STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Nursing and Rehab	420 Colonial Drive Denton, MD 21629

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety in the kitchen and the resident refrigeration units. This practice had the potential to affect all residents that eat food prepared by the facility's kitchen and stored food in the refrigeration units. The findings include:1. During a tour of the kitchen with the Kitchen Manager on 3/10/2026 at 7:14 AM the following items were found:A box of fully cooked mostly dark meat chicken had been opened and did not have an open date in the walk-in freezerA clear bag of unlabeled food identified as chicken nuggets by the KM in the walk-in freezerA box of open diced carrots not wrapped or labeled with an opening date in the walk-in freezerA box of vegetable blend not labeled with an opening date in the walk-in freezerA box of southern style biscuit dough was opened and not dated in the walk-in freezerA box of chicken meatballs had an opened bag and was not dated in the walk-in freezerA gallon bottle of [NAME] Mayonnaise opened and not labeled in the walk-in refrigeratorAn Arby's drink was in the walk-in freezer without a labelSeveral trays of cut pieces of cake were uncovered in the walk-in refrigeratorDuring an interview with the Kitchen Manager on 3/11/2026 at 7:29 AM she reported that [NAME] mayonnaise should have been labeled with an open date and then would be good for 30 days. She advised the cake should have been covered when in the refrigerator. She stated they had run out of the cart covers and advised she would cover the cake with sheet paper. She reported the Arby's shake should not be in the unit without a label. She reported items should be labeled with an opening date after being opened. During a review of the facility's Food Receiving and Storage on 3/12/2026 at 11:23 AM policy it was discovered that All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).2. During an observation of the resident refrigeration unit with the Infection Control and Prevention (ICP) nurse on 3/10/2026 at 10:53 AM. She confirmed the refrigeration unit was for Residents to store their food and it was labeled as the being in the Breezeway. The refrigeration unit was for Residents on the 100, 200, 300 and 400 units. The freezer of the Unit was found to have a build up of brownish colored and whitish colored frost built up on the interior roof, both sides and the bottom.During an interview with the Infection Control Prevention Nurse on 3/10/2026 at 10:54 AM she confirmed that the freezer needed to be cleaned.During the observation of the refrigerator of the unit it was found to be very full, and the following items were found:A temperature of 54 degrees Fahrenheit inside the refrigerator according to the facility thermometer inside the refrigerator.A disposable container labeled for Resident #75 with no date labeledA divided Tupperware container that was not labeled with a name or dateAn unlabeled salad that was not labeled with a name or date.Containers of Chinese food for Resident #47 not labeled with a dateAn opened Cloverland 2% Reduced Fat Milk carton with a Sell by date of 3/03/2026A Cloverland 2% Reduced Fat Milk Carton with a Sell by date of 3/08/2026.During an interview with the ICP nurse on 3/10/2026 at 10:59 AM she reported that Resident's food in the refrigerator must be dated and is taken out after 3 days if not eaten. She confirmed that the temperature in the refrigerator was 54 degrees Fahrenheit and that the expired items should be thrown away. She agreed the freezer and refrigerator needed to be cleaned (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and the temperature was too warm.During an observation of the refrigeration unit in the Breezeway on 03/10/2026 at 2:03 PM it was revealed that the temperature showed 49 degrees for the refrigerator. The Maintenance Director adjusted the temperature to be cooler.During an observation with Licensed Practical Nurse (LPN) #13 on 3/11/2026 at 6:11 AM the temperature of the refrigerator in the breezeway was 44 degrees Fahrenheit, she confirmed that the refrigerator was above the expected temperature and advised that sometimes the door doesn't shut all the way.During an observation with the Maintenance Director of the refrigerator in the breezeway on 3/11/2026 at 6:20 AM it was discovered that the temperature of the refrigerator was 48 degrees Fahrenheit which he confirmed was still too high.During an observation of the refrigeration unit in the breezeway on 03/11/2026 at 8:11 AM now has an out of order do not use sign.During a review of the facility's Use and Storage of Food Brought in by Family or Visitors policy on 3/12/2026 at 11:12 AM it stated, All food items that are already prepared by the family of visitor brought in must be labeled with content and dated and The prepared food must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away by facility staff.During a review of the facility's Food Receiving and Storage policy on 3/12/2026 at 11:16 AM it was discovered that ?All food items to be kept below 41 degrees Fahrenheit must be placed in the refrigerator located at the nurse station and labeled with a use by date. All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines.3. During an observation of the Resident's refrigerator on the 500 unit with the ICP nurse on 3/10/2026 at 11:07 AM it was discovered that the freezer and refrigerator did not have a thermometer inside to monitor the temperature.During a repeat observation of the Resident refrigerator on the 500 unit on 3/10/2026 at 12:45 PM it was discovered that the refrigerator and freezer now have thermometers. The refrigerator temperature showed 50 degrees Fahrenheit.During an interview with the ICP on 3/10/2026 at 12:48 PM she reported the kitchen brought thermometers to the refrigerator and freezer for the Resident refrigerator on the 500 Unit.During an observation of the refrigerator in the memory unit on 03/10/2026 at 2:05 PM with the Maintenance Director it was revealed that the temperature showed 48 degrees for the refrigerator. The Maintenance Director adjusted the temperature to be cooler in the refrigerator.During an observation of the 500 unit refrigerator on 3/11/2026 at 6:18 AM it was discovered that the temperature of the refrigerator was 40 degrees Fahrenheit.During an interview with LPN #14 on 3/11/2026 at 6:41 AM she reported that the memory care unit refrigerator hasn't had any thermometers in the refrigeration unit since they got a new one about three weeks ago. She advised the thermometers went with the old refrigeration unit.During a review of a receipt provided by the Maintenance Director on 3/11/2026 at 11:46 AM it was discovered that the refrigerator for the memory unit was delivered on February 11.4. During an observation of testing for the sanitizer sink on 3/11/2026 at 9:36 AM the Kitchen Manager used test strips from above the sink and reported those were the strips used for testing the sanitizer concentration in the sink. The sanitized water was tested three times and all 3 tests resulted below the expected 200 as advised by the Kitchen Manager.During an observation of the test strip bottle used to test the sanitizer level on 3/11/2026 at 9:41 AM it was noted to have a worn label and the expiration date for the strips was listed as Expired 09/2024.During an interview with the Kitchen Manager on 3/11/2026 at 9:41 AM she reported they test the sanitizer water every time they do dishes and advised the test strips shouldn't be used since they expired.5. During an observation of the kitchen dishwasher on 3/11/2026 at 10:32 AM with the Kitchen Manager on it was discovered that there was no documentation of the sanitizer levels for the dishwasher.During an interview with the Kitchen Manager on 3/11/2026 at 10:34 AM she reported that the staff does not test the sanitizer in the dish washing machine and added we don't have any testing strips for it. She advised the staff maintains a temperature log for the dishwasher, but they do not maintain a sanitizer log.During an interview with the Regional Maintenance Director on 3/12/2026 at 11:54 AM he confirmed the kitchen should have a test kit and log for documenting sanitizer testing. During a review of the facility's (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dishwashing Machine Use Policy on 3/12/2026 at 12:36 it was revealed that A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution and Concentrations will be recorded in a facility approved log. The policy adds, Corrective action will be taken immediately if sanitizer concentrations are too low. