STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215178	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederick Villa Healthcare	711 Academy Road Catonsville, MD 21228

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on facility documentation and an interview, it was determined that the facility failed to have a qualified Infection Preventionist (IP). This failure has the potential to affect all residents in the facility.The findings include:An Infection Preventionist is responsible for assessing, developing, implementing, and monitoring a facility's Infection Prevention and Control Program to prevent and control infections.During an interview with the Director of Nursing (DON) on 8/26/25 at 12:38 PM, the DON stated that Staff #29 (regional Assistant Director of Nursing and Infection Preventionist) was collaborating as the IP for the facility. The DON clarified that until she completes IP training, Staff #29 is a resource person who comes to the facility once a month.A phone interview was conducted with Staff #29 on 8/26/2025 at 1:12 PM. She confirmed that she is an employee of a regional company and is working as a resource person to cover the vacancy of a qualified IP. She started this role at the end of March 2025. Staff #29 stated that she comes to the facility once a month and is available when the current DON needs help.In an interview with the DON and the Nursing Home Administrator (NHA) on 8/27/25 at 7:30 AM, the DON confirmed that the facility failed to have an IP onsite.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint 337259 and the facility's pest problem logs and interview with facility staff, it was determined that the facility failed to maintain an effective pest control program. This deficient practice had the potential to impact all residents.The findings include:Review of complaint 337259 on 8/25/25 at 12:13 PM revealed that the facility was infested with roaches and rodents.The surveyor requested the facility's pest logs from 2025 on 8/27/25 at 7:42 AM. Review of the Pest Problem Log on 8/27/25 at 9:42 AM revealed the following entries in patient care areas:11/13/24 room [ROOM NUMBER]: roaches, mice11/13/24 room [ROOM NUMBER]: roaches, mice1/21/25 room [ROOM NUMBER]: roaches2/6/25 Medication room [ROOM NUMBER], 2, 3: ants, roaches, mice, mice droppings4/21/25 Rooms 118, 115, 120, 116, 117: roaches4/21/25 Rooms 217-220: roaches, mice4/22/25 Rooms 105, 106, 111, 112: roaches4/23/25 Break room: ants4/25/25 Front area: roaches5/2/25 Rooms: 207-209: water bugs5/2/25 Rooms: 100, 109: mice5/15/25 Rooms 204: spiders5/20/25 Unit 3 nurse's station: ants 5/20/25 room [ROOM NUMBER]: roaches 5/25/25 Rooms 211, 220: ants5/26/25 room [ROOM NUMBER]: bugs5/27/25 room [ROOM NUMBER]: bugs5/29/25 Rooms 211, 220: ants5/31/25 room [ROOM NUMBER]: spiders5/31/25 room [ROOM NUMBER]: ants6/1/25 room [ROOM NUMBER]: spiders6/1/25 room [ROOM NUMBER]: roaches 6/2/25 room [ROOM NUMBER]: spiders6/2/25 Rehab: roaches6/4/25 Rooms 102, 104, 106: ants, roaches6/4/25 room [ROOM NUMBER]-120: ants, roaches6/24/25 Laundry room: roaches7/16/25 Conference room: roaches, mice8/6/25 Rooms 202, 208, 314, 315: roaches, mice8/6/25 room [ROOM NUMBER]: roaches, mice8/6/25 Shower rooms 1, 2, 3: ants, roaches, mice8/8/25 room [ROOM NUMBER]: gnats8/12/25 room [ROOM NUMBER]: flies, gnats8/15/25 room [ROOM NUMBER]: flies On 8/27/25 at 8:21 AM in an interview with the Nursing Home Administrator (NHA) when asked if he has seen roaches and rodents in the facility he stated, Yes, we live in the state of Maryland and so I have seen roaches and rodents in the facility. We do have a pest management company. On 8/27/25 at 9:16 AM in an interview with the NHA, the surveyor shared the concerns that there was a complaint filed regarding the roaches and rodents, that the logs show sightings of roaches and rodents, and that he verified and confirmed that there are roaches and rodents in the facility. During the interview, the NHA stated this building was an old building and being surrounded by woods and water, it was a continuous effort to keep the pests and rodents out of the building. The surveyor shared this issue was a concern and the NHA stated, sure, I understand.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility reported incidents (Intake #2578127, # 337212 and #337236), record review, and interview, it was determined that the facility failed to ensure that all alleged resident violations were reported in a timely manner, including: abuse, neglect, exploitation or mistreatment. This was evident for 6 (Resident #86, # 143, #71 #101, #2, and #140) of 76 Residents that were part of the survey sample.The findings included: 1) On 08/19/2025 at 9:04 AM, during the initial screening phase of the survey, Resident #86 alleged to the surveyor that “on the last Sunday night shift (8/17/2025) a nurse was very mean and rough with the resident during care and when her attitude was brought to her attention by Resident #86, she just left the room and never came back. When asked if the incident was reported to anyone, Resident #86 stated “no”. The resident’s roommate (Resident #143) confirmed that nurse was rough with her during care pushing Resident #86 roughly towards the bedrail. The nurse was described as “African” by both residents. On 08/19/2025 at approximately 9:10 AM, during the initial screening phase Resident #143 reported to the surveyor that the staff were “mean and they have very bad attitude, they refuse to attend to our needs when we need help. ‘They get mad when we ring the call bell.” On 08/19/2025 at approximately12:28 PM, unit manager (RN #13) was made aware of Residents #86 and #143 above-mentioned concerns. RN #13 stated that he would speak with the residents. On 8/21/2025 at approximately 11:45 am, the Director of Nursing (DON) was notified that the unit manager (RN #13) was made aware of Resident #86 and #143 concerns; however, there was no documented evidence to support that a follow-up investigation was initiated and reported to the Office of Health Care Quality (OHCQ) in a timely manner. On 08/25/2025 at 3:20 PM, the Regional Director of Clinical Operations (RDCO) was notified that Resident #86 and #143’s concern was reported to RN #13 by the surveyor on 8/19/2025 and the Director of Nursing (DON) was notified of the concern on 8/21/2025. However, there was no report was made to OHCQ. The RDCO stated that she will look into it further. On 8/26/25 at 8:20 AM interview with DON, she was asked, when an abuse incident is reported what was the expectation. The DON reported they start an investigation, if a staff member was involved, they would be removed from the unit; for resident- resident we would separate them. Conduct the follow up investigation immediately; assessment of the residents (complete skin sheet or any kind of notes under assessment section). On 08/26/2025 at 1:45 PM, in a follow-up interview with RN#13, he stated that he was removed from the unit for a few days and therefore he was unable to complete the investigation. RN #13 stated that he would typically report concerns of abuse to his supervisor immediately but in this case, it was not done. He stated that he planned to continue with the follow-up investigation upon his return the next day. However, he was then pulled off the floor for an unrelated issue and was immediately sent home. He stated that he could not complete the investigation. He was notified by the surveyor that there was a concern in regard to late reporting to OHCQ for allegations of abuse and or neglect. RN #13 provided the surveyor with a one page document titled “Statement form” where an apparent interview was conducted with Resident #86, however, there was no additional documents (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided. On 08/27/2025 at approximately 10:14 AM, a review of the documentation provided revealed that the facility conducted an internal investigative form; however, there was no documentation to suggest that the allegation of abuse was filed with OHCQ as required. On 08/28/2025, the DON was once again informed that the facility failed to report the allegations of abuse/neglect for Resident #86 and #143 to OHCQ in a timely manner. 