

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
NAME OF PROVIDER OR SUPPLIER Shady Grove Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9701 Medical Center Drive Rockville, MD 20850	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to maintain food storage and food service equipment in a safe and sanitary manner to help prevent potential foodborne illness. This deficient practice was evident for 1 of 1 resident food storage refrigerator reviewed, and during the kitchen tour conducted during the annual survey. The findings include1. On 5/4/2026 at 8:10 AM, the surveyor observed a refrigerator in a dining area on the Ambassador unit. Dried tan and red spills covered one-third of the refrigerator's bottom, which also contained crumbs. A container with lacking a name or date sat on the top shelf of the refrigerator. On 5/8/2026 at 11:30 AM, the surveyor showed the Administrator the refrigerator's location and a picture taken during the 05/04/2026 observation. The Administrator acknowledged the concern, stated the spills happened over the weekend, and confirmed that they subsequently cleaned the refrigerator. Based on observation, and interview with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the kitchen tour of the annual survey. 2. A food-contact surface refers to any surface of equipment and utensils that typically comes into contact with food; or from which food may drain, drip, or splash onto food; or a surface that is usually in contact with food. On 05/07/2026 at 9:00 AM, the surveyor conducted a tour of the kitchen alongside the Healthcare Services Group Regional Manager and identified the following deficient practices: The hand sink near the ware washing station was not dispensing cold water. Multiple cove base tiles were missing throughout the kitchen areas, which created gaps/holes on the wall for possible pests and bacterial harborage. There were multiple gaps/holes in the drywalls, measuring about 12-inch by 24-inch throughout the kitchen and within the kitchen manager's office. The drain lines for the two food prep sinks were leaking grey water directly onto the kitchen floor. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The two wall-mounted faucets of the 3-compartment sink were not securely attached to the wall. The two faucets were falling off the wall. The surveyor observed steam, vapor, and heat were escaping from the high temperature conveyor dish machine. In addition, the walls and caulked edges showed significant buildup of mold-like substances. At 2:05 PM, a follow-up tour of the kitchen was conducted with the Administrator, Maintenance Director and the Regional Manager to go over the findings listed above.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint investigation, record reviews, and interviews, it was determined that the facility staff failed to ensure a resident was able to exercise the rights to leave the facility against medical advice without interference. This deficient practice was evident for one (Resident # 154) resident reviewed for resident rights during the annual survey. The findings include: On 05/04/2026, the surveyor reviewed complaint intake and medical records for Residents #154. A review of complaint #2807564 revealed the resident reported facility staff physically blocked the door, preventing the resident and the resident's family member from leaving the facility against medical advice (AMA) on 03/05/26. The resident further reported that staff informed the resident, they could not leave the facility because the resident had a peripherally inserted central catheter (PICC) line in place. The resident's family member contacted local law enforcement. On 05/07/2026, a review of progress note written by the Assistant Director of Nursing (ADON) #26 on 03/05/26 revealed the resident was admitted to the facility on [DATE]. During a follow up, the resident expressed dissatisfaction with the care provided and stated a desire to leave the facility and return home. Nursing staff educated the resident on the importance of remaining in the facility to complete prescribed intravenous therapy and explained the risk associated with leaving. Staff also informed the resident that it was unsafe to leave the facility with a PICC line in place due to safety and infection risks. The resident acknowledged understanding of the information provided but continued to insist on leaving the facility. An individual arrived to pick up the resident, which resulted in a disagreement and local law enforcement was contacted. Following the law enforcements assessment, the resident was cleared to leave the facility. During an interview with the ADON # 26 on 05/07/2026 at 12:35 PM, she recalled the incident involving Resident #154 on 03/05/26. The ADON #26 stated an individual who was not listed as the resident's emergency contact arrived at the facility. The ADON reported that the facility was not comfortable allowing the resident to leave with a PICC line while being escorted by an individual unfamiliar to the facility. The ADON further stated that the facility did not physically force the resident to remain in the facility but asked the resident to remain in the facility until local law enforcement arrived.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, medical record review, and interviews it was determined the facility failed to document the interdisciplinary team assessed and deemed appropriate for a resident to self-administer medication. This was evidenced in 1 (#70) of 1 resident reviewed for self-administering medication during the survey. The findings include: On 5/7/26 at 8:49 AM, the surveyor conducted an interview with Resident #70. During the interview Resident #70 reported that after the survey team came into the building the staff removed Resident #70's inhaler that was kept at the bedside. On 5/7/26 at 9:04 AM, the surveyor observed Licensed Practical Nurse (LPN) #9 along with Unit Manager (UM) #3 bring Resident #70's his/her inhaler for administration and leave the room with the inhaler. On 5/7/26 9:20 AM, the surveyor conducted an interview, UM #3. The surveyor asked if residents could have inhalers left at the bedside. UM #3 stated that it was allowed and that she was not aware that Resident #70 desired to do so. On 5/7/26 at 9:33 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON