STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on record review and interview, it was determined that the facility failed to have 3 years of survey results available for residents, family members, and visitors to review. This was evident during the survey. The findings include:On 01/07/2026 at 12:18 PM a review of the survey binder that was on the table in the front lobby, failed to reveal the last 3 years of survey results. An interview with the Nursing Home Administrator (NHA) on 01/07/2026 at 12:20 PM revealed he had reviewed the binder. He stated the standard was to have 1 year of survey results available in the binder. Reviewed the concerns with the NHA.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with staff and resident representative (RP) it was determined that the facility failed to keep a representative updated and notified of changes in condition and refusals of treatments including medications. This was evident for 1 of 8 residents (Resident #7) reviewed during a complaint. The findings include:Review of complaint #2666803 on 1/7/26 at 1:35 PM revealed representative concerns for Resident #7 that they were not notified regarding changes in the resident condition when s/he had a fall and then was transferred to the hospital for altered mental status days later. Resident #7's family representative was interviewed on 1/7/26 at 2:35 PM. The submitted complaint information was reviewed regarding the failure of the facility to notify her of changes in condition related to an 11/7/25 fall. Additionally, she stated that there was a plethora of failures to notify her of changes throughout the residents' stay. Continued review of Resident #7's medical record on 1/7/26 at 2:55 PM revealed that Resident #7 was admitted in the summer of 2025 for rehabilitation following an extended hospital stay. At a 7/24/25 care plan meeting with the family the resident representative (RR) was notified that the resident was having frequent refusals of medications, vitals and general nursing care. It was established at that time, to call the residents [representative] when the resident refused to take medications, treatments or any procedures. This request from the RR was entered into the residents' care plan and as a physician order that was reviewed and signed off on the medication administration record (MAR) every day and shift from admission to discharge. However, further review of the MAR it was noted that Resident #7 continued to have daily refusals of medications from admission to discharge, that although the attending physician was made aware, the family was not according to documentation in the electronic health record.Additionally, nursing progress notes documented Resident #7 having a fall on 7/28/25 with subsequent orders for x-rays and laboratory work related to observed and assessed swelling. These x-rays and laboratory work orders were refused and never completed. There was no documentation that the RR was ever notified. On 11/7/25 Resident #7 had a witnessed fall. Subsequent labs and imaging were ordered for treatment; these labs included a urinalysis. As per Resident #7's documented history, all the labs and treatments were refused. On 11/8/25 it was documented throughout the nursing progress notes that Resident #7 had a change in condition and was noted as less responsive. The on-call physician was notified and ordered to monitor the resident and Respect patient's refusal of labs today; re-offer if condition changes or if patient becomes more agreeable. However, at no time was the family notified or contacted to come in and assist as per the noted orders and care plan. Resident #7 was then transferred to the hospital on [DATE] for the following 2 months with a diagnosis of sepsis. The DON was interviewed on 1/9/26 at 9:08 AM regarding the concern of notification to Resident #7's RR. At the time of exit no further documentation was provided to the survey team regarding notification to the RP about the residents' refusals of either the medication from admission to discharge or the ordered x-rays and subsequent treatments ordered and recommended from the falls that occurred on 7/28/25 and 11/7/25 respectively.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined the facility failed to ensure that resident had a homelike environment to live in. This was evident for 2 of 2 nursing units in the facility. The findings include:A tour of on 1/7/26 at 9:46 AM of the C and D nursing unit revealed the following observations:1. A partially dissembled hand sanitizer dispenser laying on a personal protective equipment (PPE) cart outside room [ROOM NUMBER].2. There were wheelchairs (w/c), geriatric chairs, and mechanical lifts stored in 3 of the hallways.3. There were 2 paper cups and a plastic drip tray for a hand sanitizer dispenser laying on the handrail to the left of room [ROOM NUMBER].4. There was a box of gloves on the handrail and a green mesh bag containing trash bags hanging on the handrail outside room [ROOM NUMBER]. A tour of the A and B wing nursing unit on 1/7/26 at 9:55 AM revealed the following observations: 1. In room [ROOM NUMBER] there was a trash bag with linens laying on the floor beside the A bed to the right of the doorway.2. Drip trays for the hand sanitizer