2) On 08/25/2025 at 3:35 PM, in an interview with Resident #71, the resident alleged to the surveyor that the Geriatric Nursing Aides (GNAs) in the facility have bad attitudes, especially when we need to get to the hoyer lift. The resident alleged that on one particular occasion, a GNA made some hurtful statements to Resident #71 while providing personal care about a month ago. The resident alleged that the GNA stated to the resident that he/she was “too fat, his/her thighs are too heavy, and he/she needed to lose weight because he/she was hurting the GNA’s back”. The resident alleged that sometimes they are afraid to call for help.” Resident #71 reported that GNAs were sometimes using their cellphones while providing care to residents. The resident also reported that on a separate incident he/she had an episode of incontinence and a GNA told Resident #71 to wait until the next shift, the resident stated that they waited from 2pm to 6pm before help was provided. The resident’s roommate Resident#7) confirmed the above-mentioned concerns. Resident #71 stated that a manager was notified about the concerns and asked that the GNA did not return to the resident’s room; however, the GNA returned to the resident’s room once after the complaint was made to the manager. On 08/25/2025 at approximately 3:45 PM, the Regional Director of Clinical Operations (RDCO) was informed by Resident #71 of the concerns shared with the surveyor. The RDCO stated that the issues would be addressed. On 08/26/2025 at 9:13 AM, in a follow-up interview with the RDCO, she was asked if the complaints were reported to OHCQ and she stated they were not reported. She stated that the staff were educated on reportable events. She stated that the concern was investigated and the GNA stated that she was not talking to Resident #71 about their weight, she was talking to someone on the cellphone. The RDCO stated that the GNA was educated on customer service and cellphone policy by the administrator. On 08/26/2025 at 9:48 AM, a review of a facility’s internal document revealed that Resident #71 made an official complaint to the facility that on 6/5/2025 at 11pm- 7am shift, the assigned GNA (GNA #47) was rude and told Resident #71 that the resident needed to lose some weight. A signed human resource statement revealed that “GNA #47 changed her work status to PRN (as needed). GNA #47 has not worked at the facility since July 28, 2025 and she is not currently schedule to pick up any shifts for this month (august) or the next (September).” A review of another internal document revealed that on 8/22/2025 Resident #71 reported to the facility that on about 7 -3pm shift, a GNA refused to provide personal hygiene care and the GNA told the resident to wait until next shift. Resident reported that he/she was not changed until 6 pm that evening. This incident was reported by the resident to the Nursing Home Administrator (NHA). On 08/26/2025 at 10:55 AM, in an interview with the NHA, the NHA was notified that the facility failed to report the allegation of abuse/neglect to OHCQ as required and he acknowledged the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor’s concerns. The NHA reported that the incidents were not reported to him as a case of abuse. NHA stated he saw the resident in the hallway, and it was expressed more as a customer service issue and not abuse. The NHA stated that they did go back to check the schedule and found that the GNA was accidentally in her room again after the reported incident. The NHA stated that he spoke to the unit supervisor to ensure the GNA was not sent back or assigned to Resident #71’s room again. He stated that the GNA was also educated not to enter Resident #71’s room again. When asked if there was any documented evidence to support that the unit supervisor and GNA were notified of the resident’s request he stated that it was communicated verbally to both of them. 3) On 08/27/2025 at approximately 10:16 AM, a review of a facility reported intake # 2578127 revealed that Resident #101 reported to the facility that his/her cellphone went missing on Sunday 9/8/2024 at around 1PM from his bed. Further review of the facility’s documentation related to this report revealed that a staff member was notified of the Resident’s alleged missing cellphone on 9/8/2024 at approximately 2:30pm; however, documentation suggests that the alleged incident was reported to the Office of Health Care Quality (OHCQ) on 9/9/2024 at 4:57 PM, which was more than 24 hours after the facility was made aware of the incident. On 08/28/2025 at 10:07 am, in an interview with the Nursing Home Administrator (NHA), the NHA was notified the facility failed to report the alleged incident to OHCQ in a timely manner. He acknowledged the surveyors’ concern, and he stated that he was not notified by Staff until 9/9/2024 at 9:30 AM (the following day) as a result the report to OHCQ was submitted late. 4) On 8/26/2025 at 1:34 PM, a review of facility reported incident 337212 was conducted and revealed Resident #2 alleged that he/she was pushed into bed and forced to lie down by GNA #45. Review of the facility’s investigation revealed that the incident was reported to the Social Worker, Staff #46 on 4/20/2023. The initial self-report was emailed to OHCQ on 4/24/2023, which was not within 2 hours of the alleged abuse. On 8/26/2025 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who stated that an allegation of abuse must be reported to OHCQ within 2 hours of the allegation. However, DON stated she was not employed at the facility during that time. The DON confirmed the findings. 5) This surveyor investigated intake #337236 on 8/26/25 and 8/27/25. As part of the investigation, this surveyor asked Resident #140, Are you getting along with your roommate? The resident responded by shaking their head no and pointing towards the roommate (privacy curtain was pulled to allow for privacy). Resident #140 said that the roommate did foul things to them. This surveyor asked if he/she told anyone and they replied that they told one of the board ladies. This surveyor asked if they meant one of the GNA's (Geriatric Nursing Assistant) and the resident shook their head up and down. This surveyor asked when did they tell the GNA and they replied about two months ago. This surveyor told the Director of Nursing (DON) on 8/26/25 at 8:35 AM that the resident alleged the roommate does foul things to the resident. She said she would investigate. This surveyor emailed the state survey agency on 8/27/25 and was informed that no self-report was sent. The Administrator was interviewed on 8/28/25 at 9:10 AM. He was informed of the resident’s (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegation and that this surveyor told the DON. He replied that he would find out what happened. The Administrator was interviewed on 8/28/25 at 10:00 AM. He said the social worker followed up and the resident agreed to a room change. This surveyor stated that it was not reported to the state reporting agency, and any allegation needs to be reported. It is up to our office to decide if we are going to investigate. Telling a surveyor or getting an allegation from a surveyor does not constitute notification. He replied he understood.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a review of resident medical records, and interviews with facility staff, it was determined that the facility failed to: 1) review and revise the resident's care plan as required, 2) hold or document interdisciplinary team care plan meetings at the time of quarterly revisions, and 3) to ensure participation in the care planning process by the required interdisciplinary team (IDT) members. This was evident for 7 (Resident #10, #74, #8, #13, #15, #68, and #130) of 34 residents reviewed during the investigation phase of the facility's recertification/complaint survey. The findings included: Care plans are developed to guide the care residents receive and must be created within seven days of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). An interdisciplinary team, including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (when practicable), is required to develop and revise these plans. 