explained the process before a resident would be able to self-administer medications and keep the medication at their bedside. She stated that an interdisciplinary team would complete an assessment and if appropriate an order would be in place for the resident to self administer the medications. The DON stated she was not aware of any medications kept at the bedside or taken away from Resident #70. Next the surveyor reviewed Resident #70's inhaler orders. On 10/20/25 an order was written for Resident #70 to have Fluticasone Propionate one puff twice a day for wheezing. The order stated may keep at resident's bedside. Additionally, an order placed on 9/16/25 for Ventolin (albuterol) 2 puffs every 8 hours as needed for shortness of breath was written with the same instructions, may keep at resident's bedside. No care plan or assessment was noted for Resident #70 to self medicate and/or keep medications at the bedside. On 5/7/26 at 9:33 at 12:49 PM, the surveyor conducted a follow-up interview with the DON. The DON confirmed that the facility did not complete the process for a Resident to self administer medications and that she had started the process for Resident #70.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined that the facility failed to ensure a safe, clean, comfortable and homelike environment with adequate lighting. This was evident for 6 (200, 300, 608, 701, 805 and 908) out of 27 rooms observed during the initial tour and throughout the recertification survey. The findings include: 1. On 05/04/26 at 7:50 AM, room [ROOM NUMBER]'s bathroom had a running toilet, a rusted sink, a bucket of fluid beneath the sink, an overflowing trashcan, and a tied bag of trash with rags lying on the floor. On 05/04/26 at 8:20 AM, room [ROOM NUMBER] (Bed A) had stained privacy curtains and water stains located on the ceiling tiles. On 05/04/26 at 9:07 AM, room [ROOM NUMBER] had a large dent located behind the head of Bed A. On 05/04/26 at 9:26 AM, room [ROOM NUMBER] had a flickering light in the bathroom. On 05/04/26 at 11:59 AM, the Administrator and Maintenance Director acknowledged the concern. 2. On 05/06/2026 at 10:50 AM, the surveyor observed that the windowsill in Resident #14 was in a state of disrepair. The bottom right corner of windowsill had detached from the wall and about one inch of the nail was protruding from it. An interview with the Maintenance Director confirmed that the windowsill would be repaired, and the nail would be either removed or secured flushed to the surface to prevent any hazards. At 10:55 AM, the surveyor noted there were two one-door armoire closets in Resident #6's room. However, one of the armoire closet door was missing, while the other armoire closet door was falling off the hinges. In addition, an interview with the resident indicated that the toilet seat was missing from the toilet. The surveyor verified that the toilet seat was missing and observed multiple speckles on the bathroom wall. An interview with the Maintenance Director confirmed that the armoire closet would be removed and/or replaced, a new toilet seat would be provided, and the wall speckles would be sanded down.		

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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. Based on interviews and record reviews, it was determined that the facility failed to ensure residents receive written bed hold notice upon hospital transfer. This deficient practice was evident for 2 (Resident #126 and Resident # 1) of 4 resident's reviewed for discharge process during the annual survey. The findings include: 1.) During an interview with Resident #126 on 05/04/26 at 4:01 PM, the resident stated they were transferred to the hospital in April 2026 due to a gastrointestinal bleed. The resident further reported that they did not receive bed hold notice information at the time of transfer. A review of Resident #126's electronic health records (EHR) on 05/05/2026, revealed the resident was admitted to the facility in April 2026 to a bed on the 2nd floor of Lifeworks unit. Further review of the records indicated the resident was transferred to the hospital in April 2026, however, the EHR failed to show evidence that the resident was provided with written bed hold information at the time of transfer. Records revealed the resident had decision making capacity at the time of transfer. The resident later returned to the facility in April 2026 and was admitted to a bed on the 1st floor of Lifeworks unit. The surveyor reviewed the bed hold concern with the Director of Nursing (DON) #2 and requested evidence supporting that the resident received bed hold information upon hospital transfer. On 05/05/2026 at 12:01 PM, the DON #2 provided a copy of an unsigned, undated bed hold form that was reportedly transported to the hospital with the resident. The DON also provided a copy of a bed hold information email sent by the Discharge Planner #5 to the residents' emergency contact only. During an interview with the Discharge Planner #5 on 05/05/2026 at 12:07 PM, she explained that the resident's emergency contact is identified at the time of admission and this information is used to determine who receives the bed hold information at the time of hospital transfer. She further acknowledged that even when a resident has decision making capacity, the facility's process is to provide the bed hold information to the resident's emergency contact. 2.) A review of Resident #1's EHR on 05/06/2026, revealed the resident was transferred from the facility to the hospital in April 2026. At the time of transfer, the resident was identified as their own responsible party. Further review of the records failed to show evidence that written bed hold information was provided to the resident upon hospital transfer. On 05/06/2026 the surveyor requested documentation from the DON indicating Resident #1 was provided with written bed hold information upon hospital transfer in April 2026. The DON provided the surveyor with a Social Worker Assistant progress note dated 05/06/26, documenting that the Social Worker contacted the resident on 05/05/2026, regarding the facility's bed hold policy.