dispenser were laying on the handrail outside the following rooms: 108, 114, 115, and room [ROOM NUMBER].3. There was a partial roll of paper towels on the handrail outside room [ROOM NUMBER].4. A mesh bag containing trash bags was hanging on the handrail outside room [ROOM NUMBER].5. At the end of the B wing hallway to the right of the window was a bedside commode and a urine hat lying on the seat cover. The urine hat was not covered.6. In the short A wing hallway there were 4 tall dressers and 1 short dresser stored at the end of the hallway near the recreation room. There were 3 boxes stacked on the floor outside the rec room door. There was another dresser and a large blue trashcan sitting to the right of the recreation room door.7. There were w/c, geriatric chairs, and mechanical lifts stored in each hallway on the unit.On 1/7/26 at 11:55 AM an observation of the main dining room, where some residents gather to eat their meals and participate in activities, revealed large pieces of plastic hanging from the ceiling with blue painter's tape securing some pieces. Behind the plastic was a large assortment of building supplies. Partially covered behind the plastic was the vending machines for snacks and drinks. A second tour of the nursing units on 1/8/26 at 10:32 AM revealed the following observations: 1. A linen cart sitting between rooms [ROOM NUMBERS] was open with no cover and there were linen supplies and wash basins lying on the shelves. 2. There was a box of gloves on the handrail. 3. There were w/c, geriatric chairs, a room chair, and mechanical lifts lining the hallways. 4. A wheelchairs between rooms [ROOM NUMBERS] and had 3 basins, a container of bleach wipes, toiletries, and trash bags lying on the seat. At the time of this tour a housekeeping aid was observed to have a difficult time to get the cleaning cart between the items that lined the hallway and the medication cart sitting on the opposite side near room [ROOM NUMBER]. An interview with Licensed Practical Nurse (LPN) #15 on 1/8/26 at 10:42 AM revealed that staff store the resident's w/c and geriatric chairs in the hallway, the resident's room, and the shower rooms on the unit. An observation of the shower room on the C and D wing nursing unit on 1/8/25 at 10:43 AM revealed that there were wheelchairs and geriatric chairs stored as well as a shower bed with 2 large trash bags of clothing and some shoes in one shower stall. The other shower stalls had shower chairs and shower stretchers in them. An observation of the shower room on A and B wing nursing unit on 1/8/26 at 10:47 AM revealed 3 men where wheeling a bed from the shower room. Inside the women's side the room was full of maintenance equipment. The middle room had a bed with bags of clothing on it. The men's side had 3 geriatric chairs lined up blocking the back shower stall. There were 2 shower stalls that were accessible. The concerns were reviewed with the management team and Nursing Home Administration at the time of exit on 1/9/26 at 3:00 PM. The NHA acknowledged the concerns.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, it was determined that the facility failed to respond to a resident's concern by failing to provide a resolution. This was evident for 1 (#10) of 3 residents reviewed for grievances. The findings include:On 1/9/26 at 12:15 PM a review of 9 grievances received by the facility revealed 2 grievances regarding Resident #10. On 12/9/25 three concerns regarding Resident #10 were reported to the social services staff. The statement was that the briefs leaked more than the previous ones and the resident's clothing had a urine smell more frequently, there were 2 medical shoe boots missing, and the smell of construction was bothering the resident. The form noted that the Nursing Home Administrator (NHA) investigated the grievance. The response failed to mention the concern about the incontinence briefs leaking. It was signed as resolved on 12/10/25. A second grievance form dated 12/24/25 that was completed by unit manager (UM) #4 was regarding Resident #10's incontinence briefs leaking on his/her clothing and smelling of urine. The resident noted that the previous incontinence briefs did not leak like the current ones. The resident noted that they missed a facility event due to this issue. In addition, the resident noted they had been complaining and no one was listening. The grievance official follow-up section read that the current brief was not new and they will add a pad under the brief. That the resident agreed with the plan. It was marked as resolved. There was no investigation to determine the reason the incontinence briefs were leaking in order to determine an intervention to ensure it did not continue to happen. An interview with Resident #10 on 1/7/26 at 12:00 PM revealed that the resident continued to feel that facility staff were not responsive to the grievances. An interview with the NHA on 1/9/26 at 1:45 PM revealed that he was the Grievance Officer. Reviewed the concerns with him and he acknowledged that the concern was not addressed on 12/9/25 when it was first brought to the facility staff's attention and failed to investigate the second grievance to ensure a response that was going to fix the concern for the resident.