1) On 08/19/2025 at 12:01 PM, Resident #10 reported to the surveyor that I have a broken tooth and its hurting. I have a few broken teeth. I have been seen by a dentist, and they said I might have to get some of the teeth pulled out. It's been about 2 years since I've seen the dentist. On 08/20/2025 at 1:20 PM, in an interview with Staff #12, she explained that she was responsible for scheduling resident's appointments and if a consult or referral was recommended while the resident was in the facility, the doctors would give the nurse an order- then order goes to medical records, then she would schedule the appointment. For residents with dental concerns, if they have Medicaid the dental insurance Medicaid will cover dental, if they had no dental insurance facility will pick up the cost. She stated that the dentist that comes into the facility, if asked to see a resident the dentist will see them no matter their insurance. For tooth aches the dentist will see and make recommendations usually in the middle of the month.Staff #12 was asked if she was aware of any dental concerns for Resident #10 and if the resident had any scheduled dentist appointment and she stated that she was not aware of any dental appointment for Resident #10. On 08/20/2025 at 2:06 PM, a review of Resident #10's dental exam completed on 9/21/2024 revealed that the resident presented with missing restoration on tooth #30 with poor restorability and mobility on tooth #12 and #13. Referral Date: September 21, 2024. Reason For Referral: Extraction tooth #30, #12 and #13. On 08/20/2025 at 2:13 PM, a review of the 10/3/2024 progress notes in Resident #10's chart revealed that the resident had a referral for dental consult at the University of Maryland Medical Center, for oral and maxillofacial surgery and for extraction of tooth #30, #12 and #13. The note stated that the medical records department was contacted for follow up. The Physician and resident were both informed. On 08/20/2025 at approximately 5:58 PM, a review of the resident care plan revealed that the facility failed to review and update the care plan at least quarterly. The dental care plan was initiated on 12/01/2023 and it stated the resident will be free of pain in the oral cavity and that the facility will coordinate arrangements for dental care, transportation as needed/as ordered. However, the resident had an active dental referral as of 9/21/2024 for tooth extraction and was using lidocaine gel for tooth ache, the facility failed to update the care plan to reflect the resident's change in dental status (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for approximately 11 months. On 08/19/2024 at approximately 1:45 PM, during the initial pool phase the Resident #74 was observed to have a black eye and when the resident was asked what happened he/she stated that he/she fell; surveyor asked the resident if he/she would answer some question regarding the fall and the resident stated he/she was not up to talking to the surveyor. 08/27/2025 at approximately 5:00 PM, a review of Resident #74's medical records revealed that on 8/13/2025 at approximately 8:08 PM, the resident was observed laying on the floor lateral on the left side. The resident was observed to have a small hematoma on the left side of the face. The resident was alert and oriented and reported to staff that he/she fell from the wheelchair and hit his/her head on the floor. The resident was sent to the emergency room due to the fall. CT scan was completed and negative. On 8/14/2025 at approximately 9:54 PM the resident returned from the hospital with new orders: Apply ice to the left eye if swelling increases; Tylenol Oral Tablet 325 MG, give 3 tablet by mouth every 8 hours as needed for headache and continue neuro checks for 24 hours and a follow-up care appointment with a medical doctor. On 08/28/2025 8:13 AM, a review of the resident care plan revealed that the facility failed to review and revise the care plan to include that the resident had an actual fall with injury on 8/13/2025 and there were also no documented interventions identified after the 8/13/2025 fall on the resident's care plan. On 8/28/2025 1:30 PM, the Director of Nursing (DON) was notified that the facility failed to provide documented evidence to support that they reviewed and revised Resident #74's care plan after the 8/13/2025 fall and the DON verbally acknowledged the issue brought to her attention by the surveyor. 2) On 08/27/2025 at 10:53 AM, a review of Resident #10 care plan meeting revealed that the facility failed to conduct an interdisciplinary care plan meeting at least quarterly as required. Care plan meetings were completed a total of 3 times between January 2024 to survey date (1/2/2024, 9/27/24 and to survey date). On 08/27/2025 at 1:52 PM Interview with Staff #6 (social worker), the social worker was notified that Resident #10 care plan meetings were not completed as required, she was asked how often care plan meetings should be conducted, she stated that the goal was to have care plan meetings quarterly. Staff #6 stated that the missing care plan meetings was an oversight. On 8/28/2025 at approximately 1:30 PM, the Director of Nursing (DON) was notified, and she acknowledged the issue brought to her attention. On 8/19/25 at 11:10 AM, a review of Resident #8's medical record revealed the resident has been at the facility for more than 10 years. The most recent two years of MDS assessment reports showed that the resident's quarterly assessments were completed on 7/28/23, 1/08/24, 4/09/24, 7/10/24, 1/08/25, 4/10/25, and 7/08/25. Annual assessments were completed on 10/08/23 and 10/08/24. A further review of Resident #8's progress notes revealed that the facility held care plan meetings on 7/10/24, 10/10/24, and 1/13/25. During an interview with Staff #6 (Social Worker) on 8/20/25 at 11:25 AM, she stated that the care plan meetings were arranged by the facility's social worker after the MDS assessment and should be (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented in the progress notes. When the surveyor asked why Resident #8's care plan meetings weren't documented in the progress notes, Staff #6 replied, I have them in my notes. She confirmed that those were not part of the official medical record. On 8/28/25 around 4 PM, the surveyor informed the Director of Nursing (DON) of these concerns, and she validated the findings. On 08/19/2025 at 8:33 AM, in an interview with Resident #13, the resident stated he/she was unaware of what a care plan meeting was and has not had one. On 08/21/2025 at 10:53 AM, a review of Resident #13's medical records revealed he/she has resided in the facility since 2019. Further review of Resident #13's MDS (Minimum Data Set is a comprehensive, federally mandated assessment tool used to evaluate a resident's functional, cognitive, and health status to create individualized care plans, monitor quality of care, and support reimbursement for Medicare and Medicaid certified facilities.) assessments showed that the facility staff completed quarterly assessments on 11/19/2024, 04/15/2025 and 07/16/2025, and an annual assessment on 01/15/2025. However, only one care plan meeting note was documented in the resident's electronic medical record titled care conference for 11/21/2024. On 08/19/2025 at 1:51 PM in review of Resident #15's medical records revealed care plan meetings were held on 10/2/2024 and 07/09/2025, with a nine-month interval between them. On 08/21/2025 at 10:35 AM, continued review of Resident #15's medical records revealed he/she has resided in the facility since 2023. Further review of Resident #15's MDS assessments showed that the facility staff completed quarterly assessments on 01/15/2025, 03/11/2025, 04/01/2025 and 07/02/2025 and an annual assessment on 12/29/2024. However, only two care plan meeting notes were documented in the resident's electronic medical record titled care conference for 10/02/2024 and 07/09/2025. On 08/20/2025 at 11:25 AM, in an interview with the Social Worker (Staff # 6), she stated that residents' care plan meetings were scheduled according to when the MDS was due. The care plan meeting was documented in the resident's electronic medical record under the title care conference. On 08/21/2025 at 1:37 PM, Staff # 46 confirmed that care plan meetings were not held and that corresponding documentation was missing from the