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or Parts Per Million are adjusted.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews it was determined that the facility failed to ensure essential equipment was in safe operating condition. This was found to be evident in the kitchen. This practice has the potential to affect all residents. The findings include:1. During a tour of the kitchen on 3/10/2026 at 7:24 AM it was discovered to have a reach-in refrigerator that had tape around a hole on the left side door where the embedded handle was previously located. The rectangular area had tape surrounding all four sides and the inside of the door was exposed. There was no handle on the left door.During an interview with the Kitchen Manager on 3/10/2026 at 7:24 AM she reported the handle on the reach-in refrigerator had been missing for a long time.During an interview with the Maintenance Director on 3/10/2026 at 11:23 AM he reported attempts had been made to fix the refrigerator handle. He advised the previous Maintenance Director had tried to secure the handle with duct tape. The Maintenance Director reported he has been unable to find a refrigerator handle for the unit.During a review of the facility's Sanitation policy on 3/12/2026 at 11:32 AM it reported that The food service area shall be maintained in a clean and sanitary manner. And All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.2. During a tour of the kitchen on 3/10/2026 at 7:33 AM the sink used to sanitize dishes after washing was found to have a fast and steady leak. There was a large black bin sitting under the sink catching the leaking water. A wet floor sign was near the sink.During an additional observation on 3/10/2026 at 8:12 AM the sink was noted to still be leaking and had overfilled the black bin spilling water into the floor.During an interview with the Kitchen Manager on 3/10/2026 at 7:32 AM she reported that the sink had been leaking for a while. She advised that when the staff is doing dishes they have to continue refilling the sanitizer sink to complete the task due to the water draining out of the bottom of the sink.During an interview with the Maintenance Director on 3/10/2026 at 11:35 AM he advised the leak is at the base and I need a new sink, he added, I have fixed it a few times the past few months and it leaks again. He reported he's waiting on corporate to buy a new sink.During an interview with the Maintenance Director on 3/11/2026 at 9:14 AM he reported that he was able do a temporary fix on the leaking sink with a new rubber seal and liquid sealant. He also advised that a replacement sink had been ordered.During a review of the facility's Sanitation policy on 3/12/2026 at 11:32 AM it reported that The food service area shall be maintained in a clean and sanitary manner. And All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.3. During a tour of the kitchen on 3/10/2026 at 7:47 AM the walk-in freezer was found to have white towels lying under the freezing unit. After removing the towels an icicle was found coming from the rear of the freezer unit. There was leakage under the icicle with a wet spot noted on top of a box of Chef [NAME] Pumpkin Pies. There was also a big chunk of ice under the food rack.During an interview with the Maintenance Director on 3/10/2026 at 11:36 AM he advised the freezer had a leak a few months ago and reported the ice cycle and block of ice on the floor was from that.During an observation on 3/10/2026 at 2:23 PM a contractor, EMR, was servicing the freezer.During a review of a Service Report from EMR dated 3/10/2026 on 3/11/2026 at 11:32 AM it reported, Inspected unit and replaced section of insulation on back of evaporator. One icicle hanging down from condensation from bad insulation but replaced4. During a tour of the kitchen on 3/10/2026 at 8:21 AM the ice machine was noted to have a whitish brown leakage between the machine and the ice bin on both sides of the machine.During an interview with the Kitchen Director on 3/10/2026 at 8:21 AM she reported that maintenance and an outside service provider handled the service of the ice machine.During an interview with the Maintenance Director on 3/10/2026 at 11:20 AM he reported the ice machines are maintained by a subcontractor that comes every couple of months. He advised he (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was not sure when they were here last to service the ice machines.During a review of a Service Report on 3/11/2026 at 10:32 AM it showed the ice machine was installed on 8/04/2025.During a review of a Service Report provided EMR on 3/11/2026 at 10:34 AM it was revealed that EMR serviced the ice machine on 3/10/2026 and they Found filter is very old and needs replaced. Two water filters were ordered to replace the current filter and one was ordered as an extra.5. During an observation of the Dish Washing Machine on 3/10/2026 at 2:26 PM several observations revealed dishes were being washed with the temperature gauge at 118 degrees Fahrenheit during the wash cycle.During an interview with the kitchen manager on 3/10/2026 at 2:30 PM she reported the temperature for the Dish Washing Machine should be at least 120 degrees Fahrenheit during the washing cycle. She advised the Dish Washing Machine was serviced last year.During a repeat observation of the Dish Washing Machine on 3/11/2026 at 9:50 AM it was noted to continue to show a temperature of 118 during the wash cycle.During an interview with the Kitchen manager on 3/11/2026 at 9:50 AM she advised the only way to check the temperature for the dishwasher was the gauge attached to the machine. She denied performing any other checks to confirm the dishwasher temperature was accurate.During a review of a Kitchen Service Report from the contractor Cleanslate on 3/11/2026 at 11:22 AM it was discovered that the dishwasher was last serviced on 10/09/2025 and the report identified Gauges Needs Attention.During an interview with the Kitchen Director on 3/11/2026 at 11:22 AM she reported that she was not aware of the dishwasher needing any work for the gauges.During a review of the facility's Dishwashing Machine Use Policy on 3/12/2026 at 10:48 AM it was revealed that, The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. The policy added that The supervisor will check the calibration of the gauge weekly by: Running a secondary thermometer through the machine to compare temperatures; or Using commercial temperature test strips following manufacturer's instructions. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or Parts Per Million are adjusted.During an interview with the Maintenance Director on 3/16/2026 at 6:23 AM he reported that the contractor Cleanslate was here yesterday to work on the dishwasher and they would be back today to repair the gauge.