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record reviews, it was determined that the facility failed to provide the resident and/or the resident's representative with a summary of the baseline care plan. This deficient practice was evident for 2 (Resident #1, Resident #23) of 5 residents reviewed for baseline care plans during the annual survey. The findings include:1.) During an interview with the Director of Nursing (DON) #2 on 05/05/2026 at 12:56 PM, the surveyor inquired about the facility's baseline care plan process. The DON #2 stated that the admitting nurse will initiate the baseline care plan at bedside with the resident and/or the resident's representative. She further stated that the resident and/or representative are provided a summary of the baseline care plan. The DON #2 explained that the unit manager is responsible for ensuring baseline care plans are completed and uploaded into the resident's electronic health record (EHR).A review of Resident #1's EHR on 05/06/2026, revealed the resident was admitted to the facility in March 2026. Further review of the records failed to show evidence a summary of the resident's baseline care plan was provided to the resident and/or representative.The surveyor informed the DON #2 that Resident #1's EHR failed to show evidence a summary of the resident's baseline care plan was provided to the resident and/or representative. The DON later followed up with the surveyor and provided a copy of the sign-in sheet for attendees of the baseline care plan meeting. The sign-in sheet contained signatures from a Registered Nurse (RN) supervisor, and an RN; however, there was no signature from the resident and/or the resident's representative. The document failed to show the resident and/or the resident's representative received a summary of the resident's baseline care plan.2.) A review of Resident #23's EHR on 05/07/2026 at 2:52PM, revealed the resident was admitted to the facility in October 2024. Further review of the record failed to show evidence that a summary of the resident's baseline care plan was provided to the resident and/or the resident's representative. The surveyor reviewed the findings with the DON #2 and Discharge Planner #5. Both acknowledged that a summary of the resident's baseline care plan was not provided to the resident and/or the resident's representative.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to hold care plan meetings composed of an interdisciplinary team after the completion of the Minimum Data Set assessment. This was evident for 3 (Resident #10, #11 and #55) of 3 residents reviewed for care planning during the survey. Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. The findings include: On 5/6/26 at 11:06 AM the surveyor reviewed Resident #10, #11, & #55's care plan attendance sheets dated 2/20/26, 3/24/26 and 3/10/26 respectively, and noted that in all three care plan meetings only two people were in attendance. One person from the social service department and the other was the resident and/or the Responsible Party (RP). On 5/6/26 at 1:23 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that multiple resident's care plan meetings were conducted with only the social services staff in attendance. The DON confirmed that a care plan meeting should be conducted with an interdisciplinary team and just having the social service staff there was not the expectation.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews and record review, it was determined that the facility failed to provide treatments to assure proper care was provided for residents with documented skin issues. This was evident in 2 (Resident #10 and Resident #83) out of 14 residents reviewed for skin integrity during the recertification and complaint surveys. The findings include: 1. On 05/04/2026 at 8:15 AM, Resident #83 reported a medical history of herpes and the presence of blisters in the private and buttocks regions that caused discomfort during urination. Resident #83 further indicated that although a request for medication was made to the physician in February 2026 to alleviate the symptoms, the request was not successfully addressed. On 05/06/2026 at 8:30 AM, a record review determined that the resident is immunocompromised. In addition, a progress note revealed that Resident #83 was seen by a Nurse Practitioner (NP) for a comprehensive skin exam on 04/28/2026. The NP's summary stated Patient was seen today for a comprehensive skin exam, patient reports sores present since February. Reported sores cause discomfort with urination. Does not know any current treatment. Reports history of herpes. The comprehensive exam identified two new wounds (private area and buttocks) and their treatments were to be determined but treatment recommendations were listed. The assessment/plan noted: Comprehensive skin assessment performed during skin sweep, initiate treatment as above and further treatment may require testing and/or referral. The orders for Resident #83 were not entered until a week after (05/06/2026) seeing the NP. On 05/06/26 at 10:00 AM, the Director of Nursing acknowledged the concern. 2. On 5/7/26 at 11:49 AM, the surveyor Reviewed Resident #10's medical record. The review revealed a care plan that stated Resident #10 was at risk for worsening pressure ulcers related to frequent incontinence, immobility and inability to turn and repositions independently. Next the surveyor reviewed a weekly wound care note written after a treatment on 5/4/26. The provider documented that Resident #10 was at high risk for skin breakdown related to decreased mobility and comorbidities. Next it was recommended that ongoing pressure reduction and turning/repositioning precautions were provided per protocol. In the assessment plan section the providers wrote, continue carefully off-loading elbow off the edge of the bed. The surveyor did not find documentation that these cares were provided. On 5/8/26 at 6 AM, the surveyor conducted an interview with the Director of Nursing (DON). The surveyor requested documentation that the turning and offloading recommendations for Resident #10 were completed. On 5/8/26 at 7:35 AM the surveyor conducted a follow-up interview with the DON. During the interview the DON stated that on Resident #10's Kardex it was noted that he/she needed to be turned and repositioned often, however, she was not able to provide documentation that these cares were signed off on and/or provided.		