residents' (Resident #13 and #15) electronic medical records. On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns. A review of Resident #68's medical records on 8/26/2025 at 2:44 PM revealed care conference notes done on 1/22/2025 and 7/10/2025 for care plan meetings held by the Interdisciplinary Team (IDT). [of note: These care conferences were 6 months apart instead of 3 months (quarterly)]. Further review of Resident #68's medical record on 8/26/2025 at 2:54 PM revealed that Resident #68 had a quarterly MDS assessment completed on 1/15/2025 and 4/16/2025, and an Annual MDS done (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 6/26/2025. Based on the MDS assessments, the resident should have had a care plan meeting following the 4/16/2025 quarterly MDS assessments. However, there was no evidence in the medical records that a care plan meeting had been held with the resident and the IDT in April 2025 following the 4/16/2025 quarterly MDS assessment. The surveyor interviewed the Social Worker (Staff #6) on 8/27/2025 at 9:15 AM. During the interview, Staff #6 indicated that social services staff were responsible for coordinating the care plan meeting with residents. She stated that care plan meetings were scheduled based on MDS /ARD (Assessment reference date) and added that care plan meetings were to be held at least quarterly with long-term care residents. The surveyor requested that Staff #6 provide the survey team with any evidence of care plan meetings held in 2025 for Resident #68. In a follow up interview with Staff #6 on 8/27/2025 at 9:55 AM, she presented documentation that showed Resident #68 was invited to care plan meetings in January and July of 2025, including documentation of the care plan meetings held on 1/22/2025 and 7/10/2025. However, there was no invitation letter and/care plan meeting documentation for April 2025. When asked if there was a care plan meeting in April 2025, Staff #6 stated she was going to find out. In an interview with Resident #68 on 8/27/2025 at 12:50 PM, the resident was asked if s/he was invited to and/or attended a care plan meeting in April 2025, the resident said no. In another interview with Staff #6 on 8/27/2025 at 1:59 PM, she confirmed that there was no care plan meeting scheduled for Resident #68 in April 2025. On 8/27/2025 at 3:25 PM, during an exit conference, surveyor informed the Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional Clinical Educator of the missed care plan meeting in April 2025. No additional information was provided to the surveyor. 3) On 8/27/25 at 8:02 AM review of complaint 337226 revealed a care plan meeting for Resident #130 was held on 7/19/23 that did not include a nurse, nurse practitioner, or doctor. On 8/27/25 at 9:33 AM review of social services documentation revealed a care plan meeting was held on 7/19/23. On 8/28/25 at 9:15 AM in an interview with the Director of Nursing (DON), the surveyor requested all documentation related to Resident #130's July 2023 care plan meeting. On 8/28/25 at 10:04 AM review of the Education Attendance Record for Resident #130 and dated 7/19/23 failed to reveal a staff member from nursing (a nurse and/or nurse aide), physician or dietary representative had attended the care plan meeting. On 8/28/25 at 10:05 AM in an interview with the Nursing Home Administrator (NHA), a dual observation of the Education Attendance Record was conducted and the surveyor noted there was not a staff member from the nursing or dietary department or a physician. The NHA verified and confirmed the findings. When asked if the expectation was that a physician and nursing staff members attended care plan meetings, the NHA stated yes. When asked if there was evidence that a nurse or physician attended this care plan meeting, he stated no.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interviews with residents and facility staff, it was determined that the facility failed to ensure that the environment of resident care was maintained in a manner that minimized the potential spread of infection. This was evidenced by: 1) an isolation sign for a COVID-19 positive resident was not posted, 2) antiviral medication for the COVID-19 positive resident was not administered in a timely manner, and 3) staff in the laundry failed to use standard precautions when they handled contaminated linens. This was evident for two (Resident #46 and #67) of two residents reviewed for COVID-19 positive and was also observed in the laundry room during the survey.The findings included: 1) Isolation SignageDuring an entrance conference with the Director of Nursing (DON) and Regional Clinical Director (Staff #1) on 8/19/25 at 8:15 AM, they stated the facility had two active COVID-19 cases. The DON said, the resident's isolation is completed today.During an initial tour of the facility on 8/19/25 at 8:22 AM, the surveyor observed that Staff #9 (Licensed Practical Nurse) took off the EBP (Enhanced Barriered Precaution) signage from Resident #67's room door. Staff #9 said, The patient no longer needs any type of precaution. There was no sign on the door.A second observation of Resident #67's room door on 8/19/25 at 10:56 AM revealed that there was EBP signage but no contact and droplet precaution signage.A review of Resident #67's medical record on 8/27/25 at 8:49 AM revealed that the resident was diagnosed with COVID-19 on 8/14/25 with audible wheezing and crackles. Additionally, there was an order for contact and droplet precautions from 8/14/25 to 8/24/25.In an interview with the DON on 8/28/25 at 12:50 PM, she stated that precaution signage for residents should be placed on their room door immediately after they are diagnosed. She noted that each unit manager, nurse, or herself should put up the signage. The surveyor shared the concerns regarding Resident #67's precaution signage. The DON confirmed that contact precaution signage should have been placed for the resident.2) Antiviral Medication AdministrationOn 8/27/25 at 10:40 AM, a review of Resident #46's medical record revealed that the resident was diagnosed COVID-19 positive on 8/10/25. The facility's attending provider ordered [name of antiviral medication for COVID-19] twice a day for 5 days, starting on 8/10/25.Further review of Resident #46's Medication Administration Record (MAR) for August 2025 revealed that the resident received antiviral medication on 8/12/25, which was two days later than prescribed. Also, the progress notes on 8/12/25 at 20:42 (8:42 PM) documented that the medication was not given due to awaiting pharmacy delivery.In an interview with the Director of Nursing (DON) and Staff #3 (regional nursing educator) on 8/27/25 at 10:56 AM, they confirmed that the medication was not stocked in the Pyxis (emergency use medication storage). The DON stated that pharmacy delivery usually did not take long and the medication should be administered as soon as possible. Additionally, when the surveyor asked why the medication was given for the morning dose on 8/12/25 but was still awaiting delivery for the evening dose, the DON said, Yes, it did not make sense. The DON and Staff #3 both validated the concerns.3) Standard Precautions in LaundryDuring a tour of the laundry room on 8/26/25 at 1:33 PM, it was observed that one of the laundry staff members (Staff #32) was putting soiled linens into the washer without applying a gown (or apron) and face protection.In an interview with the Director of EVS (Staff #31) on 8/26/25 at 1:37 PM, she stated that staff were required to have personal protective equipment such as gloves and an apron (the facility staff had their own gown) when handling soiled linens.Additionally, Staff #31 pointed to the laundry room wall where the staff's own gowns were located. However, there were two personal jackets hanging with an apron. Staff #31 was asked if it was their normal practice to hang an employee's personal clothes with the laundry apron. Staff #31 said, No, it should not be.On 8/28/25 at 2:01 PM, a review of the facility's policy named Laundry Handling Policy showed that staff must wear tear-resistant gloves, gowns, and face protection when handling soiled linens.On 8/28/25 at 2:30 PM, the surveyor shared the above concerns with the Director of Nursing, and she validated them.