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record reviews and staff interview, it was determined that the facility failed to ensure that residents were offered written information regarding advance directives. This was evident for 4 (Residents #8, #10, #47, and #86) out of 6 residents reviewed for advance directives during the recertification and complaint survey process. The findings include: An Advance Directive is a legal document in which a person specifies their wishes regarding medical treatment in situations where they may no longer be able to express informed consent. It can include instructions about end-of-life care and may appoint a healthcare proxy (someone to make medical decisions on their behalf). On 03/10/2026 at 6:29 PM, a review of medical records revealed no written documentation indicating that the facility offered advance directives or provided education regarding advanced directives to Residents #8, #10, #47, and #86 or their resident representatives.On 03/13/2026 at 1:15 PM interview with Regional Social Worker (LMSW) reported that residents or their responsible party are asked upon admission whether an advance directive is in place. If an advance directive is not in place, the facility provides the Maryland Attorney General's Office Advance Directive packet. On 03/13/2026 at 1:30 PM the LMSW reviewed the medical records of Residents #8, # 10, #47, and #86 with the surveyor and confirmed there was no written documentation indicating that advance directives were offered or that education regarding advance directives had been provided to the residents or their responsible parties. She further stated that the Interdisciplinary Team (IDT) recently discussed incorporating advance directive discussions into care plan meetings, particularly for long-term care residents.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, it was determined that the facility failed to ensure services were provided in accordance with professional standards for quality of care. This was evident for 6 (Resident #28, #5, #47,#90, #91, and #44) out of 6 Residents reviewed for professional standards during the medication administration facility task conducted as part of the annual/complaint survey. The findings include: 1) Medication is considered unnecessary if it is administered without a valid medical indication, is continued longer than clinically needed, or is not properly monitored or evaluated for effectiveness and safety. On 03/11/2026 at 10:23 AM during an unnecessary medication review, the surveyor noted that Resident #28 had an active physician's order for Bacitracin External Ointment 500 UNIT/GM (Topical) to be applied into both nostrils twice daily for dry/irritated nostrils, with a start date of 09/03/2025. Further review of medical records revealed that the order for Bacitracin External Ointment 500 UNIT/GM (Topical) for Resident #28 had been active for over six months with no documentation of reassessment, evaluation of ongoing need, or clinical justification for continued use. On 03/12/2026 at 9:12 AM review of Resident #28's Medication Administration Record (MAR) revealed that nursing staff documented administration of Bacitracin External Ointment 500 UNIT/GM (Topical) from September 3, 2025, through March 12, 2026. On 03/12/2026 at 9:20 AM an interview was conducted with the Director of Nursing (DON) regarding topical antibiotics use. She stated that all topical antibiotic orders should include a stop date. On 03/12/2026 at 9:30 AM an interview was conducted with the Medical Director (MD) regarding the use of topical antibiotic ointment. The MD stated that antibiotic ointments are normally used to treat skin tears or minor skin issues for approximately 5–7 days or until the wound is healed, depending on the condition of the skin and physician discretion. He further stated that orders should include a stop date. The surveyor brought the concern regarding Resident #28's prolonged Bacitracin order to the MD's attention. The MD acknowledged the oversight and confirmed, that is a mistake on our part, I will discontinue the order. Further review of the medical record revealed that following the surveyor's intervention, the order for Bacitracin External Ointment 500 UNIT/GM (Topical) for Resident #28 was discontinued on 03/12/2026. 2) Enteral feeding is the delivery of liquid nutrition directly into a resident's stomach or intestines through a tube when they are unable to eat or swallow safely, but their digestive system still works. The process involves preparing the feeding formula, connecting it to the feeding tube, and administering it at the prescribed rate. All feeding bottles and water flush bags must be properly labeled with the resident's name, date, time, and feeding rate and changed every 24 hours to ensure safety and prevent infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/2026 at 11:40 AM during rounds in Resident #5's room, the surveyor observed an enteral feeding bottle and water flushing bag hanging with no start date or time labeled to indicate when the feeding was initiated. The Kangaroo water bag had no date and was labeled Levity. The enteral feeding bottle was labeled exp 48 hrs, indicating the expiration time, but without a documented start date and time, staff cannot determine when the 48-hour period began. On 03/10/2026 at 11:47 AM interview with Registered Nurse (RN) #5, regarding the process for enteral feeding administration. She stated that before hanging the feeding, the feeding bag and water bag must be labeled with the date, name of the feeding, resident's name, rate, start time of the feeding, and flushing schedule. She further stated that the expectation is for labeling to be accurate and complete. The RN #5 confirmed that the eternal feeding bottle and water bottle observed had no date or start time documented. During an interview conducted with the Director of Nursing (DON) on 3/11/2026 at 1:30 PM regarding expectations for enteral feeding administration, the DON stated that nursing staff are expected to properly label the feeding bottle and water flush bag with the date, time, resident's name, and feeding rate. She further stated that enteral feeding bottles and water flush bags must be changed every 24 hours. 3) During 400-unit rounds on 03/10/2026 the following were observed by the surveyor: 11:34 AM Resident #28, the surveyor observed oxygen tubing in use had no date or label. 11:34 AM Resident #47, the surveyor observed a nebulizer treatment machine placed on a plastic container on the floor. The tubing and mask were lying on top of the resident's clothes on the floor, and the tubing had no label. 11:38 AM during observation of Resident #90, the surveyor observed a nebulizer treatment mask, tubing, and oxygen tubing without a label. On 03/10/2026 at 11:55 AM during an interview, Registered Nurse (RN) #5 stated that the expectation is for staff to label oxygen tubing and humidifier bottles. RN #10 confirmed that Residents #28, #44, and #90's oxygen tubing was not labeled. On 03/11/2026 during 400-unit rounds the surveyor observed the following: 07:56 AM Resident #47's nebulizer treatment machine was placed on a plastic container on the floor, and the tubing and mask were lying on top of the resident's clothes on the floor. Additionally, the tubing had no label. 