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F 0689 Level of Harm - Minimal harm or potential for 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 review of medical records and interviews it was determined that the facility failed to adequately assist a dependent resident during Activity of Daily Living (ADL) cares. This was found evident for 1 (Resident #80) out of 6 residents reviewed for abuse. The findings include: On 5/4/26 at 8:30 AM, the surveyor conducted an interview with Resident #80. During the interview Resident #80 stated that over the weekend one of the Certified Nursing Assistants (CNA) woke him/her up in the early morning and was rough while providing cares. The surveyor reported the concern to the Director of Nursing (DON). On 5/6/26 at 9:50 AM, the surveyor reviewed Resident #80's medical record. The review revealed that on 4/14/26 a Physical Therapy (PT) evaluation was ordered along with therapy services for 4 weeks. Next the surveyor reviewed the PT notes. A note dated 5/4/26 wrote, Resident #80 provided bed mobility training for rolling with moderate to maximum assistance of 2 to roll to the left and moderate assistance of 2 to roll to the right. Following the PT note the surveyor reviewed a provider note dated 5/1/26 that documented, Resident #10's bed mobility self-performance (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep) as totally dependent - requiring full staff performance. If further stated the Resident #10's ability to roll left to right and the ability from lying on the back to left and right and return to lying on the back was also dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. On 5/8/26 at 11:14 AM, the surveyor reviewed the facility's investigation into the incident. The review revealed that the abuse was unsubstantiated and that Certified Nursing Assistant (CNA) #11 assisted Resident #10 by herself. On 5/8/26 at 11:55 AM, the surveyor conducted an interview with the DON and reviewed the concern that Resident #80 was not assisted with 2 staff members as determined he/she needed in the plan of care during the cares provided by CNA #11.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interviews, observations, and record reviews, it was determined that the facility failed to ensure central line dressings were changed according to the physicians' orders. This deficient practice was evident for one (Resident #117) resident review for intravenous therapy during the annual survey. Intravenous (IV) therapy is the administration of parenteral fluids or medications through an IV catheter to treat a condition. A central line (also known as a central venous catheter) is a catheter (tube) that healthcare providers often place in a large vein in the neck, chest or groin. The findings include: On 05/04/2026 at 12:01 PM, during an interview, Resident #117 reported having a central line that was placed while hospitalized. The resident stated the central line dressing had not been changed since admission to facility. The surveyor observed a loose, cloudy dressing covering the central line site. The date on the dressing was 04/07/2026. On 05/05/2026 a review of Resident #117's electronic health records (EHR) revealed the resident was admitted to the facility on [DATE]. Further review revealed physician orders directing staff to change the needless device weekly and as needed, measure the external portion of the central line catheter weekly during dressing changes, and change the transparent dressing weekly during the evening shift. The order further directed staff to initial and label the dressing after each dressing change. During an interview with the Director of Nursing (DON) #2 on 05/05/2026 at 2:05 PM, she explained the facility's process of managing central lines. She stated that central line dressings are changed within 24 hours of admission. The following changes are according to the physician's orders. The surveyor informed the DON #2 of the observation made regarding Resident #117's central line dressing. The DON later followed up with the surveyor and acknowledged that staff failed to change the resident's central line dressing as ordered.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review it was determined that the facility failed to administer pain medications consistent with professional standards. This was found evident of 1 (Resident #5) out of 4 Residents reviewed for pain management during the survey. The findings include: On 5/7/26 at 7:06 AM, the surveyor reviewed Resident #5's medical record. The review revealed a care plan that was revised on 3/5/26 that stated, Resident #5 was at risk for pain related to a history of falls and abdominal pain. One of the interventions was to administer medication as ordered. Next the surveyor reviewed Resident #5's medications. The review revealed that Resident #5 had morphine sulfate 15mg tablets ordered to be given by mouth every 6 hours as needed for severe pain 7-10 as well as tramadol 50mg tablet to be given every 6 hours as needed for pain. Following the medication review the surveyor reviewed Resident #5's May Medication Administration Record (MAR). The review revealed that on May 3rd 2026 at 7:27 PM, Resident #5 rated their pain a 5 out of 10. A dose of morphine sulfate was given even though the instructions stated to give for severe pain 7-10. Additionally, a dose of tramadol was given one minute later at 7:28 PM. On 5/8/26 at 6:00 AM, the surveyor conducted an interview with the Director of Nursing (DON) and during the interview the surveyor reviewed the concern the two pain medications were given at the same time and one of the medications was given out of the pain scale range in the instructions.