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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 review, interview and review of the facility abuse policy, it was determined that the facility staff member failed to treat a resident with respect and free from verbal abuse. This was evident during the review of 1 of 8 facility reported incidents and complaints (Resident #3). The findings include: Review of the facility reported incident 2634927 on 1/8/26 at 3:10 PM revealed that on 10/3/25 at approximately 4:10 PM during the 4 PM smoke break a verbal altercation occurred between activity assistant staff #12 and Resident #3. According to a statement from the investigation, Resident #3, who was unable to be interviewed during the survey process due to independent activities, stated that when activity assistant staff #12 came out to the smoking area he asked the group if they wanted to listen to music and the majority of the people said they didn't want to listen to the music. However, staff #12 went ahead and played the music anyway. Resident #3 reported that s/he didn't like the music choices because they were derogatory in nature, inappropriate for public listening and extremely loud making it hard to hear one another. This then caused a verbal back and forth between Resident #3 and staff #12 where yelling and cursing between both individuals started and continued until a supervisor was brought to the courtyard and escorted staff # 12 out of the facility for the rest of the day. The Recreation Program Director, staff # 11 was interviewed on 1/8/26 at 3:45 PM. He was asked by this surveyor if there had ever been occurrences between Resident #3 and staff #12 before. Staff #11 stated that yes, Resident #3 had complained prior about the music staff #12 played and that staff #12 had come to him about it. Review on 1/9/26 of the employee file staff #12 revealed disciplinary action less than 3 weeks prior for negative interactions with resident, where a resident was singled out making him/her upset. Staff education on the facility smoking policy and abuse education and prevention was completed after the 10/3/25 incident and Staff #12 was relieved of their employment at the facility officially on 10/9/25 according to documentation provided in the facility investigation packet reviewed on 1/9/26. The current Nursing Home Administrator was notified of the concern regarding the surveyors' findings of substantiated abuse on 1/9/26 prior to exit and again during the exit conference on 1/9/26.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on the review of a facility reported incident 2598625, medical record review, interview with facility staff and review of facility policies, it was determined that the facility failed to ensure that residents medications were free from misappropriation. This was evident for 1 of 1 allegation of misappropriation.The findings include:The facility reported incident 2598635 was reviewed starting on 1/7/26 at 2:50 PM. The facility had initially only provided the initial report and an initial report that was sent to the Board of Nursing regarding staff RN #3, the previous Unit A manager. According to what was provided, on 8/11/25 the previous unit manager took 2 sheets of narcotics (Oxycodone) from a medication cart and destroyed them without following proper procedures including having a witness. Staff RN#3 also left early that day and failed to notify the nurse of that medication cart. Therefore, when the nurse that was working on that cart went to appropriately waste the medication from her cart, she found that it was already gone. She contacted staff RN #4, asking if she did it. Staff RN #4 found the Controlled Dangerous Substance Destruction Report used when narcotics are destroyed, on staff RN#3's desk with her and staff #6's signature and initials. When staff RN#6 was then immediately interviewed, he stated that he was only aware of his medications being wasted not the other 2 narcotics listed. This concern was then brought to the attention of the DON by Unit manager, staff RN#4, who stated that this was not the first time there has been an incident regarding narcotics and relating to [staff RN# 3].The facility was toured by this surveyor starting at 3:00 PM on 1/7/26 and the narcotic logs were reviewed at that time that were available on the medication carts. The narcotic logbook on the A unit revealed multiple days with holes noted on the log. The current unit A manager, staff RN# 2, was notified and copies were requested of the surveyors' findings in the narcotic log. Staff RN#2 was also asked at this time what the process was for destroying narcotics. She reported that 2 licensed nurses need to be present for the entire process from gathering the medications to signing the paperwork and destroying the medication. The DON was notified of the concern regarding the missing signatures in the logbook on 1/7/26 at approximately 3:28 PM when she was also asked about the incident of the previous unit manager allegedly destroying narcotics by herself. She was asked at this time for the entire facility investigation. The DON stated at that time that there was not much to the investigation and that it was hard to do the investigation because they didn't have the names of the residents whose narcotics were destroyed. On 1/8/26 at 7:08 AM the entire investigation was provided at this time. The DON was