08:01 AM Resident #90, the surveyor observed the resident receiving oxygen therapy. The oxygen tubing in use had no label. Additionally, a nebulizer treatment mask, tubing, with no labeling sitting on resident's bed. 08:05 AM Resident #91, the surveyor observed the resident lying in bed with oxygen tubing lying on the floor. Lead Geriatric Nursing Assistant (GNA) #7 entered the room to assist the resident, picked up the oxygen tubing from the floor and placed it back on the resident's nose. At 08:56 AM, the surveyor observed Resident #44 lying in bed with oxygen in use and noted that the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen tubing had no label. On 03/11/2026 at 12:10 PM The surveyor conducted rounds on the 400-unit with RN #5 and confirmed the above concerns. On 03/11/2026 at 1:35 PM an interview was conducted with the Director of Nursing (DON) regarding the facility's expectations for oxygen tubing and nebulizer treatment equipment. The DON stated that oxygen tubing, nebulizer tubing, and masks are expected to be labeled and stored in a plastic bag when not in use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record reviews and interviews, it was determined that the facility failed to ensure Staff were competent in their skills. This was found to be evident for 4 (GNA #1, #2, #8, & #9) out 5 Geriatric Nursing Assistants reviewed for skill competency evaluations during the recertification and complaint survey.The findings include:During a review of employee files conducted on 03/16/26 at 9:12 AM for Geriatric Nursing Assistants (GNA) #1, #2, #8, & #9 it was discovered that there were not any current records of skills competencies.During an interview conducted on 03/16/26 at approximately 9:45 AM, the Director of Nursing (DON) reported that the facility conducted skills clinics that included return demonstrations. She further stated that she would obtain the records for the GNAs.On 03/16/26 at approximately 10:15 AM, the DON returned and reported that the facility failed to conduct the skill competency clinics for 2025. She also reported that she had 2026 skill competency clinics scheduled for May and June of 2026.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, it was determined that (1) the facility failed to ensure residents were offered and educated on COVID-19 vaccinations and (2) the facility failed to maintain staff documentation of COVID-19 screening, education, offering, and current vaccination status. This was evident for 5 of 5 residents reviewed (Resident #15, #5, #47, #7, and #81) and 5 of 5 staff reviewed (Geriatric Nursing Assistants #1, #2, #6, #7, and Registered Nurse #10) for COVID-19 immunization status.The findings include:(1)On 03/11/2026 at approximately 12:00 PM, this surveyor conducted a record review of electronic health records for Resident #15, #5, #47, #7, and #81 to determine COVID-19 vaccination status. The review revealed that Resident #15 had not been offered the COVID-19 vaccine since 04/12/2025, Resident #5 since 12/03/2024, Resident #47 since 02/18/2025, and Resident #81 since 12/05/2024. Resident #7, admitted in February 2026, had no documented evidence of being offered the COVID-19 vaccine.On 03/11/2026 at 3:12 PM, an interview was conducted with the Infection Control Preventionist (ICP), who reported starting in the role on 02/05/2026 in a part-time capacity. She stated that prior to her, the Assistant Director of Nursing (ADON) had served as ICP.On 03/11/2026 at 3:50 PM, a joint interview was conducted with the ADON and ICP. During the interview, the ADON reported that there was a transition period toward the end of 2025 when the ICP position was vacant. She stated that during this time, ensuring residents were offered vaccinations may have been missed and some residents may not have been accounted for. The ADON reported that the expectation is for nursing staff to offer vaccinations upon admission, including providing education, obtaining consent, and documenting this in the electronic health record. She further stated that residents should be offered influenza, COVID-19, RSV (Respiratory Syncytial Virus), and pneumococcal vaccines as appropriate on admission. On 03/11/2026 at 4:10 PM, during continued interview, the ICP reported that after the previous ICP left (approximately November 2025), there were no designated staff responsible for monitoring and ensuring residents were offered vaccinations. The ADON confirmed that no staff member had been assigned to oversee this responsibility during that time. It was communicated that this lack of oversight resulted in residents not being offered COVID vaccines, as evidenced by record review of Residents #15, #5, #47, #7, and #81. It was further explained that Resident #7's recent admission without any documented COVID vaccination offer demonstrated a continued gap in practice. The ADON and ICP acknowledged that responsibilities associated with the ICP role were not consistently maintained during the transition period. On 03/13/2026 at 10:48 AM, this surveyor conducted an interview with the Director of Nursing (DON). The DON confirmed awareness of the identified concerns and reported that a Performance Improvement Plan (PIP) had been initiated to address the issue. The DON stated that the facility had begun conducting a vaccination audit, and documentation of the audit and PIP was provided to the surveyor. (2)On 03/13/2026 at approximately 1:30 PM, this surveyor conducted a record review of COVID-19 immunization records for GNA #1, #2, #6, #7, and RN #10. The review revealed that the last COVID-19 vaccination dates were: GNA #1 - 02/27/2022, GNA #2 - 01/16/2022, GNA #7 - 05/28/2021, and RN #10 - 05/02/2022. GNA #6 had a COVID-19 vaccine declination statement, but it was incomplete and undated. No recent documentation was found demonstrating that these employees had been offered, educated about, or provided the opportunity to receive the COVID-19 vaccine.On 03/13/2026 at approximately 3:35 PM, this surveyor interviewed the Infection Control Preventionist (ICP) and Assistant Director of Nursing (ADON). They confirmed that no active process has been in place for offering COVID-19 vaccinations to staff, providing education, or obtaining declination forms. They presented a document including COVID-19 vaccine education and a declination section, which they reported will be used moving forward. When asked if documentation existed showing staff had previously been offered the vaccine, received education, or completed declination forms, they (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported none was available. It was communicated that this lack of process and documentation represents an infection control concern. The concern is further supported by the record review of the five employees (GNA #1, #2, #6, #7, and RN #10), which showed no evidence of screening, offering, or education regarding COVID-19 vaccination. The ICP and ADON acknowledged and confirmed understanding of the concern.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews it was determined the facility failed to ensure a functioning call bell system was available for all residents. This was found to be evident for 4 (Resident's #75, #51, #58 and #98) of 18 Residents review for call bell access during the recertification survey.The findings include:1. During an interview with Resident #75 on [DATE] at 9:06 AM he/she reported that his/her call bell had been broken for a year and it comes on without the Resident activating the bell.During an observation of the call bell alerts on [DATE] at 9:15 AM it was revealed that the call bell for Resident #75 was actively alerting.During an additional observation of the call bell system on [DATE] at 11:15 AM it was discovered that the call bell for Resident #75 was again alerting.During an interview with the Infection Control and Prevention nurse (ICP) on [DATE] at 11:16 AM she reported that Resident #75 doesn't want anything, maintenance is working on getting his/her call bell fixed.During an interview with the Maintenance Director on [DATE] at 11:17 AM he reported that he has made attempts to fix the call bell for Resident # 75 and still had problems. He advised he was now going to