal was [Resident's name] will be able to make basic needs known through the review date initiated on 8/26/2023 with revision on 12/19/2024. Interventions included but not limited to Monitor effectiveness of communication strategies and assistive devices (Communication board) initiated on 8/26/2023 with revision on 8/26/2023.[Of note: There was no communication board found in the resident's room and the care plan interventions have not been updated/revised since 8/26/2023].On 7/24/2025 at 9:43 AM, in an interview with Speech Therapist (ST #20), she confirmed that there was no communication board in the resident's room and staff did not use any communication board/assistive devices with Resident #126 as mentioned in the care plan interventions. ST #20 stated that the staff were very familiar with Resident #126 and knew how to communicate with the resident by asking closed ended questions since s/he (resident) responds via head nod/shake. On 7/24/2025 at 10:59 AM, in an interview with the Director of Nursing (DON), she stated that Speech therapy had evaluated Resident #126 and decided that the resident did not need the communication board. DON added that Resident #126 usually communicates with head nod and hand gestures and has padded call bell that s/he (resident) knows how to use. DON confirmed the facility staff failed to review and revise the care plan for Resident #126 to reflect current and appropriate interventions. However, DON stated that she was going to revise the resident's care plan right away.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, medical record review, and interviews, it was determined the facility staff failed to provide treatment and care in accordance with professional standards. This was evident for 3 (Resident #45, #74, #5) of 50 residents reviewed during a recertification/complaint survey.The findings include: A piston syringe, often referred to as a syringe, is a medical device and tool used across various fields for both injecting and withdrawing fluids. It is also used for irrigating feeding tubes and adding liquid medication to existing gastrostomy tubes. 1) On 7/16/2025 at 8:00 AM Surveyor observed Resident #45 in bed awake, alert, and oriented to person, place, and situation. Surveyor observed the resident was connected to a tube feeding pump that was turned off. The tube feed bottle (Glucerna 1.5cal) was dated 7/15/2025, shift noted as 12N and rate 70. The bottle was almost empty. There was also a water flush bag that was not dated connected to the pump. Hanging on the pole beside the water flush bag was a piston syringe dated 7/14/2025. Surveyor asked Resident #45 when the tube feeding pump was turned off and the resident stated that s/he did not know. On 7/16/2025 at 8:15 AM, Both the Unit Manager (UM #21) and night shift supervisor, Licensed Practical Nurse (LPN #22), verified and confirmed that the tube feeding bottle was almost empty and pump turned off but still connected to Resident #45. They confirmed the date on the tube feed bottle was 7/15/2025 and piston syringe 7/14/2025. UM #21 stated that the resident had a down time but acknowledged that the feeding set should have been disconnected from the resident. Night shift supervisor, LPN #22 stated that the piston syringe was supposed to be changed daily. On 7/22/2025 at 9:13 AM, a review of physician orders revealed the following active orders dated 7/4/2025: Enteral Feed: Change syringe every 24 hours. On 7/22/2025 at 9:34 AM, a review of Resident #45's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2025 revealed staff documentation that the syringe was changed on 7/14/25, 7/15/2025, and 7/16/2025. However, when surveyor made observations on 7/16/2025 at 8:00 AM, the piston syringe was dated 7/14/2025, hence, not changed every 24 hours as ordered. On 7/22/2025 at 11:14 AM, in an interview with the Director of Nursing (DON), surveyor reviewed above observations made on 7/16/2025. DON stated she was made aware by staff of surveyor's findings and corrections were made immediately. 2) On 7/22/25 at 1:20 PM, the surveyor went to see Resident #74 per request. The resident complained that their medications were always given late, and that some of their renal medications were given randomly and not with meals as ordered. On 7/22/25 at 2:30 PM, the Director of Nursing (DON) was asked to print a copy of Resident #106's medication administration record (MAR) showing the actual time their medications were given. A review of the Medication administration policy dated 12/14/22 on 7/23/25 at 10:14 AM had on Section 11c that Medications (Meds) are to be administered 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Review of the residents' actual medication administration records showed that: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/25, residents 6pm meds were given at 8:09 PM On 6/15/25 residents 4pm meds were given at 6:27 PM On 6/23/25, residents' 4pm meds were given at 6:08 PM On 7/19/25, residents 5pm meds were given at 7:21 PM In an Interview with Staff #17 a Registered Nurse (RN) on 7/23/25 @ 10:45, she was asked to explain their medication administration policy. She stated that medications are expected to be given one hour before and one after the administration time. She explained that sometimes staffing could be a cause of the delay in medications administration. She was asked about dialysis residents, and she stated that their medications are given post dialysis. Resident #106 was a dialysis resident, but review did not show that the late medications were given on dialysis days. On 7/23/25 at 1:45 PM the DON was made aware of the above concerns. She said she will provide more staff education. 