

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/04/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Laplata LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Magnolia Drive Laplata, MD 20646	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 record reviews and interviews it was determined that the facility failed to provide services that met professional standards of practice. This was found to be evident for 4 (Resident #50, Resident #124, Resident # 32, Resident #11) out of 8 Residents reviewed for professional standards of practice during the recertification and complaint survey. The findings include: 1)According to the National Institute of Health (NIH) enteral feeding (tube feeding) delivers essential nutrients directly to the stomach or small intestine for individuals unable to meet nutritional needs orally. Common tubes include nasogastric (short-term) or PEG/J-tubes (long-term), which help manage conditions like dysphagia, stroke, or cancer. It can be delivered via pumps or gravity and is used until oral intake is safe. A PEG tube (percutaneous endoscopic gastrostomy) is a soft, flexible feeding tube inserted through the abdomen into the stomach, used for long-term nutrition, hydration, and medication delivery. It allows food to bypass the mouth and esophagus, typically for people with swallowing difficulties or chronic illnesses. Jevity 1.5 Cal is a high-calorie, fiber-rich formula designed for individuals who need extra calories and balanced nutrition, whether for short- or long-term tube feeding. Whether used as a sole source of nutrition or a supplement, Jevity 1.5 CAL nutrition provides concentrated calories and essential nutrients to help maintain a healthy weight and support overall well-being. During an observation conducted on 04/28/2026 at 3:21 PM, the Surveyor observed Resident #11's water bag dated 4/26/26 with a time of 8pm and a bottle of enteral feeding hanging labeled Jevity 1.5 dated 4/26/26 with a time of 8 pm, photos taken. A review of Resident #11's Medication Administration Record (MAR) was conducted on 04/28/26 at 3:33 PM. The following order was discovered: Enteral Feed Order every shift Jevity 1.5 CAL Administer continuous via Pump 60 ML [milliliter] per hour. 8 Hours per day Downtime: 4:00 AM and Up at 8:00 PM. (8:00 PM to 4:00 AM) -Order Date09/25/2025. During an interview conducted on 04/28/2026 at 3:55 PM, the Surveyor notified the Director of Nursing (DON) of the observation that Resident 11's enteral feeding was dated from 2 days ago and the concern that the Resident may not have received the ordered enteral feeding and water flush on (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/29/2026. The DON reported that she would investigate and return. The DON returned on 04/28/2026 at 4:22 PM and confirmed that Resident #11's enteral feeding and water bag was dated for 04/26/26 with a time of 8 PM. The DON stated that she had begun an in-service for enteral feedings and provided education for the nurse assigned to the Resident. 2)On 04/30/2026 at 9:36 AM, this surveyor observed LPN (Licensed Practical Nurse) #7 administer medications to Resident #50. It was observed that the privacy curtain between Resident #50 and his/her roommate was not pulled prior to medication administration. It was also observed that LPN #7 did not explain the medications to the resident before administration. Med Pass 2.0 is a concentrated nutritional supplement used to provide additional calories and protein to residents who may be at risk for weight loss or poor nutritional intake. On 04/30/2026 at 9:47 AM, this surveyor observed LPN #7 administer medications to Resident #124. It was observed that LPN #7 did not explain the medications to the resident prior to administration. Additionally, 120 mL of Med Pass 2.0, ordered four times daily for additional protein and calories, was left unattended at the resident's bedside without confirmation that the resident had consumed the supplement before LPN #7 exited the room. On 04/30/2026 at 9:52 AM, this surveyor interviewed LPN #7 regarding medication administration expectations. LPN #7 acknowledged that medications should not be left unattended at bedside and stated that anything requiring administration by nursing staff constitutes a medication. It was explained that leaving the Med Pass supplement unattended was a concern. LPN #7 further reported that she explains medications if residents ask about them or if there has been a change in the medication regimen. During the interview, it was also explained that not providing privacy during medication administration was a concern. LPN #7 acknowledged understanding of the concerns. Hydrocodone/Acetaminophen is a prescription pain medication used to treat moderate to severe pain. It combines hydrocodone, an opioid pain reliever, with acetaminophen, a medication that helps reduce pain and fever. On 04/30/2026 at 12:12 PM, this surveyor observed RN (Registered Nurse) #9 administer Hydrocodone/Acetaminophen 5 mg/325 mg, ordered every six hours as needed for pain, to Resident #32. The medication was administered from the medication cart located in the hallway rather than inside the resident's room. During the administration, at least one additional resident and one staff member were observed walking through the hallway while the medication administration occurred. On 04/30/2026 at 12:14 PM, this surveyor interviewed RN #9 regarding medication administration expectations. RN #9 reported that medications are normally administered in residents' rooms, although sometimes medications are given in the hallway if no one is present. It was explained that administering medications from the medication cart in the hallway did not ensure resident privacy, particularly since other individuals were present in the area during the medication administration. RN #9 acknowledged understanding of the concern. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2026 at approximately 1:00 PM, record review of the facility's Medication Administration policy revealed the following compliance guidelines: Provide Privacy, Review the MAR (Medication Administration Record) to identify medication to be administered, and Observe resident consumption of medication. On 05/01/2026 at approximately 11:00 AM, this surveyor conducted an interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) regarding the medication administration observations and concerns related to professional standards of practice. It was explained that concerns included failure to provide privacy during medication administration, failure to explain medications to residents, and failure to observe medication consumption. The DON acknowledged understanding of the concerns.