reprogram the call bell for the Resident to see if that works.During an interview with GNA #11 on [DATE] at 11:31 AM she reported that she didn't answer the call bell for Resident #75 earlier because it's broke and he/she usually calls on his/her phone.During an observation on [DATE] at 6:11 AM it was discovered that the call bell for Resident #75 was alerting.During an interview with GNA #16 on [DATE] at 6:31 AM she reported she didn't answer the call bell for Resident #75 because it's broke, it's been broken.During an interview with Resident #75 on [DATE] at 6:46 AM he/she reported they did not ring the call bell and did not need anything.During an observation on [DATE] at 8:30 AM it was revealed the Maintenance Director was in the room of Resident #75 to repair the call bell. During a review of the maintenance repair requests from the TELS system on [DATE] at 11:16 AM it was discovered that the request to repair the call bell was placed on [DATE] and it reported the call bell won't go off.During an interview with the Maintenance Director on [DATE] at 6:24 AM he reported there have been problems with the call bell for Resident #75 for a while and the problems have been off and on. He reported he replaced the cable for the call bell.During a review of the facility's Call Lights: Accessibility and Timely Response policy on [DATE] at 10:38 AM it was discovered that Staff will report problems with a call light or the call system immediately to the supervisor and /or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. 2. During an observation of Resident #51 on [DATE] at 9:54 AM it was revealed that the Resident did not have a call bell or another device to call for assistance from the facility staff. His/her roommate, Resident #77 had a call bell.During an interview with Resident #77, the roommate for Resident #51, on [DATE] at 9:57 AM he/she reported that Resident #51 uses my bell, he/she tells me to call and I ring mine. He/she advised Resident #51 had not had a call bell since moving into the room with Resident #77 about 3 months ago and confirmed that he/she has had to use their own call bell to ring for Resident #51.During an interview with Licensed Practical Nurse (LPN #4) on [DATE] at 9:58 AM she reported he/she should have a call bell and if not a hand bell to alert for help. She confirmed that Resident #51 did not have his/her own call bell and reported that she would notify maintenance.During an observation of the Maintenance Director on [DATE] at 10:04 AM it was revealed that he was replacing the single wire call bell going to resident #77 with a dual wire call bell device designed for two residents.During an interview with the Maintenance Director on [DATE] at 11:21 AM he reported that the facility did room changes and they didn't notify me.During an interview with the Director of Nursing on [DATE] at 8:28 AM she reported that Every resident should have a call bell. She advised the rooms were single rooms and the rooms were turned into a room for two Residents.During a review of medical records for Resident #51 on [DATE] at 7:45 AM it was discovered that he/she was admitted to his/her room on [DATE]During a review of the facility's Call Lights: Accessibility and Timely Response policy on [DATE] at 10:38 AM it was discovered that The (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet and the Call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.3. During an observation of Resident #58 on [DATE] at 10:06 AM it was revealed that the Resident did not have a call bell or another device to call for assistance from the facility staff. His/her roommate Resident #36 had a call bell.During an observation with the Maintenance Director on [DATE] at 10:07 AM he confirmed that Resident #58 did not have a call bell. He advised the call bell in his/her room was only a single wired call bell going to Resident #58 roommate. He would replace it to a double.During an interview with Resident #58 on [DATE] at 10:08 AM he/she reported that he/she would catch the nurse when they go by or have his/her roommate use his/her call bell to get help if needed.During an interview with the Director of Nursing on [DATE] at 8:28 AM she reported that Every resident should have a call bell. She advised were single rooms and the rooms were turned into a room for two Resident.During an interview with the Maintenance Director on [DATE] at 11:21 AM he reported that the facility did room changes and they didn't notify me.During a review of medical records for Resident #58 on [DATE] at 7:45 AM it was discovered that he/she was admitted to his/her room on [DATE].4. During an observation of Resident #98 on [DATE] at 10:10 AM it was revealed that the Resident did not have a call bell or another device to call for assistance from the facility staff. His/her roommate Resident #81 had a call bell.During an interview with the Director of Nursing on [DATE] at 8:28 AM she reported that Every resident should have a call bell. She advised were single rooms and the rooms were turned into a room for two Resident.During a review of medical records for Resident #98 on [DATE] 11:12 AM it was discovered that he/she was admitted to his/her room on [DATE].During an interview with the Maintenance Director on [DATE] at 11:21 AM he reported that the facility did room changes and they didn't notify me.During a review of the facility's Call Lights: Accessibility and Timely Reponse policy on [DATE] at 10:38 AM it was discovered that , Staff will report problems with a call light or the call system immediately to the supervisor and /or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. All staff members who see or hear an activated call light are responsible for responding.

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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. Based on record reviews and interviews it was determined that the facility failed to ensure that residents remained free of neglect. This was evident for 1 (Resident #75) of 1 Resident reviewed for neglect during the recertification survey. The findings include:During a review of Facility Reported incident #2730935 on 3/10/2026 at 8:35 AM it was revealed the incident was submitted to the Office of Health Care Quality on 1/30/2026. The incident reported an allegation was made by Resident #75 that no staff provided care to him/her during the 11p - 7a shift.During a review of the facility incident folder for incident #2730935 on 3/11/2026 at 10:46 AM a Follow-Up Investigation form was discovered that validated the allegation and reported it was confirmed that Geriatric Nursing Assistant (GNA) #12 did not go into the room of Resident #75 to provide care during the 11p - 7a shift on the shift of 1/29/2026. The facility noted the concern was a Verified allegation and that GNA #12 was disciplined.During a review of the GNA tasks documentation on 3/11/2026 at 11:32 AM it was revealed that there was no documentation for Bathing, Bed Mobility, Oral Hygiene, Toileting, Barrier Cream after incontinence care, Bowel Elimination, Urinary Incontinence or Foam Ankle Boots on in bed as tolerated being completed on 1/29/2026 for the 11p - 7a shift.During an interview with the Director of Nursing on 3/12/2026 at 8:28 AM she stated that care provided during the shift should be documented by the GNA. She confirmed that there should not be blank spaces on the GNA tasks documentation, she added refusals and anything related to the care the GNA provided should be documented. She reported that if the task wasn't documented she advised we don't have the support to show it was completed. She confirmed that if care was provided to Resident #75 on the night shift of 1/29/2026 then it should have been documented and not left blank.