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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. Based on observation and staff interview, it was determined the facility staff failed to treat a resident in a dignified manner by leaving a urinal that contained urine hanging on the bedrail during meal time. This was evident for 1 (Resident #49) of 74 residents reviewed during a recertification / complaint survey. The findings include: During an observation of Resident #49 on 8/19/2025 at 8:40 AM, the surveyor observed the resident sitting in bed eating breakfast. Hanging on the resident's left upper bed rail was a urinal containing clear yellow urine (about 1/3 full). When asked if the resident had used the urinal prior to breakfast, s/he said yes. Resident #49 stated that s/he had used the urinal a while back. S/he added that when staff served him breakfast the urinal containing urine was hanging on the bedrail but they did not empty it.On 8/19/2025 at 8:45 AM, Surveyor observed Geriatric Nursing Assistant (GNA #4) come into the room and left without removing the urine containing urinal at the resident's bedside. Surveyor immediately interviewed GNA #4 who stated that she was not assigned to the resident but was in the room to pick up trays. When asked about the urinal containing urinal at the resident's bedside during meal time, GNA #4 stated that it was not appropriate that Resident #49 was eating breakfast and there was a urinal with urine in it next to him/her.On 8/19/2025 at 8:50 AM, Resident #49's nurse, Licensed Practical Nurse (LPN #5) was notified of surveyor's observation. LPN #5 came into the resident's room and validated surveyor's observation. LPN #5 stated that staff should have emptied the urinal when they served the resident breakfast. She apologized to Resident #49 and stated she was going to empty the urinal right away. The above concerns were reviewed with the Director of Nursing (DON) on 8/20/2025 at 11:32 AM. DON stated that she was aware of surveyor's observation and she has done education/ training with the staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of medical records and interviews, it was determined that facility staff failed to 1) ensure that two physicians' certificates of incapacity were obtained and that Advance Directives were completed in accordance with the Health Care Decisions Act. This failure occurred before allowing resident representatives to make informed health care decisions on a resident's behalf. The Facility also failed to 2) provide written information to all residents concerning the right to formulate an Advanced Directive (AD). This was evident for 2 (Resident #8 and Resident #11) for 32 residents records reviewed for advance directives during the initial pool phase of the survey. The findings include: Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form that includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. According to the Health Care Decisions Act: 5-602 (d) (1) states that any competent individual may make an oral advance directive to authorize or refuse life-sustaining procedures or to appoint an agent. (2) An oral advance directive is as valid as a written one if made in the presence of an attending physician, physician assistant, or nurse practitioner and one witness, and if the substance is documented in the individual's medical record, dated, and signed by both the practitioner and the witness. 5-602 (e) (1) specifies that an advance directive becomes effective when the patient's attending physician and a second physician certify in writing that the patient is incapable of making an informed decision. According to the Centers for Medicaid and Medicare (CMS), an Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law. 1) On [DATE] at 11:54 AM, a review of Resident #8's medical records revealed the resident had been at the facility for more than 10 years, but there was only one physician certification signed on [DATE]. A further review showed that Resident #8's BIMS (Brief Interview for Mental Status) has been '00' since their admission. BIMS is a cognitive screening tool used to assess a resident's mental status. During an interview with Staff #6 (Social Worker) on [DATE] at 10:21 AM, she confirmed that two physician certifications with signatures are required and should be filed in the resident's paper chart. When asked if the form had been reviewed, she stated that chart reviews were conducted during significant changes. The surveyor informed her that Resident #8 only had one signed certification, which was completed more than 10 years ago. Staff #6 said she would look further. In a follow-up interview on [DATE] at 9:15 AM, Staff #6 confirmed that Resident #8's medical record did not have a two-physician certification. She stated, we are actually working on to update current (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status. During an exit conference on [DATE] around 4 PM, the surveyor shared these concerns with the Director of Nursing and the Nursing Home Administrator. 2) On [DATE] at 12:47 PM a review of the Resident's #11's medical record revealed that there was no documentation to support that the advance directives (AD) were obtained as required and in an interview with the Regional Director of Clinical Operation (RDCO), she stated that the advanced directives should be in the Electronical Health Records (EHR). On [DATE] at 10:18 AM, in an interview with the social work director, she stated that during a new admission she would assess if the resident had his/her AD documents, if they were unable to provide it, the AD would also be discussed in the resident's care plan meetings. AD documentation could be found in the care plan note section of the residents' EHR. If the resident or family had a copy of the AD it would be obtained by the social worker and placed on file under the miscellaneous tab in the EHR. During the interview the social worker was informed by the surveyor that there was no documented evidence that Resident #11's AD was addressed as required. The social worker stated that she would follow up and address the AD documentation. On [DATE] at 9:23 AM, in a follow-up interview with the social worker, she was asked for the documentation related to Resident #11's AD documentation, she stated that the form was previously completed; however, she was unable to locate Resident #11's AD. She stated that she will revisit with the resident to obtain the new AD. The social worker was notified that the missing documentation was required and was a concern for the surveyor.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on complaint intake, record review and staff interviews, it was determined that the facility failed to 1) notify the Power of Attorney when a resident fell out of bed and 2) notify the physician of a missed medical appointment. This was evident for 1 (Resident #127) of 42 Intakes reviewed during a recertification/complaint survey.The findings include:1) On 8/26/25 at 8:15 AM review of a complaint intake #337221 had that resident fell out of bed and the facility failed to notify the Power of Attorney (POA) until 36 hours later when the POA found out from the physical therapist.Review of the nurses progress note on 8/26/25 at 10:15 AM had that resident was found on the floor and stated s/he was trying to reach at something on the floor by the bedside. No pain or injury was noted. Further review of the medical records did not show that the resident's POA were notified of the fall Incident.In an interview with the Director of Nursing (DON) On 8/26/25 at 11:10 AM, she was asked who was notified when a resident had an incident. She stated that if the resident have a POA, then the POA is notified. She was made aware of the concern and asked to provide evidence that the POA was notified.On 8/26/25 at 12.15 PM she brought an incident document #1749 that showed under Agencies/People notified that it was the resident that was notified not the POA. She was made aware that this was a concern and agreed that the POA should have been notified.2) On 2/26/28 at 9:00 AM continue review of intake # 337221 had that Resident #127 also missed a medical appointment that was crucial to rehabilitation.Review of the medical records on 8/26/25 at 9:32 AM revealed that resident had a scheduled post op appointment on 10/30/23 to see the surgeon that repaired the resident's fractured tibia. This appointment was rescheduled for 11/7/23 because the Heart-to-Heart transportation used by the facility to transport residents to their medical appointments did not show up to take the resident to their appointment.In an interview with Staff #12, a medical records director, on 8/26/25 at 11:54 AM, she was asked to explain what happened. She stated that the appointment was scheduled, but the transportation company failed to show up, so they had to reschedule the appointment. She was asked if the facility has backup plans for transporting residents in case of cancellations, and she said they didn't have one at the time of the incident but have a wheelchair van which they use as back up now. She was asked if the attending physician was notified of the cancelled appointment and she said the doctor's office was called to reschedule the appointment and that the consulting doctor was made aware of the cancellation, but she did not know if the attending physician was notified. Further review of the medical records did not indicate that the attending physician was notified.The DON in an interview on 8/28/25 at 11:58 AM was asked if the facility should have notified the attending physician when this medical appointment was cancelled and she said yes. She was asked to find the proof that the attending physician was notified. On 8/28/25 at 1:57PM The DON came back to report that she could not find any documentation to that effect. She was made aware that this was a concern