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interviews with staff, it was determined that the medical provider failed to review the total program of care for 2 (Resident #8 and #5) out of 55 residents reviewed during the survey. The findings include: On 5/6/26 at 12:45 PM, the surveyor reviewed Resident #8's medical record. The review revealed that on 9/29/25 a care plan was created for Resident #8 that stated he/she was experiencing acute signs and symptoms of delirium as well as, Resident #8 was at risk for adverse reactions related to the use of antipsychotic medications. One of the interventions was to have psychiatric services as needed. Next the surveyor reviewed the psychiatric medications ordered for Resident #8 in September of 2025. The medications included Mirtazapine (Remeron) 7.5mg (an antidepressant) to be given nightly and Olanzapine (Zyprexa) 2.5 mg (an antipsychotic) also to be given nightly. On further review on 11/19/25 Zyprexa was decreased by half and was ordered to be given a half a tablet (1.25mg) nightly. Following the medication review the surveyor reviewed Resident #8's psychiatric notes. Psych services saw Resident #8 on 12/14/25 and documented that Resident #8 was on Zyprexa 1.25mg, however, documented the dose was twice a day. Additionally there was no mention of the Remeron that was ordered for Resident #8. On 2/21/26, 3/22/26 and 4/15/26 the psych note documented the Resident #8 was on Remeron, however, continued to document that Zyprexa 1.25mg was given twice a day. Next the surveyor reviewed Resident #8's medical care provider note dated 5/1/26. The note listed all Resident #8's prescribed medications, however, Zyprexa was listed as a full tablet of 2.5mg nightly. This dose had not been given since November 2025 when it was decreased to half. On 5/8/26 at 6:00 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that both the psychiatric and medical providers were not accurately reviewing and/or documenting Resident #8's prescribed medications regimen. 2) On 5/7/26 at 7:06 AM, the surveyor reviewed Resident #5's medical record. The review revealed a care plan that was revised on 3/5/26 that stated, Resident #5 was at risk for pain related to a history of falls and abdominal pain. One of the interventions was to administer medication as ordered. Next the surveyor reviewed Resident #5's medications. The review revealed that Resident #5 had an order of morphine sulfate 15mg tablet to be given by mouth every 6 hours as needed for severe pain 7-10 as well as tramadol 50mg tablet to be given every 6 hours as needed for pain. Following the medication review the surveyor reviewed Resident #5's provider progress note dated 4/29/26. The provider documented that there was no change in Resident #5's reported pain. The note listed Resident #8's medications, however, Resident #5's morphine and tramadol were not part of the list. The list also had a lidocaine patch written to be applied every 12 hours as needed for left shoulder pain even though there was no active order for this medication for Resident #5. Further in the note the plan for pain stated lidocaine patches. On 5/8/26 at 6:00 AM, the surveyor conducted an interview with Director of Nursing (DON) and during the interview the surveyor reviewed the concern the provider's notes were not accurate in documenting the plan of care for Resident #5.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and observation, it was determined the facility failed to provide sufficient staff to respond to the call system promptly. This was found to be evident for 1 (#14) out of 2 residents observed for call system response. The findings include: On 05/04/2026 at 7:44 AM Resident #14 told the surveyor, I'm thirsty, I need water. No water was observed at the bedside. Resident #14 was encouraged to use the call bell to request water. The surveyor heard the call bell activate and observed the light go on in the room and above the room door in the hall. Certified Nursing Assistant (CNA) #8 was observed sitting at the nurse's station outside the room and Licensed Practical Nurse (LPN) #9 was observed at the medication cart in the hall near the room. On 05/04/2026 at 8:04 AM, when no one had responded to the call light, the surveyor approached CNA #8 who was sitting at the nurses station. When asked why she did not respond to the ringing call bell, she replied, I saw the call light hanging off the wall. It is broken, that's why I didn't go into the room. LPN #9 was asked why she did not respond to the call bell on 05/04/2026 at 8:05 AM. LPN #9 responded that she was passing medications. On 05/04/2026 at 8:13 AM, the Director of Nursing (DON) stated she expected call bell to be answered in a maximum 15 minutes. When asked if the call system was functioning properly, she stated she would look into it. At 8:28 AM the DON stated the call system was functional and someone should have responded.		