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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 reviews and interviews, it was determined that the facility failed to thoroughly investigate allegations of neglect. This was evident for 1 (Resident #75) of 1 Resident reviewed for neglect during the recertification survey.The findings include:1. During a review of medical records for Resident #75 on 3/16/2026 at 9:25 AM a Hospital Consult Report had been uploaded into the medical records for Resident #75 on 12/13/2025. Upon reviewing the consultation report it was discovered that Resident #75 had went to the Emergency Department on 12/13/2025. The Emergency Department Provider Note stated the resident had complained that Resident #75 reported that he/she constantly has been getting neglected by the night shift 11p - 7a shift at the nursing facility and He/she frequently sits in his/her urine and says that they purposely ignore his/her call bell. This time, he/she called 911 for help.During an interview with the Administrator on 3/16/2026 at 9:38 AM he reported that he was not aware of the complaint that Resident #75 had made to the Emergency Department. He also advised that he was not aware of an investigation being conducted for this complaint. He confirmed that the Emergency Department Note found in the medical records for Resident #75 had been uploaded by staff from the nursing facility. He confirmed that the Administrator should be made aware of any reports of neglect and those concerns should be investigated.During an interview with the Director of Nursing on 3/16/2026 at 9:50 AM she reported that when a Resident returns from the hospital the admitting nurse would screen the resident and review discharge paperwork for discharge information and orders. She confirmed that the nurse that admitted Resident #75 should have reviewed the discharge paperwork and should have noted the resident's complaint of neglect.2. During a review of Facility Reported Incident #2690114 on 3/16/2026 at 9:56 AM it was discovered that Resident #75 had reported an allegation of neglect to the facility and being left in soiled conditions for an extended period.During an interview with the Director of Nursing (DON) on 3/16/2026 at 10:17 AM she reported she could not find the investigation file for incident #2690114 concerning Resident #75. She was able to provide documentation of the initial incident report that was submitted to the Office of Health Care Quality on 12/10/2025 at 5:15 PM. She was unable to find any additional files or documentation related to the incident.During an interview with the DON 3/16/26 at 10:58 AM she reported that a file would be kept containing any interviews or evidence that was obtained during an investigation of a Facility Reported Incident. She confirmed that Resident #75 should have an investigation folder for incident #2690114 but they were unable to find the investigation folder.During an interview with the Administrator on 3/16/26 at 10: 58 AM he confirmed the investigation notes and interviews from a facility reported incident would be kept in a folder which would be kept in a file cabinet. He advised the previous DON handled the investigation for incident #2690114 and confirmed that they were unable to find the investigation file.

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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 interviews and medical record reviews it was determined that the facility failed to ensure 1) quarterly care plan meetings with the interdisciplinary team were held and 2) a Residents care plan intervention was implemented. This was found to be evident for 2 (Resident #75 and #1) out of 18 Residents reviewed for care plans during the recertification and complaint survey. The findings include: 1) 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. Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse with responsibility for the resident, nursing assistant with responsibility for the resident, dietary services, the resident, and the resident's representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. During an interview with Resident #75 on 03/10/2026 at 12:15 PM he/she denied having regular care plan meetings. During a review of medical records for Resident #75 on 3/11/2026 at 11:07 AM it was discovered that he/she had care plan meetings held on 12/04/2024, 9/17/2025 and 1/16/2026. There were no additional care plan meetings documented between the meetings held on 12/06/2024 and 9/17/2025. During an interview with the Regional Social Worker on 3/11/2026 at 12:52 PM she reported there were no care plan meetings held for Resident #75 between the care plan meetings that were held on 12/04/2024 through 9/17/2025. She confirmed meetings were missed and should have been held in March and June of 2025. 2) During a review of Resident #1's progress notes conducted on 03/11/26 at 9:15 AM, it was discovered that the Resident had multiple occasions where he/she displayed inappropriate sexual behavior. During a review of the Resident #1's Care Plan conducted on 03/11/26 at 9:22 AM, it was discovered that the Resident had a Care Plan for inappropriate sexual behavior with an intervention for a 1 to 1 supervision. During an observation of Resident #1 conducted on 03/11/26 at 10 :33 AM, the Resident was observed on the unit without 1 to 1 supervision. During an interview conducted on 03/10/2026 at 10:42 AM, The Surveyor asked Registered Nurse (RN) #10 if Resident #1 continued to have inappropriate sexual behavior. The RN reported that the Resident continued to display inappropriate behaviors with other Residents. When asked if the Resident had 1 to 1 supervision, the RN replied not presently. When asked when the last time the Resident had 1 to 1 supervision the RN stated that it had been a while maybe 2 months ago. When asked if the Resident had displayed inappropriate behaviors in the last 2 months the RN replied that the Resident had those behaviors daily. During an interview conducted on 03/13/26 at approximately 11:00 am, the Director of Nursing (DON) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that Resident #1 displayed inappropriate sexual behavior and did not presently have a 1 on 1 supervision as noted in the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews it was determine that the facility failed to provide Residents with quality of care. This was found to be evident for 5 (Resident #88, #39, #41, #47 and #90) out of 18 Residents reviewed for quality of care during the recertification and complaint survey. The findings include: 1) On 03/11/2026 at 10:02 AM, this surveyor observed Licensed Practical Nurse (LPN) #4 administer medications to Resident #88. When administering medications, LPN #4 did not explain the medications to the resident or offer the opportunity for the resident to be informed. On 03/11/2026 at 10:58 AM, this