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of employee records and staff interview, it was determined that the facility staff failed to complete required performance reviews of geriatric nursing assistants at least once every 12 months. This was evident for 4 (Employee #27 # 28, #29 and #30) of 5 employee records reviewed during recertification survey process. The findings include: Performance appraisals are to be completed at least every 12 months to identify in-service education needed to address competencies of the geriatric nursing assistants. On 05/01/2026 at 7:52 AM, a review of employee records revealed the following: Employee #27, hired on 04/18/2021, had documented performance evaluations dated 06/08/2025 and 04/24/2026. Employee #28, hired on 04/18/2021, had a documented performance evaluation dated 02/07/2025. Employee #29, hired on 09/03/2023, had no documented performance evaluation. Employee #30, hired on 11/12/2025, had no employee record available for review. On 05/01/2026 at 8:23 AM an interview was conducted with Staff #15, who reported being in the position for one year and stated that staff evaluations are conducted annually, as well as at 60-day and 90-day intervals for new hires. At that time, a review of staff records was initiated with Staff #15 for Employee #27; however, the records were not found in the personnel files at the time of review. Staff #15 stated that the records had been processed and were located at her desk. On 05/01/2026 at 8:48 AM the surveyor reviewed employee records with Staff #15, who confirmed that the expectation is to conduct staff performance evaluations annually, as well as at 60-day and 90-day intervals for new hires. Staff #15 also confirmed the hire dates for Employee #27, #28, #29, and #30. Staff #15 further stated that she has only been in the position for one year and is in the process of organizing records.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to be free of a medication error rate of 5% or more. This was found to be evident during the Medication Administration task completed during the Annual/Complaint survey and had the potential to affect all residents receiving medications in the facility. The findings include: Insulin is a medication used to control blood sugar levels in individuals with diabetes. Because insulin affects blood glucose levels, it must be administered exactly as ordered to prevent potential harm, including low or high blood sugar. Calcium-Vitamin D is a dietary supplement used to support bone health and help maintain adequate calcium and vitamin D levels in the body. A chewable formulation is intended to be chewed before swallowing. Med Pass 2.0 is a concentrated nutritional supplement used to provide additional calories and protein to residents who may be at risk for weight loss or poor nutritional intake. Polyethylene glycol is a laxative medication used to treat constipation by helping the body retain water in the stool to promote bowel movements. Oxybutynin Chloride ER is an extended-release medication used to treat overactive bladder symptoms, such as urinary urgency and frequency. Extended-release medications are designed to release slowly over time and should not be crushed. On 04/30/2026 at 9:14 AM, this surveyor observed LPN (Licensed Practical Nurse) #7 administer medications to Resident #50. LPN #7 reported that she was administering 21 units of insulin to the resident and was observed administering 21 units into the resident's right arm. After the medication pass, this surveyor reviewed the physician order in the MAR (Medication Administration Record) with LPN #7. The MAR directed staff to administer 18 units of insulin one time daily at 0800 for diabetes mellitus. LPN #7 reported that the MD (Medical Director) had verbally instructed her the previous day to increase the insulin dose from 18 units to 21 units but acknowledged that the physician order in the MAR had not yet been updated. It was explained that administration of insulin that did not match the active MAR order constituted a medication error. On 04/30/2026 at 9:42 AM, this surveyor observed LPN #7 prepare medications for Resident #124. The resident had an order for Calcium-Vitamin D Chewable 600-400 mg-unit supplement, one tablet by mouth twice daily for bone health. During the observation, LPN #7 stated that the resident preferred the regular tablet formulation instead of the chewable form and reported that this preference had existed since the medication was initially ordered on 02/03/2026. LPN #7 stated that the physician had been informed of the preference when the medication was first ordered. LPN #7 was observed removing a non-chewable Calcium-Vitamin D 600 mg tablet and placing it into the medication cup for administration instead of the chewable formulation ordered in the MAR. LPN #7 also prepared 120 mL of Med Pass 2.0 (four times a day for additional protein & calories) per physician order. During the preparation, LPN #7 additionally stated that Resident #124 typically refused Polyethylene Glycol 3350 Powder - 17 grams by mouth one time a day for constipation and reported that she usually asked the resident whether he/she wanted to take the medication. On 04/30/2026 at 9:47 AM, this surveyor observed LPN #7 administer medications to Resident #124. The resident received the non-chewable Calcium-Vitamin D tablet instead of the chewable formulation ordered. LPN #7 did not ask the resident whether he/she wished to take the Polyethylene Glycol powder medication. The Med Pass 2.0 supplement was observed left unattended on the resident's bedside table after the nurse exited the room. On 04/30/2026 at 9:52 AM, this surveyor interviewed LPN #7 regarding medication administration expectations. LPN #7 reported that medications should not be left unattended at bedside and acknowledged that anything requiring administration by nursing staff constituted a medication. It was explained that leaving the Med Pass supplement at bedside, administering a formulation of the Calcium-Vitamin D that differed from the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician order, and failing to offer the ordered Polyethylene Glycol medication were medication administration concerns. LPN #7 acknowledged understanding. On 04/30/2026 at approximately 1:00 PM, a record review of the facility's Medication Administration policy revealed the following compliance guidelines for medication administration: Compare medication source (bubble pack, vial, etc.) with the MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time, and Observe resident consumption of medication. On 04/30/2026 at approximately 1:15 PM, a record review of the facility's Verbal/Telephone Orders policy revealed the following: prescribed orders are to be repeated back to the physician or healthcare provider for clarification to avoid misunderstandings; orders are to be entered into the medical record manually or electronically; and verbal or telephone orders are to include the date, time, resident name, complete order, and signatures of the physician or healthcare provider and nurse, or be electronically signed in accordance with the facility's software system guidelines. The policy further stated that the physician is to sign the order at the next facility visit or within the timeframe required by the facility. On 05/01/2026 at 8:40 AM, this surveyor observed LPN #11 prepare medications for Resident #77. During the medication preparation, LPN #11 stated that due to the resident's dysphagia, certain medications would be crushed if able to be crushed. Record review revealed that Resident #77 had an active order for Oxybutynin Chloride ER (Extended Release) 24 Hour 10 