interviewed on 1/8/26 at 12:49 PM about the investigation. She stated that they were unable to determine whose resident's medication were destroyed, however a call to the pharmacy could have been made to determine this information by providing the prescription number. During the review of the narcotic logs on 1/7/26 it was noted that sometimes the narcotics were documented as sent home with the resident and sometimes they were destroyed. The DON stated that it was all based on a physician order. She was asked if they went back and verified if the narcotics were sent home and/or destroyed on the ‘A' unit at any time during the tenure of the previous unit manager as part of the investigation and she stated ‘no.' This surveyor asked how they were able to determine that no other resident was affected by this potential misappropriation and she stated that all medications were signed off. This surveyor verified that that was all they did to confirm that other residents were free from medication misappropriation and she stated ‘yes,' and took notes, no other information was presented prior to exit on 1/9/26. Cross reference F609, F610

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that the facility failed to ensure that an allegation of abuse was reported to the state agency (SA) within the required 2-hour timeframe. This was evident for 2 (Resident #1 and 2598625, 2593945) of 7 residents/investigations reviewed for abuse allegations.The findings include: 1. A medical record review for Resident #1 on 1/9/26 at 10:36 AM revealed a care plan meeting note initiated on 8/12/25 at 3:19 PM by unit manager (UM) #4 was incomplete. Another care plan meeting note was entered by Social Services Director (SSD) on 8/13/25 as a late entry for 8/12/25 at 10:33 AM, indicating the care plan meeting occurred at that time. On 1/8/26 at 4:19 PM a review of the facility's investigation file for the facility reported incident #2593945 revealed the initial report form that documented Resident #1 made an accusation that 2 male therapists kicked him/her in the chest and stomach. Staff documented they became aware of the allegation of abuse on 8/12/25 at 4:00 PM and failed to include to whom it was reported. Review of the final investigation report revealed that the resident's family member reported the allegation of abuse during a care plan meeting on 8/12/25. A review of the statement written by the social services director (SSD) revealed she failed to document the date and time she was told of the allegation of abuse and when she had reported the allegation and to whom. On 1/9/26 at 9:08 AM a review of the email confirmation for when the facility reported the allegation of abuse to the state agency (SA) revealed it was sent on 8/12/25 at 5:55 PM. During an interview with the Assistant Director of Nursing (ADON) on 1/9/26 at 9:19 AM she reported that she documented the date and time she became aware of the allegation of abuse on the initial report form. She confirmed she was aware that she should have reported the date and time the Social Services Director (SSD) was told of the allegation but failed to do so. The SSD was interviewed on 1/9/26 at 9:59 AM and she reported that the care plan meeting for Resident #1 was on 8/12/25 at 2:30 PM. She reported that the meeting lasted about 45 minutes that day and as soon as the meeting was over, she reported the allegation of abuse to the ADON between 3:19 PM and 3:30 PM. The concerns were reviewed with the NHA on 1/9/26 at 1:30 PM. 2. Review of the facility reported incident regarding the misappropriation of resident medication revealed that the facility was made aware of the concern by staff #4 on 8/11/25, however the state agency was not notified until 8 business days later on 8/21/25 at 6:00PM. Initially when interviewed regarding incident 2598625, the DON stated that this was considered an unusual circumstance. However, after surveyor review and interviews were completed, a follow up meeting was held on 1/8/26 at 12:49 PM and she was notified of the concern and classification of this incident as misappropriation of resident medication which is a form of abuse. The survey team requested email confirmations of submissions to ensure the appropriate time frames when reviewing the incident times. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concerns of reporting time frames were reviewed throughout the survey and again during exit on 1/9/26.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that the facility failed to conduct a thorough investigation and ensure a written record of the investigation was maintained. This was evident for 2 (#1 and #5) of 7 residents reviewed for abuse allegations and an incident (2598625) regarding misappropriation. The findings include: Minimum Data Set (MDS) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1. A medical record on 1/9/26 at 11:29 AM for Resident #5 revealed an admission Minimum Data Set (MDS) with the assessment reference date of 10/10/25. Review of the MDS revealed the resident had no cognitive impairment. Staff documented in section F that it was very important for the resident to choose if s/he wanted a shower or a bed bath. Staff documented in section I that the resident had a diagnosis of chronic pain syndrome (which is chronic pain associated with significant psychosocial dysfunction per icd10data.com). Further review of the medical record failed to reveal