surveyor observed LPN #4 administer medications to Resident #40. LPN #4 did not explain the medications or offer the resident the opportunity to be informed. On 03/13/2026 at 8:42 AM, this surveyor observed Registered Nurse (RN) #5 administer medications to Resident #39 in a shared room with Resident #41 present. RN #5 did not provide privacy during the medication administration, as the privacy curtain was not drawn and Resident #41 was able to observe the process. On 03/13/2026 at 8:57 AM, record review of the facility's medication administration policy under Policy Explanation and Compliance Guidelines indicated Provide Privacy. On 03/13/2026 at 10:40 AM, this surveyor conducted an interview with the Director of Nursing (DON), who reported that staff are expected to offer residents the opportunity to be informed about their medications during administration, as this supports resident choice and the ability to refuse medications if desired. During the interview, the DON was informed of the above concerns, including failure to explain medications and failure to provide privacy during medication administration. The DON acknowledged and confirmed understanding of the concerns. On 03/16/2026 at 8:46 AM, this surveyor conducted an interview with the Administrator and communicated the concerns related to medication administration practices. The Administrator acknowledged and confirmed understanding. 2) On 03/10/2026 at 12:05 PM the surveyor observed two urinals filled with urine on top of the nightstand in Resident #47's room. The resident stated, Some of the aides empty it for me, and some don't. It depends on who is working. This happens all the time. On 03/10/2026 at 12:10 PM during room rounds, the surveyor observed a urinal filled with urine and a trash can sitting on the bed in Resident #90's room. During room rounds in 400-411 on 03/10/2026 at 12:15 PM, the surveyor observed a trash can under the sink that was approximately one-quarter full of coffee-colored water and trash. Resident #47 stated, Don't worry, it has been there for a couple of days. On 03/10/2026 at 12:44 PM during an interview, the Lead Geriatric Nursing Assistant (GNA) stated that GNAs empty residents' urinals during rounds, conducted every two hours and as needed. She confirmed that, while some residents may empty their own urinals, it is the responsibility of GNAs to ensure all urinals are emptied during the shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During room rounds on 03/11/2026 at 1:59 PM in room [ROOM NUMBER]-411, the surveyor and the Director of Nursing (DON) observed a trash can under the sink approximately one-quarter full of coffee-colored water and trash. The DON stated that it was 'probably left there to prevent water from leaking on the floor,' but acknowledged it was not supposed to be there and indicated that a work order was being placed immediately.

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observations, interviews and record reviews it was determined that facility failed to ensure a Resident was provided with supervision. This was found to be evident for 1 (Resident #1) out of 1 Resident reviewed for supervision during the recertification and complaint survey.The findings include: During a review of Resident #1's progress notes conducted on 03/11/26 at 9:15 AM, it was discovered that the Resident had multiple occasions where he/she displayed inappropriate sexual behavior. A Care Plan is a formalized, personalized, and actionable document developed by healthcare professionals in collaboration with patients and families to manage specific health conditions. It acts as a roadmap for care, outlining goals, necessary interventions, and timelines. These plans are constantly updated based on patient progress. During a review of the Resident #1's Care Plan conducted on 03/11/26 at 9:22 AM, it was discovered that the Resident had a Care Plan for inappropriate sexual behavior with an intervention for a 1 to 1 supervision. During an observation of Resident #1 conducted on 03/11/26 at 10 :33 AM, the Resident was observed on the unit without 1 to 1 supervision. During an interview conducted on 03/10/2026 at 10:42 AM, The Surveyor asked Registered Nure (RN) #10 if Resident #1 continued to have inappropriate sexual behavior. The RN reported that the Resident continued to display inappropriate behaviors with other Residents. When asked if the Resident had 1 to 1 supervision, the RN replied not presently. When asked when the last time the Resident had 1 to 1 supervision the RN stated that it had been a while maybe 2 months ago. When asked if the Resident had displayed inappropriate behaviors in the last 2 months the RN replied that the Resident had those behaviors daily. During an interview conducted on 03/13/26 at approximately 11:00 am, the Director of Nursing (DON) acknowledged that Resident #1 displayed inappropriate sexual behavior and did not presently have a 1 on 1 supervision as noted in the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Nursing and Rehab	420 Colonial Drive Denton, MD 21629

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews and record reviews it was determined that the facility failed to ensure that the individual designated as the Kitchen Manager was certified for food service management and safety. This had the potential to affect all residents. The findings include: During an interview with the Kitchen Manager on 3/10/2026 at 7:14 AM she reported she was the kitchen supervisor and managed the Kitchen. She advised she was not currently certified and did not currently hold a Certified Dietary Manager Certification (CDM). She reported she had completed her training and took the test in October; however, she needs to retake the test. She advised she's waiting for approval to retake the test. She advised the previous Kitchen Manager left about a year ago and she took over for him. She advised the facility does have a dietician that comes to the facility every Wednesday.During an interview with the Administrator on 3/10/2026 at 2:16 PM he reported the facility has a Dietician and she comes in every so often. He confirmed the Dietician was not full time. He advised he would check on the Kitchen Manager's certification.During a follow-up interview with the Administrator on 3/11/2026 at 11:16 AM he confirmed the Kitchen Manager did not have a current CDM certification. He advised she took the test for the CDM certification and needed to retake the test. He advised when the previous Kitchen Manager left we hired from within the facility and she would get her certification.During a review of documents provided by the Administrator on 3/11/2026 at 1:26 PM it was revealed that the Kitchen Manager had completed Nutrition and Foodservice Professional Training Pathway I with the University of Florida on 8/05/2025. The document notes that this is a Pre-certification course for CDM's.