mg tablet with instructions stating: Give 1 tablet by mouth one time a day. DO NOT CRUSH MEDICATION. On 05/01/2026 at 8:55 AM, this surveyor asked LPN #11 which medications should not be crushed. LPN #11 reported that extended-release medications and capsules should not be crushed. During the observation, LPN #11 was observed crushing the Oxybutynin ER tablet along with Resident #77's other medications. On 05/01/2026 at 9:00 AM, this surveyor observed LPN #11 administer the crushed Oxybutynin ER medication to Resident #77. On 05/01/2026 at 9:03 AM, this surveyor interviewed LPN #11 and explained that crushing the extended-release Oxybutynin medication constituted a medication error because the medication instructions specifically stated not to crush the tablet. LPN #11 acknowledged understanding and apologized for the error. On 05/01/2026 at approximately 11:00 AM, this surveyor conducted an interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) regarding the medication administration observations. It was explained that the observed medication errors resulted in a medication error rate of 15.63 percent. The DON acknowledged understanding and confirmed that verbal insulin orders should not be administered until the MAR and physician orders are updated and verified. The DON further confirmed that medications should not be left unattended at bedside, physician orders should accurately reflect the formulation being administered and extended-release medications should not be crushed.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review and interview, it was determined that the facility failed to ensure discontinued medications and medications belonging to discharged residents were appropriately removed and returned to the pharmacy and/or destroyed in accordance with facility expectations. This was found to be evident for 4 (Resident #37, #138, #122, and #5) out of 4 residents reviewed for medication storage and labeling. The findings include: Buspirone is a medication commonly used to treat anxiety disorders. Carvedilol is a medication used to treat high blood pressure and heart failure by helping the heart pump more effectively. Furosemide is a diuretic (water pill) used to reduce excess fluid buildup associated with conditions such as congestive heart failure. Cyclobenzaprine is a muscle relaxant used to relieve muscle spasms and discomfort and may cause drowsiness. Valproic Acid is a medication used to treat seizure disorders and certain mood or behavioral conditions. Ipratropium-Albuterol Solution is an inhalation medication used to help open the airways and improve breathing in residents with respiratory conditions. On 04/30/2026 at 2:43 PM, this surveyor conducted an observation of the medication room for the facility's C/D Wing. During the observation, several blister packets of medications were observed sitting unsecured on the medication room counter. Each blister packet contained remaining medication and was labeled with resident names and medication information. The medications observed included the following: For Resident #37, Buspirone 5 mg, Take 1 tablet by mouth two times a day for anxiety. For Resident #138, Carvedilol 12.5 mg, Take 2 tablets by mouth twice a day for hypertension, Furosemide 40 mg, Take 1 tablet by mouth every day for CHF (Congestive Heart Failure), and Cyclobenzaprine 10 mg, Take 1/2 tablet by mouth every 12 hours as needed for muscle pain; may cause drowsiness. For Resident #122, Valproic Acid 250 mg, Take 1 capsule by mouth once a day for seizure prophylaxis and agitation for 7 days. On 04/30/2026 at 2:44 PM, this surveyor additionally observed Ipratropium-Albuterol Solution labeled for Resident #5 sitting on the medication room counter. On 04/30/2026 at 2:50 PM, record review revealed that Resident #37's order for Buspirone HCl Tablet 5 mg had been discontinued on 04/23/2026. On 04/30/2026 at 2:51 PM, record review revealed that Resident #138 had been discharged from the facility on 03/12/2026. On 04/30/2026 at approximately 2:52 PM, continued record review revealed that Resident #122's order for Valproic Acid 250 mg had been discontinued on 03/14/2026. On 04/30/2026 at 2:54 PM, record review revealed that Resident #5's order for Ipratropium-Albuterol Solution had been completed on 02/17/2026. On 04/30/2026 at approximately 3:15 PM, this surveyor conducted an observation and interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) in the medication room for the C/D Wing. The medications observed on the medication room counter were shown to the DON and ADON. It was explained that this is a concern because discontinued medications and medications belonging to discharged residents should have been removed from the medication room and returned to the pharmacy and/or destroyed according to facility process. The DON and ADON acknowledged the concern and confirmed their expectation would have been for these medications to have been appropriately returned to the pharmacy or destroyed. The DON and ADON then gathered the medications to be returned and/or destroyed.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record reviews and interviews it was determined the facility failed to ensure Residents were informed of risks and benefits of psychotropic medications. This was evident for 2 out of 5 residents (Resident #7, Resident #2) reviewed for unnecessary medications during the annual recertification survey. The findings include: All residents have the right to be informed of their health status and to accept or refuse medical treatment. The intent of this form (Psychotherapeutic Medication Informed Consent Form) is to provide informed consent for the administration of psychotropic medications. Two or more medications in the same drug class simultaneously may increase the risk of side effects and or adverse reactions. 1) On 04/29/2026 at 12:50 PM, a review of Resident #7 electronic medical record showed there was no Psychotherapeutic Medication Informed Consent Form scanned into their chart. On 04/29/2026 at 2:07 PM, an interview with the Director of Nursing (DON) revealed that if the consent form is not scanned in the electronic medical record, then the paper copy would be located in the physical chart on the unit. On 04/29/2026 2:53 PM, a review of Resident #7 paper chart, located on the unit, showed a blank paper Psychotherapeutic Medication Informed Consent Form in the chart that was labeled with the Resident #7's name that was not completed by the facility or signed by the resident. On 04/29/2026 at 2:55 PM, an interview with the Assistant Director of Nursing (ADON) confirmed that the Psychotherapeutic Medication Informed Consent Form in Resident #7's paper chart was not completed as required or signed by the resident. 2) On 04/30/2026 1:00PM, review of Resident #2's electronic medical record showed there was no Psychotherapeutic Medication Informed Consent Form scanned into their chart. On 04/30/2026 at 1:09 PM, a review of Resident #2's paper chart, located on the unit, showed a blank paper Psychotherapeutic Medication Informed Consent Form in the chart. It was labeled with Resident #2's name that was not completed by the facility or signed by the resident. On 04/30/2026 at 1:30 PM, during an interview with the DON and ADON concerns were addressed about the blank and unsigned Psychotherapeutic Medication Informed Consent Form found in Resident #2's paper chart.