that staff determined if the resident preferred a shower or a bed bath and how often they preferred it to be done. A review on 1/8/26 at 7:31 PM of the facility's investigation file for facility reported incident 2643620 revealed an initial report form that documented on 10/15/25 at 12:00 PM Resident #5 reported neglectful concerns regarding [his/her] care, however they failed to document to whom the resident reported these concerns. A review of the final investigation report revealed the resident's concerns were regarding pain medication that was not given for 24 hours to which staff explained to the resident that this was how the medication was ordered. Another concern documented was the resident was used to getting a shower every day and not two times a week. Staff noted that they updated the resident's care plan to offer him/her a shower daily. The last concern documented was that the resident was experiencing trauma triggers related to stress and being in a nursing home. A review of a census sheet that had check marks beside a few resident's names and handwritten at the bottom was a note that the residents had not reported any concerns with their pain medications. There was no date and time of the interviews and no signature or name of the person conducting the interviews. Further review of the file revealed that although the resident was alert and oriented staff failed to obtain a statement from them, failed to interview other residents regarding any concerns with showers and trauma care, and failed to include staff statements regarding the concerns. Furthermore, there was no evidence that staff investigated the reason the resident was not receiving daily showers when that was his/her preference, to determine the reason the resident's pain was not control and address the concern if needed, and to determine what occurred that the resident's trauma triggers were not found during the trauma screening process. On 1/9/26 at 1:25 PM the surveyor attempted to interview the Assistant Director of Nursing (ADON) regarding the investigation, but she was unavailable. The Nursing Home Administrator (NHA) was interviewed on 1/9/26 at 1:30 PM. He stated that this incident occurred prior to him taking the role as the NHA. He stated that this was an incomplete investigation because staff should have provided dates and times of the interviews with residents and signed that they completed them, staff should have interviewed staff, and staff should have investigated the concerns brought up by the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A medical record review for Resident #1 on 1/9/26 at 10:36 AM revealed the attending physician's note for a visit on 8/12/25 documented the resident had a stroke and needed physical and occupation therapy. Review of the MDS with the assessment reference date of 11/14/25 showed the resident had mild cognitive impairment. A care plan meeting note was initiated on 8/12/25 at 3:19 PM by Unit Manager (UM) #4. Another care plan meeting note was entered by Social Services Director (SSD) on 8/13/25 as a late entry for 8/12/25 at 10:33 AM, indicating the care plan meeting occurred at that time. On 1/8/26 at 4:19 PM a review of the facility's investigation file for the facility reported incident 2593945 revealed the initial report form that documented Resident #1 made an accusation that 2 male therapists kicked him/her in the chest and stomach. Staff documented they became aware of the allegation of abuse on 8/12/25 at 4:00 PM and failed to include to whom it was reported. Review of the final investigation report revealed that the resident's family member reported the allegation of abuse during a care plan meeting on 8/12/25. The family member reported that the resident told him/her that 2 staff members had kicked the resident in the stomach on Friday (8/8/25) night. The abuse was not substantiated because the perpetrators were not identified and the resident could not pinpoint the description of the incident. Further noting that there was 1 male therapist in the facility. A review of the statement written by the social services director (SSD) revealed she failed to document the date and time she was told of the allegation of abuse and when she had reported the allegation and to whom. Review of the staff statements revealed that there were 2 male staff members who cared for the resident on 8/8/25 and provided statements and the male therapist provided a statement, however staff failed to obtain statements from other staff who had been working on 8/8/25 in the evening/night. On 1/9/26 at 9:08 AM a review of the email confirmation for when the facility reported the allegation of abuse to the state agency (SA) revealed it was sent on 8/12/25 at 5:55 PM. An interview with the Assistant Director of Nursing (ADON) on 1/9/26 at 9:19 AM revealed she failed to document the date and time the facility became aware of the allegation of abuse on the initial report form. She reported 8/12/25 at 4:00 PM was the time she was made aware of the allegation of abuse. Reviewed the concerns and she stated she was still learning how to do the investigations. The SSD was interviewed on 1/9/26 at 9:59 AM and she reported that in her Outlook calendar the care plan meeting for Resident #1 was on 8/12/25 at 2:30 PM. She reported she had no letter that was sent to the resident and the family to verify the date and time of the care plan