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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 observations, record reviews, and interviews, the facility failed to obtain, document and administer medications according to procedures that ensure accurate, safe dispensing of medications. This was evident for 4 residents (#57, #70, #98 and #141) out of 10 reviewed for medications. The findings included: 1. On 05/04/2026 at 9:35 AM, the surveyor observed Resident #57 taking pills while no nurse was in the room. Resident #57 stated, They don't always leave my pills but this time they did. At 9:40 AM on 05/04/2026, RN #15 entered the room to check if Resident #57 had taken their medications. RN #15 stated, Resident #57 is good to take medications alone. 2. On 05/04/2026 at 11:40 AM, the surveyor observed Resident #141 sitting on the side of the bed pouring liquid into the nebulizer. No staff member was present. Resident #141's family member stated, My parent administers albuterol so it can be taken immediately when needed. The facility evaluated and assessed the resident as independent to administer albuterol. A record review at 9:32 AM on 05/06/2026 revealed no documentation that the facility evaluated Residents #57 or #141 for self-administration of medications. The surveyor requested that the Director of Nursing (DON) provide documentation showing the facility evaluated the residents for self-medication. On 05/07/2026 at 9:29 AM, the DON stated that they could not provide documentation of assessment to self-administer medications for Residents #57 and #141. 3. On 5/4/26 at 9:29 AM, the surveyor conducted an interview with Resident #98 and during the interview Resident #98 stated that the facility often ran out of his/her medications. Next the surveyor reviewed Resident #98's Medication Administration Record (MAR) from January 2026. The review revealed that Resident #98 was ordered to have lamotrigine 25mg in the morning for bipolar. On 1/20/26 a (9) was coded see progress notes, on 1/21/26 the administration was left blank, on 1/22/26 (2) was coded for refusal and on 1/21/26 administration was left blank again. On review of Resident #89's April 2026 MAR hydroxyzine was marked (9) see progress notes on 4/7/26 with an administration time of 7 PM, and again on 4/8/26 but the administration time was 9 PM. On 5/5/26 at 1:59 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that in January there was three days in which Resident #98 was not given lamotrigine as ordered and in April, two days where Resident #98 was not given hydroxyzine as ordered. The DON stated that when the facility changed their pharmacy automatic renewals were not always prompted when a medication ran out but recently the facility reviewed medication order and believed they fixed the system. She stated she would look into the lamotrigine. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/26 at 9:51 AM, the surveyor conducted a follow-up interview with DON. The DON stated that Resident #98 had been refusing the medication and the medications time was adjusted shortly after. The surveyor reviewed with the DON that on 1/22/26 the staff documented refused however there was no documentation on the other day as to the reason the medication was not given, even with the code see progress note. The surveyor asked if there was no documentation, was the medications given? The DON confirmed if there was no documentation she would assume the medication was not given. 4. On 5/7/26 at 9:04 AM, the surveyor observed Licensed Practical Nurse (LPN) #9 prepare and administer a stool softener, probiotic, oral pain mediation and an inhaler to Resident #70. Following the observation the surveyor reviewed Resident #70's Medication Administration Record (MAR). The review revealed that voltaren external gel was also signed out in the 9 AM time slot, however, the application to the medication was not observed with the other 9 AM medications. On 5/8/26 at 6 AM, the surveyor requested Resident #70's Medications Administration Audit Report. On review of the report the surveyor noted that the medications observed given at 9:04 AM, were documented as given at 9:51 AM, along with the vollaren external gel. On 5/8/26 at 8:04 AM, the surveyor conducted an interview the LPN #9 and Unit Manager (UM) #3. During the interview the surveyor reviewed the concerns that the documented administration of medications was not consistent with the time they were observed administered. LPN #9 confirmed that she had gone into Resident #70's room multiple times to administer medications, however signed them all out at the same time once they were all given. UM #3 then stated that it was the expectation that staff document medications at the time of administration and confirmed this expectation with LPN #9.		