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with resident and facility staff, it was determined that the facility failed to invite residents to their care plan meetings. This was evident for 2 (Resident #8 and #6) out of 2 residents reviewed during recertification survey. The findings include: Residents have the right to be informed of and participate in the development and review of their care plan. The facility must invite the resident and/or representative to care plan meetings, allow participation in person or by phone, and document attendance or refusal. This supports person-centered care and ensures resident involvement in decisions about their care. 1). On 04/28/2026 at 9:22 AM during interview Resident #8 reported that he/she has never attended a care plan meeting and does not know the Social Worker. On 04/30/2026 at 6:50 AM, record review revealed that Resident #8 was admitted to the facility on [DATE]. Further review of the medical record revealed no documentation indicating the resident was invited to or attended care plan meetings. On 04/30/2026 at 9:25 AM interview conducted with Staff #17 stated that care plan meeting notifications are provided through written letters for long-term care residents and in-person communication for short-term residents, with responsible parties notified if the resident is unable to participate. She stated residents are informed verbally and encouraged to attend if alert and oriented. She further stated that documentation of invitations is maintained through copies of letters and that meeting attendance is recorded on a signed attendance sheet. If residents or responsible parties are unable to attend, a copy of the care plan is provided via email or directly to the residents. Staff #17 stated care plan meetings are conducted annually, quarterly and as needed. On 04/30/2026 at 10:31 AM the surveyor and Staff #17 reviewed Resident #8's medical record and confirmed there was no documentation indicating the resident was invited to or attended care plan meetings. On 05/01/2026 at 12:10 PM Staff #16 submitted care plan signature sheets for Resident #8 dated 10/15/2025 and 01/21/2026; both documents indicated no evidence of the resident #8's attendance or invitation to the care plan meetings. 2). On 04/28/2026 at 9:41 AM, Resident #6 reported, I have not had any meeting here. I have been here on and off for about four and a half years. On 04/30/2026 at 10:54 AM review of Resident #6's medical record revealed re-admission [DATE]. BIMS 15. On 04/30/2026 at 11:09 AM, review of Social Worker's notes revealed the following: On 11/14/2023 at 11:40, documentation indicated the resident was unable to attend the care plan meeting due to a COVID outbreak on the unit. On 01/03/2024 at 15:20, documentation indicated the resident was present at the care plan meeting. On 10/01/2024 at 15:42, documentation indicated the resident was invited but did not attend the care plan meeting. Additionally, only one care plan signature sheet was identified in the resident's medical record during record review. On 04/30/2026 at 1:03 PM record review with Staff #17 revealed a care plan meeting signature sheet dated 11/14/2023. Documentation indicated the resident's brother was in attendance. Further review of Resident #6's medical record revealed that the resident serves as his/her own responsible party (RP); however, there was no documentation indicating that the resident was invited or attended the care plan meeting dated 11/14/2023. On 04/30/2026 at 1:11 PM Staff #17 stated that care plan meetings for Resident #6 are conducted at the bedside due to the resident being bedbound. Staff #17 confirmed that the resident is able to participate and sign the care plan signature sheet. On 04/30/2026 at 2:23 PM Staff #17 provided one care plan meeting signature sheet dated 05/28/2025, which contained no signature from the resident or responsible party (RP), and one care plan invitation dated 01/29/2025. Staff #17 confirmed there was no documentation indicating that the resident or RP attended care plan meetings.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews, it was determined that the facility failed to ensure that residents were offered written information regarding advance directives. This was evident for 1 (Resident#120) out of 3 residents reviewed for advance directives during the recertification survey process. The findings include: An advance directive is a written instruction, such as a living will or durable power of attorney for healthcare, that is completed by a resident to outline their preferences for medical care in the event they are unable to make decisions for themselves. In a long-term care facility, an advance directive guides staff and providers in honoring the resident's choices regarding treatment, life-sustaining measures, and designation of a representative to make healthcare decisions on their behalf, in accordance with the resident's rights. On 04/28/2026 at 1:47 PM review of Resident #120's medical record revealed no documentation in the electronic health record (EHR) to indicate that the facility offered an advance directive or provided education regarding advance directives to the resident and/or the resident's Responsible Party (RP). On 04/30/2026 at 2:30 PM an interview was conducted with Staff #16, who stated that the facility's process for advance directives includes inquiring upon admission whether the resident has an advance directive. If the resident does not have one, the facility provides a Maryland Advance Directive packet for completion. Staff #16 further stated that the Social Services admission assessment is completed within one week of admission and includes providing education regarding advance directives to the resident and/or the resident's Responsible Party (RP). During an interview on 04/30/2026 at 2:54 PM, Staff #16 stated that the expectation is for the facility to offer advance directives and complete the Social Services assessment within seven (7) days of admission. On 04/30/2026 at 3:00 PM surveyor review of the Social Services Assessment with Staff #16 confirmed that the assessment was not completed. Staff #16 further stated, I am not sure why the assessment was not completed. On 05/04/2026 at 10:30 AM the facility Administrator submitted documentation of an AD HOC meeting held on 04/30/2026 at 4:00 PM, which addressed the facility's noncompliance with advance directive requirements.