meeting. She stated she calls them but does not consistently document the phone calls. She stated that meeting usually last 30 – 45 minutes. When asked about the allegation of abuse received on that day, she reported she had not written down the time of the allegation, but that as soon as the meeting was over, she reported it to the ADON. When informed the care plan note was initiated by unit manager (UM) #4 on 8/12/25 at 3:19 PM, she stated that it was probably between 3:19 PM and 3:30 PM that she reported it to ADON. The concerns were reviewed with the NHA on 1/9/26 at 1:30 PM. 3. The facility reported incident 2598625 was reviewed starting on 1/7/26 at 2:50 PM. The facility had initially only provided the initial report that was sent to the Office of Health Care Quality (OHCQ) and an initial report that was sent to the Board of Nursing regarding staff RN # 3, the previous Unit A manager. According to what was provided, on 8/11/25 the previous unit manager took 2 sheets of narcotics (Oxycodone) from a medication cart and destroyed them without following proper procedures including having a witness present during the process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 1/8/26 at 12:49 PM about the provided investigation. She stated that they were unable to determine whose medication was destroyed, however a call to the pharmacy could have been made to determine this information by providing the prescription number that was listed on the narcotic destruction sheet. During the review of the narcotic logs on 1/7/26 it was noted that sometimes the narcotics were documented as sent home with the resident at discharge and sometimes the narcotics were destroyed. This was reviewed with the DON at this time. She was asked during this interview on 1/8/26 at 12:49 PM if during their investigation they verified if the narcotics that were noted as sent home and/or destroyed on the 'A' unit at any time during the tenure of the previous unit manager as part of the investigation and she stated 'no.' This surveyor asked how they were able to determine that no other resident was affected by this potential misappropriation and she stated that all medications were signed off. This surveyor verified verbally with the DON that that was all they did to determine and confirm that other residents were free from medication misappropriation and she stated 'yes,' and took notes, no other information was presented prior to exit on 1/9/26. Cross reference F602, F609

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, it was determined that facility staff failed to identify and evaluate factors contributing to a resident's falls and ensure appropriate interventions were implemented to prevent future occurrences. This deficient practice resulted in actual harm to Resident #1. This was evident for 1 (#6) of 1 resident reviewed for accidents/hazards.The findings include: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. Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status.On 1/2/26 the state agency (SA) received a complaint 2708089 regarding Resident #6 alleging that the resident had multiple falls. The allegation stated that the resident had broken their right hip in 1/2025 and then broke the left hip on 12/31/25.A medical record review for Resident #6 on 1/7/26 at 12:31 PM revealed a care plan focus on the resident's high risk for falls related to dementia, poor gait/balance, poor safety comprehension, incontinence, and a history of falls that was initiated on 5/24/24. The goal was to keep the resident free of falls during the review period. The interventions included but were not limited to the following: ensure the resident's environment was decluttered and well lighted, initiated on 5/24/24; ensure resident was wearing appropriate footwear, initiated on 7/3/24; staff to place fall mats on the floor while the resident was in bed, initiated on 7/3/24. Staff noted a fall that occurred on 1/28/25 resulting in a right hip fracture. On 1/30/25 the following interventions were initiated: implement a toileting program to prevent falls and to review each fall for the root cause and remove the cause. However, the care plan failed to reveal an intervention addressing the level of supervision Resident #6 needed to prevent future falls. A review of the Change in Condition (CIC) forms dated 6/1/25 to current revealed the resident had a fall on 6/16/25. Further review revealed this fall was not listed on the care plan and there were no new interventions implemented. There was no evidence that staff reviewed the fall to determine the cause as stated in the care plan. A CIC form dated 7/1/25 revealed the resident had a fall and further review revealed the care plan was not updated with the fall, and no new interventions were added. There was no evidence that staff reviewed the fall to determine the cause. A review of the physician's orders, medication administration record (MAR), and treatment administration record (TAR) for 2/1/25 - 12/31/25 revealed the toileting program to prevent falls had not been implemented.The quarterly Minimum Data Set (MDS) with the assessment reference date of 11/14/25 was reviewed. The document revealed the resident had severe cognitive impairment. A review of section GG revealed that the resident was able to go from a lying to a sitting position independently but required moderate assistance to transfer from the bed to the wheelchair. Once