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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 observations and interviews, it was determined that the facility failed to ensure expired medications were removed from the medication storage room. This deficient practice was evident for one of two medication storage rooms reviewed during the annual survey. The findings include: On 05/07/2026 at 7:34 AM, an observation of the medication room on the Ambassador Unit revealed the following: 1. Breo Ellipta inhalation powder package contained pharmacy instructions directing staff to discard the medication six weeks after opening, however, the package indicated it was opened on 09/10/2025. 2. Budesonide inhalation suspension package displayed a pharmacy issue date of 10/31/2023, with an expiration date of 04/2025. 3. Enoxaparin sodium injection package displayed a package date of 12/06/2024, and an expiration date of 03/2026. 4. Budesonide inhalation suspension, pharmacy label instructed staff to use the vials within two weeks once the foil pouch was opened. No open date was documented on the package. Five foil packs were observed in the box, and two of the five packets were opened. The expiration date listed on the outside of the box was 04/2026. 5. Breo Ellipta package displayed a pharmacy label dated 08/2/2025, and an expiration date of 02/2026. 6. Juven package displayed a pharmacy label date 02/06/2025, with a manufacturer use by date of 04/01/2026. 7. Budesonide inhalation suspension contained four foil packages, with one of the four foil packages opened and no open date dated. During an interview on 05/07/2026 at 8:00 AM, the Nurse Unit Manager #14 stated that unit managers are responsible for conducting weekly checks of the medication storage room for expired medications. The surveyor informed the Nurse Unit Manager #14 of the expired medications and showed her the medications identified in the medication room. The surveyor also informed the Director of Nursing #2 of the expired medications observed in the medication room.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations and interviews it was determined that the facility failed to accommodate a resident's intolerance by not providing alternative options with similar nutritional value. This was found evident in 1 (Resident #43) in 1 resident reviewed for food preferences. The findings include: On 5/5/26 at 8:13 AM, the surveyor conducted an interview with Resident #43. During the interview Resident #43 alleged that he/she did not get substantial food during his/her breakfast meals. Resident #43 stated that he/she had dairy intolerance but continued to get milk. On 5/5/26 at 8:18 AM, the surveyor observed Resident #43 receive his/her breakfast tray from the dietitian Staff #27. At this time the tray was reviewed. Resident #43 received rice crunchie cereal, 2% milk, orange juice, coffee, and a biscuit (jelly and margarine). No source of protein was noted on the breakfast tray. Resident #43 stated that he/she would like some meat or eggs or something of substance. Staff #27 stated that she would look into the breakfast tray order. On 5/5/26 at 8:30 AM, Staff #27 returned to Resident #43's room and confirmed there was an error. Cheesy eggs were on the menu, so they were taken off the plate due to Resident #43's dairy intolerance. She stated that a new breakfast tray would be delivered. She informed Resident #43 he/she would be giving protein on the next tray. On 5/5/26 at 9:20 AM, the surveyor conducted an interview with Staff #27. During the interview Staff #27 agreed that a biscuit was not an equivalent substitution to the eggs and agreed that Resident #43 should have gotten protein as part of his/her breakfast.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility staff failed to ensure accurate documentation of treatments provided to residents and failed to ensure accurate documentation of resident's skin assessments. This deficient practice was evident for 2 (Resident #83 and Resident #117) of 2 residents reviewed for resident records during the annual survey. The findings include: 1. On 05/04/2026 at 12:01 PM, during an interview, Resident #117 reported having a central line that was placed while hospitalized. The resident stated the central line dressing had not been changed since admission to facility. The surveyor observed a loose, cloudy dressing covering the central line site. The date on the dressing was 04/07/2026. On 05/05/2026 a review of Resident #117's electronic health records (EHR) revealed the resident was admitted to the facility on [DATE]. Further review revealed physician orders directing staff to change the needless device weekly and as needed, measure the external portion of the central line catheter weekly during dressing changes, and change the transparent dressing weekly during the evening shift. The order further directed staff to initial and label the dressing after each dressing change. Review of the record indicated staff documented completion of the weekly task from 04/13/2026-05/05/2026. During an interview with the Director of Nursing (DON) #2 on 05/05/2026 at 2:05 PM, the surveyor informed the DON #2 of the observation made regarding Resident #117's central line dressing and the staff documentation indicating care was completed when it was not provided. The DON later followed up with the surveyor and acknowledged that staff documented care they failed to provide. 2. On 05/06/2026 at 9:00 AM, the surveyor conducted a record review for Resident #83. Resident #83 was seen by the Nurse Practitioner (NP) on 04/28/2026 for a comprehensive skin exam. The NP's progress note determined that Resident #83 had two new wounds but the skin assessment documentation suggested otherwise. Skin assessment documentation: On 04/24/26- No new skin conditions. On 04/28/26- Does the resident have new skin conditions? No. On 05/01/26- No new skin conditions. On 05/06/26 at 10 AM, The Director of Nursing acknowledged the concern.