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, it was determined that the facility failed to ensure that the environment was in good repair. This was found to be evident for 2 (Resident #10 & #15) out of 7 Resident rooms observed during the recertification and complaint survey. The findings include: During an interview conducted on 04/27/26 at 8:44 AM it was observed that Resident #10 had an oval shaped area where the paint had peeled from the wall behind the bed. The Surveyor also observed the wall in front of the resident's bed with 2 large white patches from a wall repair. During an interview conducted on 04/27/26 at 9:39 AM, the Surveyor observed peeling paint behind the resident's bed and on the wall facing the resident #15's bed. The Surveyor also observed the top right side of the nightstand covering had peeled off. 05/04/2026 9:27 AM during an interview the Director of Nursing (DON) reported that the Maintenance Director was recently no longer employed at the facility. The Surveyor, DON and Assistant Director of Nursing (ADON) toured the facility. The Surveyor pointed out the observations and the DON took notes. The DON reported that she would have maintenance make the necessary repairs.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview it was determined that the facility failed to ensure a resident was free of a chemical restraint. This was found to be evident for 1 (Resident #15) out of 5 Residents reviewed for unnecessary medications during the recertification and complaint survey. The findings include: A chemical restraint is a medication used to intentionally control behavior, restrict movement, or sedate a person, rather than to treat a specific, diagnosed medical or psychiatric condition. These drugs commonly antipsychotics, sedatives, or mood stabilizers are used for staff convenience or discipline, often in nursing homes or emergency care, and are not required for standard, direct treatment. A non-pharmaceutical approach (or non-pharmacological intervention, NPI) refers to evidence-based, non-invasive methods used to prevent, manage, or treat health conditions without medication. These approaches include lifestyle changes, physical therapies, and psychological strategies aimed at improving quality of life, such as exercise, diet, mindfulness, and, in public health, measures like masks or social distancing. During a review of Resident #15's Medication Administration Record (MAR) conducted on 04/29/2026 at 11:00 AM revealed an order for an antianxiety, antidepressant, and opioid medication. Further review of the MAR and Treatment Administration Record (TAR) did not show an order for a nonpharmacological approach. According to the Centers for Medicare & Medicaid Services (CMS), a care plan is a structured, person-centered document that outlines individualized medical and support services to address a patient's health conditions and goals. It includes medication management, provider coordination, and community services, developed with the patient and their representatives. A review of Resident #15's medical records conducted on 04/29/2026 at 11:07 AM did not reveal a care plan for a non-pharmacological approach for the antianxiety, antidepressant, and opioid medications. During an interview conducted on 05/01/2026 at approximately 8:30 AM, the Surveyor discussed the concern that Resident #15 had received ordered antianxiety, antidepressant, opioid medications. However, the facility had not implemented alternative interventions such as a nonpharmacological approach. The Director of Nursing (DON) reported that she would investigate and return. The DON returned and confirmed that no alternative interventions had been attempted.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and review of the facility's discharge practices, it was determined that the facility failed to notify the resident and/or resident's representative with written notification of the bed-hold policy upon transfer to an acute care facility. This was evident for 1 (Resident #131) of 1 resident reviewed for hospitalization during the annual survey process. The findings include: On 04/29/2026 at 11:02 AM record review revealed that Resident #131 was transferred to the hospital following a fall. Review of the Nurse Manager's notes dated 04/04/2026 at 13:45 confirmed the resident was admitted to Maryland University [NAME] Regional Center. Further review of the resident's medical record revealed no documentation that the facility provided written information regarding the bed-hold policy to the resident and/or the resident's Responsible Party at the time of transfer. On 04/29/2026 at 2:30 PM, an interview was conducted with the Director of Nursing (DON) regarding the discharge process. The DON stated that during hospital transfers, the physician is notified and appropriate orders are obtained, and the family or Resident Responsible Party (RP) is notified of the transfer. The DON further stated that the bed-hold policy is provided to the resident if they are capable; if not, it is mailed to the resident's RP via certified mail. Additionally, the DON stated that the admission Assistant follows up with the family or RP. On 04/29/2026 at 2:45 PM an interview was conducted with the admission Assistant who stated that when a resident is transferred to the hospital, the bed-hold policy is mailed to the resident's family/RP if the resident is unable to sign or receive the information, and a copy is maintained in a binder. On 04/29/2026 at 2:55 PM review of Resident #131's medical record with the DON and admission Assistant revealed no signature or documentation indicating that the resident or RP received the bed-hold policy at the time of transfer. On 04/29/2026 at 3:06 PM further review of Resident #131's record with the DON and admission Assistant revealed that the bed-hold policy was mailed to the resident's home address while the resident was hospitalized. There was no documentation indicating that the resident was unable to sign at the time of transfer, and no documentation that the resident's emergency contact or RP was provided with the bed-hold policy. On 04/29/2026 at 3:15 PM the admission Assistant confirmed that there was no documentation in the electronic medical record (PCC) indicating that the resident or RP was offered or provided with the bed-hold policy.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of records and interviews, it was determined that the facility failed to ensure a comprehensive resident care plan was developed and implemented. This was found to be evident for 2 (Resident #7, Resident #14) out of 28 Resident care plans reviewed during the recertification and complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. Care plans provide direction for individualized care of the resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Non-pharmacological interventions are crucial in care plans to provide holistic, person-centered care that reduces reliance on medication, manages symptoms effectively without side effects, and improves overall quality of life. They are essential for mental health goals as adjunct interventions for fostering long-term stability, skill-building, and social reintegration. 