3) On 07/16/2025 at 2:41 PM, in an interview with Resident #5 the resident stated that he/she had a possible urinary tract infection and as a result a urine sample was collected, and the result was pending. On 07/21/2025 at 3:01 PM, a review of Resident #5's laboratory orders revealed that an order was placed on 7/15/25 for a urine culture and analysis for dysuria for 1 Day. A review of the laboratory results reported on 07/17/2025 at 02:01 PM, revealed that the urine sample was contaminated. A progress note written by a nurse practitioner on 7/17/2025 at 4:06 PM stated Recollect urine for urinalysis and culture. On 07/22/2025 10:27 AM, in an interview with the resident's nurse #17, she acknowledged that the Nurse Practitioner (NP) wrote a note that the urine sample should be recollected however, she stated an order was not placed in the resident's Electronic Health Record (EHR) and as a result nursing was not notified that the urine sample was to be recollected. Nurse #17 stated that she will obtain the order as soon as possible. On 07/22/2025 at 10:33 AM, in an interview with the unit manager #21, the surveyor asked unit manager #21 to describe the process of obtaining/reviewing lab results. She explained that the laboratory results are sent to the healthcare provider, the provider would typically write a note and then place the order, if applicable. She stated that if an order was not placed in the EHR the nurse would not be aware. She stated that they will follow up with the healthcare provider to find out if the urine sample should be recollected. On 07/22/2025 at 10:36 AM, unit manager #21 reported that the specimen will be recollected per order. On 07/22/2025 at 11:14 AM, in an interview with the Director of Nursing (DON), the DON stated that 24-hour chart check/reviews were completed by the nursing staff; she acknowledged that nursing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff failed to follow up with lab results to ensure the appropriate treatment was in place. This had the potential to result in a delay of treatment. The DON explained that the issue will be addressed moving forward.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to accurately complete a resident's skin assessment sheet and failed to follow a physician's order for wound treatment. This was evident for 1(Resident #142) of 1 resident reviewed for pressure ulcers during the recertification/complaint survey.The findings include: On 7/22/25 at 9:00 AM a review of a complaint intake #310260, had that Resident #142 had bedsores, but the family member was not sure if they were facility acquired or not and if they were the cause of the resident's death.A review of the resident's medical records on 7/22/25 at 9:12AM revealed that Resident #142 was admitted to the facility on [DATE] and had many comorbidities, was cognitively impaired and immunocompromised. On admission the skin assessment sheet documented 3 pressure ulcer (PU) areas to the Right gluteal fold 6.5cm x 4.5 cm, R thigh(rear) 6x5cm X 6cm and Coccyx 4.5cm x 4.0cmx 1.0cm, meaning that resident came in to the facility with multiple wounds. Review of the care plans related to skin integrity on 7/22/25 at 9:17AM had: Resident has actual impairment to skin integrity (Right hip, left hip, BLE and ankles, sacrum, l foot, left knee, left heel, right ischium) r/t fragile skin, boney prominences, incontinence, limited mobility Date Initiated: 09/10/2024 Revision on: 10/29/2024.On 7/22/25 at 9:30 AM a review of a wound care note revealed that Resident #142 had up to 15 wound areas, some with eschar that was debrided by the wound care doctor. Continued review of the admission/readmit screener documents, dated 6/8/24, showed that the wounds were assessed on admission, measured and documented indicating that the resident came in with them.Further review of the skin assessment sheet revealed that on 6/17, 6/18, and 6/25/24, the weekly skin eval was not completed to reflect the wounds. On 9/16/24, nothing was documented and on 10/22/24, no area was documented.A review of the June 2024 Treatment Administration Record (TAR) on 7/22/25 at 9:47AM, revealed an order for an antiseptic wound medication Oxychlorosene Sodium Powder 0.004 grams every day and evening shift for wound. It was ordered on 6/7/24. This wound treatment was not signed off as done on 6/11, 6/13, and 6/19- on the day shift and, on 6/15 and 6/20 evening shift. Also, the Left butt wound treatment was not ordered until 6/21/24.On 7/22/25 at 10:26 AM in an interview with the Director of Nursing (DON) she was asked about the skin assessment sheets and how often they should be completed and she said weekly. She was asked how to indicate that treatment was completed, and she said that the nurse should sign it off. She was made aware of the skin assessment sheets not completed and the wound treatment that was ordered late. She validated that nurses did not sign the TAR to indicate that treatments were done and did not thoroughly complete the skin assessment sheets.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interview, it was determined the facility staff failed to label the oxygen tubing when oxygen therapy was initiated. This was evident for 1 (#57) of 50 residents reviewed during a recertification/complaint survey.The findings include:Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider.On 7/15/2025 at 9:55 AM during initial pool screening, the surveyor observed Resident #57 in bed. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to an oxygen concentrator set at 2LPM (liters per minute). The LPM oxygen flow rate of 2 indicates that 2 liters of oxygen should flow into the resident's nose in 1 minute. There was no date/time and/or staff initials noted on the oxygen tubing. On 7/15/2025 at 10:20 AM, Registered Nurse (RN #18) verified and confirmed that Resident #57's oxygen tubing was not labelled with the date/time it was hung. She stated that the expectation was to date label the oxygen tubing when it was changed. However, RN #18 stated that she was going to change the oxygen tubing right away so as to label it. During a review of Resident #57's medical record conducted on 7/21/2025 at 8:06 AM, surveyor noted an active physician order dated 7/15/2025 for: Oxygen at 2L/min via nasal cannula continuously for SOB (Shortness of Breath) every shift for hospice. There were additional orders dated 7/17/2025 for Oxygen Equipment - Change tubing and date tubing every week, every night shift every Sun . [of note, this order was put in after surveyor's observation on 7/15/2025).On 7/21/2025 at 9:19 AM, in an interview with the Director of Nursing (DON), surveyor reviewed the above observation regarding Resident #57's oxygen tubing not labelled. DON stated she was aware of surveyor's findings and they have already made the necessary changes.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interviews, it was determined that the facility failed to develop and implement a person-centered comprehensive care plan as required. This was evident for 1 (Resident #84) of 33 care plans reviewed during the recertification/complaint survey process.Findings Included:A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment and prepared by an interdisciplinary team.On 07/15/2025 at 1:05 PM, in an interview with Resident #84 during the initial screening phase, the resident complaint of severe back pain 9/10, and staff was made aware of the complaint.On 07/16/2025 at 11:44 AM, Resident#84 was resting in bed and reported 8/10 back pain. The resident stated that pain medication was administered that morning, including a pain patch but he/she was still in pain. LPN #7 and Unit manager #5 were notified of the resident's pain. On 07/17/2025 at 3:35 PM, a record review of the Medication Administration Record (MAR) revealed that the resident had orders for HYDROmorphone HCl Oral Tablet 2 MG (Hydromorphone HCl) Give 0.5 tablet by mouth two times a day for Pain and Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for Pain.On 07/21/2025 at 11:07 AM, a review of Resident's 84's care plan revealed that the facility failed to develop a person-centered care plan that adequately addressed the resident's pain.On 07/22/2025 at 12:05 PM, in an interview with unit manager #5, she was asked who was responsible for updating the resident's care plan and she stated that the care plan updates were done by the unit manager. She was made aware that the resident's care plan was not updated to reflect pain management as a focus area, even though the resident's pain was an active issue. She stated that the resident received additional pain management interventions from a third-party service; however, she acknowledged that Resident #84's care plan does not specifically address the resident's treatment plan for pain. She stated that the care plan will be updated.On 07/22/2025 at 2:00 PM, in an interview with the Director of Nursing (DON), she was made aware that Resident #84's care plan failed to adequately address pain management. The DON stated that the care plan addressed pain. The surveyor explained that Resident #84's care plan revealed a focus area of potential for alteration in comfort related to acute illness and chronic morbidities. However, the resident was having actual pain and had a diagnosis of chronic pain which the care plan failed to address using person- centered interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215129	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Parkville	8710 Emge Road Baltimore, MD 21234

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on record review and interview, it was determined that the facility failed to adequately monitor resident's blood pressure and heart rate prior to administering the medication. This is evident for 1(Resident #51) of 5 resident reviewed for unnecessary medications during the survey process. The findings include:On 07/24/2025 at 12:17 pm, a review of Resident #51's medical records revealed that the resident had an order for Lisinopril oral tablet 40 mg, give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure less than 110 or heart rate less than 60. A review of Resident #51 vital signs records revealed that the facility obtained vital signs twice in the month of July (July11, 2025 at 3:31 AM and July 17, 2025, at 4:25 AM). However, a review of the Medication Administration Records (MAR) revealed that the medication was administered daily (at approximately 10 am) in the Month of July; however, there was no documentation to suggest that the facility monitored blood pressure and/or heart rate prior to administering the medication.On 7/24/2025 at approximately 4:30 PM the Director of Nursing was notified of the finding, and she stated that the MAR failed to have a place to document the blood pressure and/or heart rate therefore the results were not documented. She acknowledged that the staff should document the pertinent vital signs as ordered in the resident medical record. She stated that the issue would be addressed.