in the wheelchair the resident was able to move about the room and nursing unit independently. A review of Section H revealed the resident was frequently incontinent which indicated that at times the resident was able to use the bathroom. Review of a CIC form dated 12/23/25 revealed the resident had a fall and further review revealed this fall was documented on the care plan. There was one new intervention added on 12/24/25 which was to ensure the bed was locked and in a low position. There was no evidence of the fall review to determine the cause. A CIC form dated 12/31/25 revealed the resident had a fall and was complaining of left hip pain. Further review revealed that the resident was sent to the hospital and diagnosed with a broken left hip as a result of this fall.A review of the resident's discharge summary from the acute (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	care hospital dated 1/7/26 revealed the resident had a fractured left hip requiring surgical intervention and was to be discharged back to the facility.An interview with Licensed Practical Nurse (LPN) #6 on 1/7/26 at 3:03 PM revealed he was frequently assigned to Resident #6. He reported that the resident was mostly confused due to the diagnosis of dementia and would frequently get out of bed or chair without assistance. He stated the resident was able to move about the room by holding onto things and in the hallway s/he would use the wheelchair to ambulate. He reported that staff would leave the resident's wheelchair beside the bed in hopes that the resident would get into the chair when s/he tried to get up unassisted. When asked why he thought the resident would get up unassisted he stated that at times the resident wanted to rummage through things and to go to the bathroom. He reported the resident would wander into other resident's rooms. When asked if the resident was on a toileting program, he stated s/he was not.LPN #6 reported that on 12/31/25 the resident fell while staff were passing lunch trays and he was administering medications to other residents. Staff were alerted by the roommate screaming for help. He stated that he found the resident lying inside the doorway of the room near the bathroom. The resident was unable to verbalize what had happened.A subsequent medical record review on 1/8/26 at 10:00 AM revealed the resident had returned to the facility and was admitted to a different room. The care plan for falls had been updated with 1 intervention to place the wheelchair beside the resident bed while the resident was in bed. However, per the interview with LPN #6, staff were doing this intervention. Further review revealed no evidence that the fall was reviewed for the root cause and no intervention to include the level of supervision the resident needed to prevent falls.An observation of Resident #6 in their new room on 1/8/26 at 10:32 AM revealed the resident was in the bed closest to the window and the curtain was closed so staff were unable to see what the resident was doing. There were no fall mats on the floor. The roommate's bed was pushed close to the dividing curtain to accommodate the roommate's things. The roommate's light was off, making his/her side of the room low lighting. At the end of the roommate's bed was a dresser with a TV on it and a fan that was partially hanging off. Situated beside the dresser was a metal stand that was filled with food, snacks, drinks, and miscellaneous items. On the floor next to the stand were 2 six packs of a bottled drink sticking out into the walkway between the bed and the dresser. On 1/8/26 at 12:11 PM an interview with the Director of Nursing (DON) revealed the resident was impulsive with poor safety awareness and frequently attempted to get up and walk without assistance. The DON reported that the resident had been placed in a room closest to the nurses' station prior to the fall on 12/31/25. However, due to some concerns with the interactions between the family and the Unit Manager they did not want the resident on the same unit, so when the resident was readmitted to the facility, they were unable to find a bed closest to the nurses' station on the new unit. Upon review of the concern regarding the failure to implement a toileting program for the resident, she confirmed that the toilet program would have been documented on the resident's MAR or TAR. She was unable to provide a rationale as to why it had not been implemented. She stated she would look into the concern and report back to the surveyor. She failed to report back by the end of the survey. During this interview the DON and surveyor made a subsequent observation of Resident #6's current room. She acknowledged the room was furthest from the nurses' station, however failed to implement safety measures to mitigate this concern. She acknowledged the resident's roommate's side of the room was cluttered and had low lighting increasing the resident's risk for another fall. She stated that staff were supposed to check on the resident as they came by the room and acknowledged that with the curtain closed, they could not see what the resident was doing. In addition, the DON had to lower the bed during the observation because it was too high, there were no floor mats beside the bed, and the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident's wheelchair was not positioned beside the bed. There was no room to put the resident's