1) On 04/29/2026 at 11:36 AM, a review of Resident #7's medical record revealed the resident had orders for an antianxiety medication, an antipsychotic medication, and antidepressant medication for treatment of anxiety and bipolar disorder. According to the CMS definition, a Gradual Dose Reduction (GDR) involves the careful, stepwise tapering of a medication's dosage. This is done to assess whether a resident's symptoms, conditions, or associated risks can be effectively managed with a lower dose, or if the medication can be completely discontinued. A GDR utilized primarily in nursing homes to manage polypharmacy and avoid chemical restraints, it aims for safer care by reducing side effects. On 04/29/2026 at 11:55 AM, a review of Resident #7 medical record progress notes revealed that they are currently trialing a gradual dose reduction (GDR) of buspirone and was seen by the medical provider who documented the following: Patient (Pt) was seen for continued care of anxiety, deep vein thrombosis, and chronic pain. Pt is laying in bed, he/she appears comfortable. He/She is looking forward to working with therapy. He/ She complained of increased anxiety. GDR in progress and was started on 4/20/26. On 04/29/2026 at 11:58 AM, a review of the Resident #7's care plan showed that the resident had a care plan in place for taking: 1. antianxiety medication with the goal of being free from discomfort or adverse reactions related to antianxiety therapy. The interventions included: Administer medication as ordered, monitor and document and report any adverse reactions to medication or unexpected side effects. Monitor and record occurrence of target behavior symptoms. 2. Antipsychotic medication with the goal to be free of any complications including movement disorder, discomfort, hypotension, gait disturbance, constipation or cognitive or behavioral impairment. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions included administer medication as ordered, discuss with ordering provider and resident ongoing need for use of medication, review behaviors / interventions and alternative therapies attempted and their effectiveness. Monitor, document, and report any adverse reactions. 3. Antidepressant medication with a goal of being free from discomfort or adverse reactions related to the use of the medication. The interventions include administer medication as ordered, educate the resident about the risks, benefits, and side effects of the medication. Monitor, document and report any adverse reactions related to the use of the medication. During an interview with the Director of Nursing and Assistant Director of Nursing on 04/30/2026 at 10:00 AM, concerns were discussed with Resident #7 not having specific non-pharmacological interventions included in their care plan. 2)Dementia refers to a variety of conditions that affect brain function, memory, and thinking skills. Alzheimer's disease is the most common type of dementia. The confusion that often accompanies dementia can present unique challenges for caregivers of those with dementia. During a record review conducted on 04/30/2026 at 11:11 AM, it was discovered that resident #14 had a diagnosis of Dementia. A dementia care plan in a long-term care facility is a personalized, written, or digital document that outlines the daily needs, medical care, and behavioral approaches for a resident living with cognitive impairment. It acts as a roadmap for staff, covering routines, nutrition, safety measures, and communication techniques, and it must be regularly updated as the disease progresses. During a review of Resident #14's care plan conducted on 04/30/2026 at 11:21 AM it was discovered that the Resident did not have a care plan for dementia. During an interview conducted on 05/01/2026 at approximately 8:50 AM, the Surveyor expressed concern that Resident #14 did not have a care plan for Dementia to the Director of Nursing (DON). The DON reported that she would investigate and return. The DON returned on 05/01/2026 at approximately 11:30 AM and confirmed Resident #14 did not have a Dementia care plan.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure that Pharmacy Recommendations were implemented. This was found to be evident for 3 (Resident # 3, Resident #14 & #15) out of 6 Residents reviewed for Pharmacy Medication Regimen Review (MRR) during the recertification and complaint survey. The findings include: 1)The Minimum Data Set (MDS) is a standardized assessment tool used in nursing homes to evaluate a resident's clinical condition, functional status, and care needs. Antipsychotic medications are drugs used to treat certain mental health conditions and behaviors, and because these medications can have significant side effects, facilities are expected to routinely evaluate their ongoing need. A Gradual Dose Reduction (GDR) is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Psychotropic drug is defined in the regulations as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: anti-psychotics, anti-depressants, anti-anxiety, and hypnotics. On 04/29/2026 at 10:48 AM, this surveyor conducted a record review of Resident #3's MDS assessment dated [DATE]. The MDS documented that Resident #3 received antipsychotic medications on a routine basis. The assessment further documented that a GDR (Gradual Dose Reduction) had not been attempted and that the physician had not documented that a GDR was clinically contraindicated. A continued record review on 04/29/2026 at 11:00 AM revealed an active physician order for Rexulti Oral Tablet 2 MG (Brexiprazole), Give 2 mg by mouth in the morning for Depression, with an original order date of 04/22/2025 and revision date of 01/25/2026. Pharmacy Medication Regimen Review (MRR) or Drug Regimen Review (DRR) is a comprehensive, systematic evaluation of a patient's medication list by a pharmacist to identify, prevent, and resolve medication-related problems, such as drug interactions, adverse effects, or inappropriate dosing. It involves reviewing medical records and collaborating with the healthcare team to optimize therapeutic outcomes and ensure safety, particularly in post-acute care. A Pharmacy Medication Regimen Review (MRR) Recommendation is a pharmacist-led, systematic, and documented evaluation of a patient's medication list against their medical record to identify and resolve issues like unnecessary drugs, interactions, or safety concerns. It involves proactive clinical interventions to improve outcomes and reduce risks, particularly in long-term care. On 04/29/2026 at 12:20 PM, this surveyor reviewed Resident #3's Medication Regimen Reviews (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MRRs). A pharmacy recommendation dated 04/23/2025 stated: Trazodone 50 mg - Give 50 mg by mouth every 24 hours as needed for Depression, Insomnia nightly as needed. Please consider discontinuing this (thus far) unused PRN order. If it remains active, please have STOP DATE of 14 days at which time further need may be assessed and documented. The document was signed OK on 04/23/2025; however, the Agree, Disagree, and Other sections were left blank. On 04/29/2026 at 12:39 PM, continued review of the MRRs revealed another pharmacy recommendation dated 06/17/2025 regarding the same medication. The pharmacist documented: Psychotropic medications should not be extended beyond 14 days without thorough documentation regarding continued need. Resident has orders for the following PRN medications which have not been used in greater than 60 days. Please consider discontinuing due to non-use: Trazodone HCL Oral Tablet 50 mg Give 50 mg by mouth every 24 hours as needed for Depression, insomnia nightly as needed. This was the second recommendation made by the pharmacist for discontinuation of the medication. The