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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 surveyor observation and interviews with residents and facility staff, it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment. This was evident for 2 (Resident #15 and Resident #133) of 44 residents reviewed from the complaints and facility reported incidents investigated during the facility's recertification survey. The findings include: 1) On 8/19/25 at 11:16AM. 11:46 AM and 1:52PM during an initial tour of the facility the surveyor noticed the presence of flies and gnats in rooms [ROOM NUMBERS]. Residents in both rooms complained of flies and gnats flying around in their rooms all the time. In room [ROOM NUMBER]B, Resident #15 also said that flies and gnats always fly around their room and bathrooms. Further review of a complaint incident #337246 had that the” Nursing Facility has issue with Pest Control. There are ants, fruit flies, gnats, and mice within the facility”. In an interview with Staff #18 a Maintenance Director on 8/21/25 at 12:19 PM, he was asked if the maintenance department do a kind of daily or routine checks or rounds on the resident’s rooms and he said that they have weekly/ monthly checks which they do through their “TELS System” used by staff to alert maintenance of issues requiring their attention. He stated that they don’t go around checking each resident’s room unless someone brought to their attention that something was broken and needed repair. That resident or anyone can flag him as he walks down the hallway if there was an issue. He was asked if staff or residents had brought to his attention the issue of flies, gnats or mice in residents’ rooms. He said yes that he was going around changing the fly traps on the walls in the hallways. That the fly traps are not allowed in the residents’ rooms or spraying of any kind. The surveyor told Staff #18 that she was in the resident’s room and saw flies and gnats flying around and asked what can be done to get rid of them. Staff #18 said he will talk to the administrator to see what can be done. The Administrator was made aware of the above concerns on 8/21/25 at 12:28 PM and was asked what the facility was doing about it. He stated that they have a pest control company ([NAME] Pest control), that monitors the window screens and fly traps and have done deep cleaning in some rooms. He said that the residents were given plastic containers to stow their foods/fruits which attract flies and have also added fly traps and installed blue lights in the hallways which they monitor and change periodically. He was asked how often the Pest control company comes in and he said he was not sure. He was asked if the company writes a report after each visit and he said yes, so he was asked to bring the report. On 8/21/25 at 2:06 PM The administrator [NAME] an invoice dated 7/2/25 from the [NAME] Pest control company showing that the company came and treated some rooms, laundry room and kitchen with roach sand ant sprays. The other invoice dated 8/18/25 showed bimonthly services for mice, and roaches in residents’ rooms and shower rooms. The administrator also brought in a commercial pest control agreement with the same company dated 8/21/25 for further treatment of the fly infestation and other covered pests. On 8/21/25 at 2:30PM The administrator was made aware that this was still a concern because the flies and gnats are still present in the resident’s room and needed more aggressive treatment and that whatever the facility just implemented was done after surveyor’s intervention. He agreed that it was a concern. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of complaint 337237 concerning Resident #133 on 8/27/25 at 11:09 AM revealed that the room [320] had not been painted in years and where things had been removed off the wall, the old paint was left. Further review of the complaint revealed the bathroom water faucet was corroded and the plaster on the wall in the bathroom and other parts of the walls looked loose and flaky. On 8/27/25 at 11:32 AM observation of room [ROOM NUMBER] revealed a ceiling tile in the corner of room ajar leaving a gap which led up to the ceiling. In addition, the top corners of the wall above the window had been patched, but had not been painted, the faucet of the bathroom sink was corroded, and the light above bed A did not have a pull cord. The current resident stated that there was no light bulb and that the light had not been working for some time. On 8/27/25 at 11:41 AM in an interview with the Nursing Home Administrator (NHA), a dual observation of the interior of room [ROOM NUMBER] and its bathroom was conducted. The surveyor pointed out the above observations. When asked if the findings in these observations would be considered a comfortable, homelike environment, the NHA stated no.

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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 interviews, it was determined that the facility failed to provide documented evidence to support that each resident was free from unnecessary medication administration. This was evident for 1 (Resident #74) of 5 resident's assessed for unnecessary medications during the recertification/complaint survey.The findings included:On 08/20/2025 at 10:34 AM, a review of Resident #74's medication list revealed that the resident had orders for a scheduled antianxiety medication once per day and a separate anti-anxiety medication every 6 hours as needed. However, there was no documentation to suggest that the facility adequately monitored Resident #74's behavior to ensure that psychotropic medications were administered appropriately. On 08/21/2025 at 4:13 PM, in an interview with the Director of Nursing (DON), the surveyor requested documentation of Resident #74's behavior monitoring. After further review of the resident's chart the DON stated that there was no documentation to support that the facility monitored the behavior of the resident. The DON was asked by the surveyor to explain the expectation for a resident that was receiving psychotropic medications, and she acknowledged that the resident's behaviors were to be monitored and documented every shift. She stated that it would be implemented moving forward.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility failed to accurately code a diagnosis in the Minimum Data Set (MDS). This was evident for 1 (Resident #15) of 8 resident reviewed for Antipsychotic medication (a type of drug primarily used to treat symptoms of psychosis, such as hallucinations and delusions, by blocking dopamine in the central nervous system) use and related diagnosis reviewed during the recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a comprehensive, federally mandated assessment tool used to evaluate a resident's functional, cognitive, and health status to create individualized care plans, monitor quality of care, and support reimbursement for Medicare and Medicaid certified facilities.Active diagnoses documented on the MDS assessment are attending provider-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. The Centers for Disease Control and Prevention (CDC), defines schizophrenia as a serious brain disorder that causes people to have a distorted perception of reality, leading to symptoms like hallucinations, delusions, disorganized thinking and speech, and unusual behavior. The CDC defines schizoaffective disorder as a mental health condition that combines symptoms of schizophrenia (psychosis, such as hallucinations or delusions) and a mood disorder (like bipolar disorder or depression), where a significant mood episode co-occurs with psychotic symptoms for a substantial portion of the illness.On 08/21/2025 at 11:34 AM, a review of Resident #15's medical record revealed the following:-A Physician order with a date of 01/02/2024 for Olanzapine 5 MG (is an atypical antipsychotic medication used to treat mental health conditions such as schizophrenia and bipolar disorder.) Give 1 tablet by mouth at bedtime for depression.