wheelchair next to the bed because the roommate's bed was pushed against the curtain that was hanging to separate the room. While leaving the room the DON reported that she would take care of these concerns to keep the resident safe.The Nursing Home Administrator (NHA) was made aware of the concerns via a phone call on 1/16/26 at 11:58 AM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, interview and review of facility policy, it was determined that the facility staff failed to ensure the verification of the narcotic count at the end of each shift was signed and completed. This was evident for 1 of 2 medication carts on the A wing. The findings include:The narcotic logbooks for the A wing were reviewed on 1/7/26 secondary to a facility report from August 2025 that there were discrepancies when the previous Unit Manger allegedly wasted narcotics without a witness.Review of the narcotic logbook on 1/7/26 at 3:10 PM revealed multiple days between August 2025 and December 2025 where staff failed to ensure that there were 2 nurses verifying the narcotic count at shift change.The unit manager for Unit A, staff # 2, was interviewed on 1/7/26 at 3:15 PM about the process for signing out narcotics and what is to occur at shift change. She stated that 2 nurses are to sign each shift and if someone works a double shift, they are to do the narcotic count with the shift supervisor. She was notified at that time of the multiple holes that were reviewed in the narcotic log and copies of August through December were requested at that time.This concern was brought to the attention of the DON on 1/7/26 at 3:28 PM when the copies of the narcotic log were followed up on. The DON stated that the process is that staff will work a double, one shift followed by part of another or the entire next shift, and that she will tell them to just sign their initials for both shifts. The DON stated that could be the reason for missing signatures. Schedules for the selected time frames, which included 10/24-10/29, 11/25-11/17, 11/24-11/26 and 12/24-12/26/25 were requested.Review on 1/8/26 at 12:42 PM of the requested schedules compared with the narcotic logs and corresponding signatures concurrently with the facility DON revealed that staff failed to consistently sign the narcotic log between shifts even when they worked double shifts. The facility policy on Controlled Substance Administration and Accountability dated as last revised on 3/2023, was reviewed on 1/8/26 included 1.h. The controlled drug record.serves the dual purpose of recording both narcotic disposition and patient administration. j. the charge nurse or designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify: i. controlled substances that are destroyed are appropriately documented and ii. Medications removed from.medication cart have a documented physician order. The concerns that the narcotic log shift to shift verification was not maintained were reviewed throughout the survey and again during exit on 1/9/26.Cross reference F602, F610

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on random observations, interviews it was determined that the facility staff failed to keep resident medications secure from vulnerable residents. This was evident during a random tour of the facility.The findings include: During tour of the facility on 1/8/26 at 4:20 PM upon approaching the C/D unit, a medication cart was observed pushed up against the nursing station. On this medication cart were; 2 insulin syringes, 2 hypodermic needles, and Budesonide (steroid inhaler). There was a ward clerk sitting at the desk and the C/D unit manager staff #13 was observed in her office, however, neither were assigned to or in charge of the medication cart. The facility Nurse Practice Educator (NPE), staff #14 arrived down the same hall minutes after this surveyor walked down and immediately made the same observations and was seen looking for the nurse that belonged to the medication cart that was observed against the nursing station. He was notified by this surveyor of the same observations, time frame of waiting and that this surveyor too was waiting for the nurse. He then spoke to the staff at the nursing desk, and she stated that the employee was in the bathroom. Moments later a staff member exited a bathroom across from the nursing station and returned to the medication cart that was at the nursing station where the NPE staff #14 and this surveyor had remained. Staff # 14 immediately educated RN staff #7 on the spot after verifying that this was not her first time here at the facility and this was her cart. This surveyor then was introduced and let her know the concerns as there were 2 independently mobile residents on the opposite side of the nursing station moving about that would not be seen by any staff if they were on this side and grabbed anything off her medication cart. This observation was reported to the facility DON at approximately 4:40 PM on 1/8/26. Review on 1/9/26 of the medical record for Resident # 9, 1 of the 2 residents observed on the other side of the the nursing station, revealed that s/he has a diagnosis of Alzheimer's and a care plan in place for eating and chewing inanimate objects. The concern that there were medications and administration instruments left unattended on a medication cart and in the vicinity of vulnerable adults were reviewed again with the facility on exit 1/9/26.