physician signed Agree on 06/19/2025. On 04/29/2026 at 12:40 PM, continued record review confirmed that the Trazodone order, originally dated 04/22/2025, was not discontinued until 06/19/2025, approximately two months after the initial pharmacy recommendation on 04/23/2025. On 04/29/2026 at 1:58 PM, continued review of Resident #3's MRR dated 08/13/2025 revealed another pharmacy recommendation regarding Citalopram Hydrobromide Oral Tablet 10 mg. Give 10 mg by mouth one time a day for Depression. The pharmacist documented: During the first year in which a resident is admitted on a psycho-pharmacological medication or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters. Please consider a GDR at this time. State reason if contraindicated at this time and state date if past GDR attempt was a FAIL. The physician response section for Agree, Disagree, and Other was left incomplete, and handwritten documentation stated cont some. The form was signed on 08/14/2025. Continued record review revealed that the Citalopram medication was later discontinued on 10/30/2025. On 04/30/2026 at approximately 10:00 AM, this surveyor reviewed the facility's Medication Regimen Review policy, which stated: Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities within 30 days. On 05/01/2026 at 10:17 AM, this surveyor conducted an interview with the DON (Director of Nursing). It was explained that the pharmacy recommendation dated 04/23/2025 was not acted upon until 06/19/2025, after a second recommendation had been issued, which exceeded the facility's policy requirement to address MRR irregularities within 30 days. Concerns were also discussed regarding the incomplete physician response sections on the MRR forms and the lack of clear rationale regarding the GDR recommendation for Citalopram. The DON acknowledged the concerns and reported that the facility had recently identified issues with physicians not properly completing the Agree, Disagree, and Other sections and had begun correcting the process in recent months. On 05/01/2026 at 1:53 PM, this surveyor conducted an interview with the Medical Director regarding (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's psychotropic medications and GDR process. The physician reported that Resident #3 had originally been admitted for rehabilitation with plans to return home but later transitioned to long-term care. The physician stated that if residents are admitted already taking psychiatric medications prescribed by outpatient providers, she generally does not make changes unless clinically indicated. Regarding Rexulti, the physician reported that the resident's outpatient nurse practitioner had originally prescribed the medication for major depression. The physician stated that she had discussed tapering the medication with the resident on multiple occasions, but the resident declined dose reductions. The physician stated, I cannot do a GDR on someone who does not want the meds to be touched, and reported that she attempts to evaluate these medications quarterly. When asked what specific guidelines she follows regarding GDR practices, the physician reported, No, I just know them after 15 years. 2) During a review of Resident #14's Pharmacy Medication Regimen Review (MRR) conducted on 04/30/2026 at 10:08 AM it was discovered that the Pharmacy made a recommendation on 08/17/2025. The Pharmacy recommended making Loratadine 10 milligram (mg) PRN (as needed) because the medication had not been routinely administered. The Physician agreed and signed on 09/12/2025. On 03/13/2026 the Pharmacy made the same recommendation again. During a review of Resident #14's Medication Administered Record (MAR) conducted on 04/30/2026 at 10:17 AM it was discovered that the Pharmacy recommendation was not implemented until 3/16/2026. During a review of Resident #15's Pharmacy Medication Regimen Review (MRR) conducted on 04/30/2026 at 11:00 AM it was discovered that the Pharmacy made a recommendation on 10/20/2025. The Pharmacy stated that Lidoderm patch is recommended for up to 12 hours ON with period of 12 hours OFF. Please review this resident's order and reconcile. Staff should document removal in eMAR [electronic medication administration record]. The Physician agreed and signed the recommendation on 10/27/2025. On 11/09/2025 the Pharmacy made a second recommendation that stated Lidocaine patches (two orders) are STILL being left on for almost 24 hours. Please discuss with staff and reconcile. The Physician agreed, signed the recommendation and wrote on lower back and on right rib on 11/14/2025. On 02/13/2026 the Pharmacy made a third recommendation that stated patches, according to documentation in eMAR are being left on 24 hours. Lidoderm patch is recommended for up to 12 hours on with period of 12 hours off. Please review this resident's order and reconcile. The Physician agreed and signed the recommendation. The word done was written on the recommendation on 02/20/2026. On 04/17/2026 the Pharmacy made a fourth recommendation that stated Lidoderm patch is recommended for up to 12 hours on with period of 12 hours off. Please review this resident's order and reconcile. The Physician agreed and signed the recommendation on 04/20/2026. The word corrected was written on the recommendation. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident #15's MAR conducted on 04/30/2026 at 1:00 PM it was discovered that recommendation was implemented on 04/19/2026. During an interview conducted on 05/01/2026 at 8:33 AM, the Surveyor expressed concern for the delay in implementing the Pharmacy recommendations with the Director of Nursing (DON). The DON reported that she would investigate and return. The DON returned and confirmed the delay in the implementation of the Pharmacy recommendation for Resident #14 & #15.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, it was determined that the facility failed to ensure residents were free of any significant medication errors. This was identified during the Medication Administration facility task completed during the annual/complaint survey. This was evident for 1 resident (Resident #50) out of 7 residents reviewed for medication administration. The findings include: Insulin is a medication used to help control blood sugar levels in individuals with diabetes. Because insulin directly affects blood glucose levels, incorrect dosing may place a resident at risk for adverse effects such as hypoglycemia (low blood sugar levels) which could be life-threatening. On 04/30/2026 at 9:14 AM, this surveyor observed LPN (Licensed Practical Nurse) #7 administer medications to Resident #50. LPN #7 reported that she was administering 21 units of insulin to the resident and was observed administering 21 units into the resident's right arm. After the medication pass, this surveyor reviewed the physician order in the MAR (Medication Administration Record) with LPN #7. The MAR directed staff to administer 18 units of insulin one time daily at 0800 for diabetes mellitus. LPN #7 reported that the MD (Medical Director) had verbally instructed her the previous day to increase the insulin dose from 18 units to 21 units but acknowledged that the physician order in the MAR