-A Psychiatry Progress Note dated 05/28/2025 with listed active diagnosis which did not include Schizophrenia.Further review of Resident #15 medical record revealed MDS assessments for 6/30/2024 and 09/30/2024, indicated an active diagnosis of Schizophrenia for Resident #15 in Section I, however continued review of the medical record did not corroborate the diagnosis.On 08/26/2025 at 1:13 PM, during an interview with Staff #30 (MDS Nurse), stated a Schizophrenia diagnosis should only be coded on the MDS if it was obtained from a hospital within the last six months. Schizoaffective disorder and Schizophrenia are distinct diagnoses, and a patient with schizoaffective disorder should not be coded as schizophrenia on the MDS. Therefore, the Schizophrenia diagnosis was incorrectly coded in Section I as an active diagnosis on the 6/30/2024 and 9/30/2024 MDS assessments, and confirmed by Staff #30.On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure a baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP) and documented in the medical record. This was evident for 2 (Resident #126 and #122) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to each resident and/or his/her representative and documented in the medical record. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. Brief Interview of Mental Status (BIMS) is a standardized test used to assess a resident's cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) On 8/20/25 at 11:48 AM review of the medical record revealed Resident #126 was admitted on [DATE]. The 8/25/23 MDS coded the resident as rarely understood, and as such, the BIMS assessment was not even conducted. On 8/20/25 at 1:20 PM in an interview with the Director of Nursing (DON) when asked if a copy of the BLCP was provided to the resident and/or RP she stated yes. During the interview, when asked if that was documented in the medical record, she stated yes. When asked how it was documented, she stated as a progress note. When asked for residents with impaired cognition and/or RP's, who should be signing documents for those residents, the DON stated, It had to be the RP. In a follow up interview with the DON and Regional Director of Clinical Operations (RDCO #1) on 8/25/25 at 12:05 PM, the RDCO stated that the facility's expectation was that staff printed out the BLCP, had the resident or RP physically sign the hard copy, and then that the staff member was supposed to scan the hard, signed copy into the electronic health record (EHR) under the miscellaneous tab. On 8/20/25 at 2:00 PM review of Resident #126's medical record failed to reveal a BLCP in the EHR under the miscellaneous tab. On 8/20/25 at 2:20 PM the surveyor requested a copy of the BLCP for Resident #126 and evidence from the medical record that it was provided to the resident or RP. On 8/21/25 at 8:25 AM the DON provided a copy of the BLCP; however, on the last page (7 of 7) in the Signature of Resident or Representative section, it was signed by the resident. The section stated, I have received the above information and understand the content of this information. I understand any updated information will be communicated with me prior to, or at the care conference, after the comprehensive care plan is developed. In a dual observation, the surveyor flipped to the last page and pointed out that the resident had signed (their signature was typed into the field) the BLCP. The DON stated this was an error because the resident has a BIMS of 0 and he/she should not be signing any documents. Furthermore, she stated that she looked in the medical record and was unable to find any evidence that the RP had received a copy of the resident's BLCP. She stated it should have been documented in the progress notes but it was not.2) Review of the medical record on 8/25/25 at 10:13 AM revealed Resident #122 was admitted on [DATE] with diagnoses including, but not limited to, dementia, Alzheimer's disease, muscle weakness, and need for assistance with personal care. Further review of the medical record revealed the resident's 10/14/24 MDS coded the resident with a BIMS of 2. Additional review failed to reveal a BLCP in the EHR under the miscellaneous section. On 8/25/25 at 11:14 AM, the surveyor requested a copy of Resident #122's BLCP and evidence from the medical record that it was provided to the resident or RP.On 8/25/25 at 12:05 PM the DON provided a copy of Resident #122's BLCP; however, on the last page (6 of 6), in the Signature of Resident or Representative section, it was blank. There was no information that was (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inputted into the fields. Additionally, in the Signature of Staff Completing the Baseline Care Plan section, it was also empty with no information. A dual observation of the document was conducted and the DON verified and confirmed there was not a signature from the staff or resident/RP on the BLCP. Furthermore, the DON verified and confirmed there was no evidence from the medical record that the resident or RP received a copy of the BLCP including a list of medications. The RDCO and DON stated it was the expectation that staff completed the fields, signature of staff completing plan, title and date on the last page of the BLCP.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to provide the required level of assistance for a resident to perform their Activities of Daily Living. This was evident for 1 (Resident #122) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:Activities of Daily Living (ADLs) are the basic, essential self-care tasks people need to perform to maintain their health, safety, and well-being, such as bathing, dressing, eating, and toileting.Brief Interview of Mental Status (BIMS) is a standardized test used to assess a resident's cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's health status, functional abilities, and needs. It is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident.Review of complaint 337250 on 8/25/25 9:06 AM revealed the complainant noted that on 10/11/24, he/she arrived to the facility and found Resident #122 in a soiled incontinence brief that the resident had tried to remove the feces by tearing up the brief. Further review of the complaint revealed the complainant noted on 10/13/24 he/she arrived to find the resident in bed with feces on his/her hands, under his/her nails, all inside and on his/her pants, shirt, and bed linens. The complainant noted that the Geriatric Nursing Assistant (GNA) said Resident #122 was directed to the bathroom about 90 minutes ago; however, the complainant indicated that the resident required hands on assistance using the toilet and another staff member was surprised to hear that Resident #122 needed any assistance. Review of the medical record on 8/25/25 at 10:13 AM revealed Resident #122 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia, Alzheimer's disease, muscle weakness, and need for assistance with personal care. Review of Resident #122's medical record on 8/25/25 at 11:07 AM revealed the resident had the following care plan:- Resident #122 has an ADL self-care performance deficit r/t (related to) Alzheimer's. Further review of the medical record revealed the 10/14/24 MDS coded Resident #122 with a BIMS of 2. Furthermore, the 10/17/24 MDS revealed for:- Self-care: the resident's need for assistance with bathing, dressing, using the toilet, or eating, Resident #122 was coded as Needed Some Help - Resident needed partial assistance from another person to complete any activities. - Toilet transfer: the ability to get on and off a toilet or commode, Resident #122 was coded as Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. On 8/28/25 at 11:57 AM the October 2024 Documentation Survey Report was reviewed for Toilet transfer: the ability to get on and off a toilet or commode. The key for which was as follows:09- Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.06- Independent - Resident completes the activity by themself with no assistance from a helper.05- Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.04- Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance. Assistance may be provided throughout or intermittently.03- Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunkor limbs but provides less than half the effort.02- Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.01- 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 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the activity. The review revealed that Resident #122 was coded each of these numbers from 09 down to 01. The resident was coded 06 which means the resident is Independent on 5 shifts during the month of October 2024; however, Resident #122 is coded in the MDS, which is what guides the level of care they require, as needing