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, and interviews, it was determined that the facility failed to maintain infection prevention and control practices including proper medication administration techniques and the appropriate use of cleaning equipment in a manner that minimized the potential spread of pathogens. This deficient practice was evident during 1 of 3 medication administration observations and for 2 of 2 equipment room reviewed during the annual survey. The findings include: 1. On 05/06/2026 at 10:10 AM, the surveyor noted that a commercial-grade hand sink was missing from the soiled laundry room. However, a utility sink was placed in the corner of the room, adjacent to the wall where the paper towel and soap dispensers were located. An interview with the Administrator confirmed that the utility sink was utilized for the mop and mop bucket. The Administrator acknowledged that a commercial-grade hand sink would be installed in the soiled laundry room to perform proper hand-washing practices. On 05/06/2026 at 3:00 PM, the surveyor conducted a tour of the LifeWork second floor unit alongside the Administrator and noted that the mop basin in the janitor's/soiled utility closet was blocked by a toilet, which was placed in the unit. In addition, the cleaning chemicals in the wall mounted dispensers were missing. An interview with Staff #19 revealed that the housekeeping technicians were not utilizing the janitor's/ soiled utility closet on the second floor, where ten additional resident rooms were located. Both the Administrator and Staff #19 confirmed that the second floor janitor's/ soiled utility closet would be properly maintained for the use of cleaning supplies and chemicals. 2. On 5/8/26 at 8:12 AM, the surveyor observed License Practical Nurse (LPN) #27 prepare medications for Resident #73. After preparation the surveyor observed LPN #27 take Resident #73's blood pressure with a portable blood pressure machine. After taking the blood pressure Resident #73 requested to take the medications later. LPN #27 honored this request and returned to the medication cart explaining she would move on to the next resident. On 5/8/26 at 8:24 AM, the surveyor observed License Practical Nurse (LPN) #27 take Resident #140's blood pressure with a portable blood pressure machine and used the same blood pressure cuff, without disinfecting the cuff used with Resident #73. After taking the blood pressure LPN #27 prepared and administered the medications to Resident #140. On 5/8/26 at 8:41AM, the surveyor again observed LPN #27 utilize the portable blood pressure machine and take Resident #75's blood pressure use the same blood pressure cuff from Resident #140 without disinfecting between the residents. On 5/8/26 8:59 AM, the surveyor conducted an interview with LPN #27 and asked what the practice was for using shared equipment between residents. LPN #27 stated she should have wiped the blood pressure equipment between the two residents. On 5/8/26 at noon, the surveyor interviewed the Director of Nursing (DON) and informed her of the observations.		

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. Number of residents sampled: Number of residents cited: Based on observation and interview with facility staff, it was determined that the facility failed to ensure proper airflow in the soiled laundry room. This was evident from the tour of the soiled laundry room conducted during the annual survey. The findings include: Airborne transmission occurs when pathogens are so small that they can be easily spread in the air, and because of this, there is a risk of transmitting the disease through inhalation. These small particles containing infectious agents may be spread over long distances by air currents and may be inhaled by individuals who have not had face-to-face contact with (or been in the same room with) the infectious individuals. According to the Centers for Disease Control and Prevention (CDC), preventing the spread of pathogens that are transmitted by the airborne route requires the use of special air handling and ventilation systems. On 05/06/2026 at 10:00 AM, the surveyor conducted a tour of the clean and soiled laundry rooms alongside the Administrator, Maintenance Director, and the Environmental Services Director. The surveyor observed absence of negative pressure airflow from the mechanically operated ventilation system in the soiled laundry room. The Maintenance Director confirmed that the order for the replacement of the roof exhaust fans has been placed. On 05/07/2026 at 2:30 PM, the surveyor verified that the roof exhaust fans were delivered to the facility. Both the Maintenance Director and the Administrator acknowledged that the installation of the roof exhaust fans would ensure adequate airflow throughout the premises.		

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F 0756 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility policy review and interviews, it was determined that the facility failed to have a Medication Regimen Review policy in place with time frames to indicate when irregularities recommendations with urgent need should be acted upon. This was found evident of 1 of 3 pharmacy policies reviewed. Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the Inter Disciplinary Team (IDT), including the resident, their family, and/or resident representative. The findings include: On 5/8/26 at noon the surveyor requested the facility's policy for medication regimen reviews. On review of the policy, it was noted that MMR would be done at least monthly by a consulted pharmacist and the report would be given to the facility within 24 hours. The policy then states that Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the medical record and reported to the Director of Nursing, Medical Director and/or prescriber as appropriate. It further stated that notification mode is dependent on severity of irregularity and is determined through consultation between consult pharmacist and Director of Nursing. On 5/8/26 at 12:29 PM, the surveyor reviewed the concern that the medication regimen review policy had no timeframe or standard for reporting emergent needs. The surveyor asked if the facility had their own policy as the policy given was from the consulting pharmacy. At the time of exit no additional policy was provided for review.		