had not yet been updated. It was explained that administration of insulin that did not match the active MAR order constituted a medication error. On 04/30/2026 at approximately 1:00 PM, a record review of the facility's Medication Administration policy revealed the following compliance guidelines for medication administration: Compare medication source (bubble pack, vial, etc.) with the MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time. On 04/30/2026 at approximately 1:15 PM, a record review of the facility's Verbal/Telephone Orders policy revealed the following: prescribed orders are to be repeated back to the physician or healthcare provider for clarification to avoid misunderstandings; orders are to be entered into the medical record manually or electronically; and verbal or telephone orders are to include the date, time, resident name, complete order, and signatures of the physician or healthcare provider and nurse, or be electronically signed in accordance with the facility's software system guidelines. The policy further stated that the physician is to sign the order at the next facility visit or within the timeframe required by the facility. On 05/01/2026 at approximately 11:00 AM, this surveyor conducted an interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) regarding the medication administration observations. It was explained that the observation of LPN #7 administering a different amount of insulin than what was listed in the active order (21 units instead of 18 units) was considered a significant medication error. The DON acknowledged understanding and confirmed that verbal insulin orders should not be administered until the MAR and physician orders are updated and verified.		

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interviews with facility staff, it was determined that the facility failed to coordinate with hospice representatives to ensure coordination of care and services provided by both hospice and the facility. This was evident for 1 (Resident #8) out of 1 resident reviewed for hospice plan of care during the recertification annual survey process. The findings include: Terminal prognosis means a disease is expected to lead to death and is not expected to be cured or adequately treated. In essence, it indicates a life-limiting condition where death is anticipated, regardless of medical interventions. Hospice care is a specialized form of healthcare that provides comfort and support to terminally ill patients and their families. It focuses on managing pain, symptoms, and other physical, emotional, and spiritual needs during the end of life. On 04/29/2026 at 1:45 PM review of medical record revealed Resident #8 was admitted to Hospice of the Chesapeake on 4/19/2025. Matrix provided to the surveyor on 04/28/2026 indicated Resident #8 was receiving hospice care. On 04/29/2026 at 1:55 PM Resident #8's care plan review revealed Resident is on Hospice care related to: Cardiovascular disease and end of life. On 04/30/2026 at 8:44 AM during an interview, the Director of Nursing (DON) stated the facility is contracted with Hospice of Chesapeake and follows this process: an order for a hospice consult is obtained, the hospice agency is contacted, and a meeting is held with the resident and family. Once the resident is admitted to hospice services, the facility collaborates with hospice staff. Hospice personnel conduct visits, document care, and communicate any changes to facility staff. The facility updates the care plan and follows the hospice plan of care. When asked whether the resident is currently receiving hospice services, the DON stated that the Resident #8 was admitted to hospice on 04/19/2025 and disenrolled from hospice services on 02/11/2026. On 04/30/2026 at 9:10 AM the DON confirmed that the resident's care plan continues to indicate hospice services and Matrix report does not reflect resident's plan of care. On 04/30/2026 at 9:30 AM review of Resident #8's chart revealed no documentation in the medical records indicating resident was formally disenrolled or discharged from hospice services. On 04/30/2026 at 11:23 AM interview with Staff #14 stated that a significant change assessment is required when a resident is admitted to or disenrolled from hospice and must be completed within 14 days of the determination date, including following hospice disenrollment. Staff # 14 further stated that the MDS department was not aware of Resident #8's hospice disenrollment until 03/11/2026 at 12:01PM, when the Business Office Manager notified the department via email of a change in level of care. Staff #14 further stated that the census line was not updated until 03/30/2026. As a result of the delayed notification and failure to update the census timely, the required assessment was not initiated to reflect the resident's level of care. On 05/01/2026 at 11:48 AM interview with Business Office Manager (BOM), she stated that hospice is supposed to send a notification letter confirming a resident's disenrollment; however, this process was not followed this time. The BOM further indicated that the facility relies on receipt of this notification to initiate follow-up actions, including notifying the Interdisciplinary Team (IDT). Interview conducted on 05/04/2026 at 7:28 AM with the DON she confirmed that she is the facility designee for hospice coordination and stated that hospice normally coordinates and communicates any changes with the nursing staff, Unit Managers, and herself. The DON confirmed that hospice verbally notified the facility of the resident's disenrollment. The facility was awaiting the required documentation from hospice; however, no follow-up was conducted by the facility to obtain the supporting paperwork.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/04/2026
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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documentation and interview, it was determined that facility staff failed to ensure the Infection Preventionist and Medical Director participated in the facility's Quality Assessment and Assurance (QA) committee. The findings include: On 05/04/2026 9:10 AM review of monthly QA sign-in-sheet from 3/20/2025 until 3/20/2026 revealed IP did not attend 2/27/2026 meeting and Medical Director did not attend monthly meeting on 3/20/2025, 8/19/2025, 9/23/2025, 12/29/2025, and 2/27/2026. 05/04/2026 at 10:12 AM an interview was conducted with the Administrator regarding the frequency of committee meetings. The Administrator stated that meetings are supposed to occur monthly; however, they had not conducted consistently prior to her arrival. She indicated that she has been in the role for two months and only two meetings have been held during that time, with a plan in place to ensure meetings are conducted regularly going forward. On 05/04/2026 at 10:33 AM, a review of records was conducted with the Administrator, who confirmed that documentation did not indicate the Medical Director attended the committee meetings on the above dates. The Administrator further stated that the Infection Preventionist (IP) had an accident and was off sick for one month, and during that time there was no coverage arranged		