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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 interview, it was determined that the facility failed to ensure 1) measures were in place to prevent and monitor the growth of Legionella and other opportunistic waterborne pathogens in the building water system. This deficiency has the potential to affect all residents who utilize the facility's water system and 2) staff perform appropriate hand hygiene. This was found to be evident for 1 Licensed Practical Nurse (LPN #4) of 2 LPNs observed for infection control during the recertification and complaint survey.The findings include: 1) Legionella (and other opportunistic waterborne pathogens) is bacteria that can grow in building water systems and cause illness when exposed to contaminated water. TELS is a web-based building management and maintenance software solution specifically designed for senior living and healthcare facilities. On 03/11/2026 at 2:55 PM, this surveyor conducted an interview with the Maintenance Director. When asked whether the facility has measures in place to prevent the growth of Legionella and other opportunistic waterborne pathogens, or a system to monitor such measures, the Maintenance Director reported that the facility follows a water management program. The Maintenance Director further stated that the facility conducts in-house water testing for Legionella approximately once per year, a practice in place since around September 2022. He reported that test results are photographed and uploaded into the TELS system. When asked whether the facility has had any known cases of Legionella, the Maintenance Director reported that there have been no reported cases since his employment began in September 2022. On 03/13/2026 at 9:05 AM, the Maintenance Director reported that he was unable to locate documentation of the in-house Legionella testing results. He stated that he believed the results had been uploaded into the TELS system; however, he was unable to verify this and could not determine their location. The Maintenance Director confirmed that he did not have any additional documentation or evidence to demonstrate that in-house testing for Legionella or other opportunistic waterborne pathogens had been completed. It was then asked if the facility had any measures in place to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water system. The Maintenance Director reported that the facility utilizes mixing valves and confirmed that the water is heated and passes through mixing valves prior to reaching resident rooms. On 03/13/2026 at 9:08 AM, this surveyor and the Maintenance Director conducted a joint observation of the boiler room. It was observed that a mixing valve was in place and that heated water was being delivered from the water heaters through the mixing valve and then distributed to resident rooms. A thermometer on the outgoing water line to the resident rooms read 112 degrees Fahrenheit. The Maintenance Director was asked what temperature the water reaches in the tanks prior to passing through the mixing valve. He reported that he was not sure. It was observed that there were no thermometers present to monitor or display the temperature of the water within the tanks. When asked what the expected water temperature should be to help prevent the growth of Legionella and other opportunistic waterborne pathogens, the Maintenance Director stated that he believed it should be approximately 140 degrees Fahrenheit. On 03/13/2026 at 9:33 AM, this surveyor observed the Maintenance Director obtain a water temperature reading directly from a hose connected to the water heater tank. The temperature measured 108.5 degrees F. The Maintenance Director reported that he had consulted with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Maintenance Director, who confirmed that thermometers should be present on the exterior of the water heater tanks to monitor water temperature. He also reported plans to install thermometers on the water heater tanks to monitor water temperatures moving forward. It was communicated that the facility was unable to verify that water temperatures were being maintained at levels expected (140 degrees F) to prevent the growth of Legionella and other opportunistic waterborne pathogens. Additionally, the inability to provide documentation of in-house water testing further indicated a lack of evidence demonstrating active monitoring or prevention measures. The Maintenance Director acknowledged the concern and confirmed that, without documented test results, the facility cannot verify that Legionella testing had been performed. On 03/13/2026 at 10:12 AM, the Maintenance Director reported that he would conduct a Legionella test to assess the facility's water system. At 10:25 AM, this surveyor observed the test being completed using water directly from a sink in an unoccupied resident room; the results were negative. While this confirmed no active Legionella in the water, the surveyor noted that the facility still lacks a documented, ongoing prevention and monitoring system for Legionella and other opportunistic waterborne pathogens. The Maintenance Director acknowledged and understood this concern. On 03/16/2026 at 8:46 AM, the surveyor discussed this concern with the Administrator, emphasizing that, despite negative test results and no reported cases of Legionella, the facility does not have active preventive or monitoring measures in place. The Administrator confirmed understanding of the concern. 2) Hand hygiene is mandatory before putting on gloves and immediately after removing gloves to prevent cross-contamination, as gloves are not a substitute for hand hygiene. Health care workers must change gloves and perform hand hygiene when moving from a soiled to a clean body site on the same patient, or between patient contacts On 03/13/2026 at 1:42 PM, LPN #4 was observed providing wound care for Resident # 11. LPN #4 changed gloves between the cleaning of the wound and placing the clean dressing. LPN #4 failed to perform hand hygiene between changing gloves. When LPN #4 finished applying a dressing on one wound, they again changed gloves and failed to perform hand hygiene before putting on another pair of gloves to apply a clean dressing to a second separately located wound on Resident #11 sacrum. On 03/13/2026 at 1:45 PM, an interview with LPN #4 confirmed that they should have performed hand hygiene between changing gloves.

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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. Based on record review and interview, it was determined that the facility failed to provide influenza and/or pneumococcal immunizations as required or appropriate for residents. This was found to be evident for 4 (Resident #15, #47, #7, and #81) out of 5 Residents reviewed for influenza and pneumococcal immunizations during the Infection Control facility task conducted as part of the annual/complaint survey. The findings include:On 03/11/2026 at approximately 12:00 PM, this surveyor conducted a record review of residents' charts (Resident #15, Resident #5, Resident #47, Resident #7, and Resident #81) to determine influenza and pneumococcal vaccination status. The review showed no documentation that these vaccines were offered during the 2025-2026 season for the residents listed, with the exception of Resident #5, who was offered the influenza vaccine on 10/01/2025 and refused. Additionally, for Resident #7, admitted in February 2026, there was no documentation of vaccination status or that influenza or pneumococcal vaccines were addressed upon admission.On 03/11/2026 at 3:12 PM, this surveyor conducted an interview with the Infection Control Preventionist (ICP), who reported she began working in the role on 02/05/2026 in a part-time capacity. She stated that prior to her assuming the role, the Assistant Director of Nursing (ADON) had been serving as the ICP.On 03/11/2026 at 3:50 PM, a joint interview was conducted with the ADON and ICP. During the interview, the ADON reported that there was a transition period toward the end of 2025 when the ICP position was vacant. She stated that during this time, ensuring residents were offered vaccinations may have been missed and some residents may not have been accounted for. The ADON reported that the expectation is for nursing staff to offer vaccinations upon admission, including providing education, obtaining consent, and documenting this in the electronic health record. She further stated that residents should be offered influenza and pneumococcal vaccines as appropriate, and that influenza vaccines should be offered annually during the flu season (October 1 through March 31).On 03/11/2026 at 4:10 PM, during continued interview with the ICP and ADON, the ICP reported that after the previous ICP left (approximately November 2025), there were no designated staff responsible for monitoring and ensuring residents were offered vaccinations. The ADON confirmed that no staff member had been assigned to oversee this responsibility during that time. It was communicated that this lack of oversight resulted in residents not being offered required immunizations, as evidenced by record review of Residents #15, #47, #7, and #81. The ADON and ICP acknowledged that responsibilities associated with the ICP role were not consistently maintained during the transition period.On 03/13/2026 at 10:48 AM, this surveyor conducted an interview with the Director of Nursing (DON). The DON confirmed awareness of the identified concerns and reported that a Performance Improvement Plan (PIP) had been initiated to address the issue. The DON stated that the facility had begun conducting a vaccination audit, and documentation of the audit and PIP was provided to the surveyor.