some help and supervision or touching assistance. On 8/25/25 at 12:47 PM in an interview with the Rehab Director when asked what was the expectation for a resident coded as Supervision/touching assistance, she stated that meant either eyes or a hand are on the resident. GNA #49 was interviewed on 8/28/25 at 1:19 PM. During the interview when asked how she knows what level of assistance each resident on her assignment needs with toileting and eating she stated, We get report from the off going GNA. GNA #50 was interviewed on 8/28/25 at 1:22 PM During the interview when asked how she knows what level of assistance each resident on her assignment needs with toileting and eating she stated, I would find that out in the computer. I would go back and click to see how it was completed on the previous shift and if they were set up last shift, that's what I'd do. On 8/28/25 at 12:16 PM in an interview with the Director of Nursing (DON) when asked how GNA's know the level of assistance residents need for eating and toileting she stated that they are told during report. When asked if there was a place for GNAs to look in the medical record for that information, she stated no, they are given report. The surveyor shared concerns that when reviewing the resident's medical record for toileting transfer, there was documentation that ranged all the way from dependent to independent even though the resident is coded as Supervision or touching assistance and residents not getting the required level of assistance required. The DON verified and confirmed understanding.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint incidents, record reviews, and staff interviews, it was determined that the facility failed to provide quality of care services to residents in their facility. This was evident for 2 (Residents #135 and #127) of 42 intakes reviewed during the recertification/complaint survey.The findings include:1) On 8/20/25 at 10:19AM, review of a complaint Intake #337242 had that Resident #135 complained of pain at their J-tube feeding site and that resident had multiple issues when their feeding tube was clogged because it was not flushed. The complainant stated that some days, Resident #135 was not fed at all and that they were later taken to the hospital and diagnosed with a clogged J-tube.A review of the physician's order regarding tube feeding on 8/20/25 at 10:19 AM read:1/10/24: Every shift enteral feeding formula: osmolyte 1.2; Rate: 55; start at 1 pm time and run until 1100 MLs has infused; Tube type: J tube; Size of Tube: 22 F. Flush with water: Amount: 55 ml q 4 hrs. Monitor Q shift1/10/24: Every day shift- Aspirate stomach contents with syringe to visualize stomach contents and then reˆinstill.1/10/24: Every shift Flush enteral tube with 30 MLs of water before and after medication administration and 5-10MLs of water between each medicationReview of the March 2024 Medication Administration Record (MAR) and the Treatment Administration Records (TAR) on 8/20/25 at 11:20AM did show that on 3/21/24 Evening/Night and 3/22/24(night), the MAR and TAR were not signed off for tube feeding, residual check and tube flushes. There were no notes to explain why it was left blank, which was an indication that it was not done.On 8/20/25 at 12:35 PM the Director of Nursing (DON) in an interview was asked the process for maintaining the J-tubes to prevent clogging. She stated that the tube should be flushed before and after tube feeding, site assessment should be done before feeding to look out for drainage, redness, skin issues and if found, notify the wound team to follow up. She was asked to explain what could happen when feeding tubes are not flushed or assessed. She stated that the tubes would get clogged because that's where the residents receive their medications. She was asked to explain what it means when the meds/treatments records are not signed off by the nurses. She stated that it meant the treatments were not done.She was made aware that the nurses did not sign off on the MAR/TAR to indicate that treatments and tube feeding were given on the above dates. She agreed that it was a problem and said she would provide more education including institute quality improvement measures.2) On 8/26/25 at 8:30 AM, review of an attachment to a complaint intake #337221 had that resident #127 was over and under medicated by the facility. The complaint had that resident missed their dose of the Medication Modafinil use to treat excessive sleep on January 1st and 2nd 2024.Review of the physician's order on 8/26/25 at 8:36 AM revealed an order dated 10/27/23 that read: Modafinil oral tablet 200mg, give 1 tablet by mouth one time a day for stay awake. Further review of the Medication Administration Record (MAR) for the Month of [DATE] revealed that this medication was not given on [DATE] and 3 of 2024. Review of the Nurses progress notes revealed that the staff were initially waiting on pharmacy to deliver the medication. The next day, they documented that they sent the control substance form (C2) to the nurse practitioner to complete , and the 3rd day, were still waiting on pharmacy to bring the medication.On 8/28/25 at 9:02 AM In an interview with Staff #20 a Registered Nurse/ Unit manager regarding prescription refills, she was asked what a C2 form was for, and she said it's used to order narcotics refills. She explained that a physician must complete the form first, before it could be faxed to pharmacy. She was asked how long it took to get medications back from pharmacy. She said it depends on when the order was faxed, that pharmacy makes their delivery run 2-3 times a day up until midnight. She explained that all medications can be ordered STAT to expedite same day delivery.On 8/28/25 at 4:00 PM the Director of Nursing (DON) was made aware that Resident #127 did not get their medication for 3 days because it took that long to be delivered by pharmacy. She agreed that it was a concern and said she will follow up.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined the facility failed to:1) provide timely, consistent care and treatment for a resident with pressure ulcers, 2) ensure a wound consult was completed timely, 3) provide services to promote healing of pressure ulcers, and 4) have interventions on plan of care for pressure ulcers. This was evident for 2 Resident (Resident #126 and Resident #5) of 3 residents reviewed for Pressure Ulcers during the facility's recertification/complaint survey. The findings included: A pressure ulcer also known as pressure sore or bed sore, is any lesion caused by unrelieved pressure that results in damage to the underlying skin. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (partial thickness loss of skin presenting as a shallow open ulcer), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with exposed tendon, muscle or bone) to Unstageable (the depth of tissue damage cannot be determined due to the presence of slough or eschar (both are types of dead skin that prevent healing). Consistent care is essential for treating and preventing pressure ulcers. Inconsistent care can lead to severe complications, including infection and worsening of the wound. 1) On 8/20/25 at 11:48 AM review of Resident #126's medical record revealed the resident was admitted on [DATE] with diagnoses including, but not limited to multiple sclerosis, pressure ulcer of right ankle, unstageable (present on admission), generalized muscle weakness, need for assistance with personal care, aphasia, and dementia. On 8/21/25 at 8:31 AM in an interview with the Director of Nursing (DON) when asked what the plan of care would be for a resident with a pressure ulcer, she stated, Automatically we would have them seen by the wound team, but we [nurses] do not stage wounds, the Wound Nurse Practitioner (NP) does. During the interview, when asked if they are seen by the Wound NP, she stated, Yes, on Tuesday or Thursday, those are the days she [Wound NP] comes into the facility. They would be seen whichever day comes first, so, if a resident was admitted on a Saturday, then they would be seen by the Wound NP on Tuesday. When asked if the Wound NP documents after each visit, the DON stated, Yes, she documents when she sees a resident and it would be a note in PCC [PCC, the electronic health record] in the miscellaneous tab. When asked if all wound notes were in PCC, she stated, Yes, all wound notes are in PCC. Additionally, the DON stated, We also have the Wound doctor who comes every Friday. On 8/21/25 at 8:57 AM review Resident #126's medical record revealed the resident was admitted [DATE] which was a Friday. The next Tuesday would have been 8/15/23. The next Thursday would have been 8/17/23. The next Friday would have been 8/18/23; however, the resident was not seen by a wound provider until 8/24/23. Further review of the medical record revealed three progress notes from the wound provider dated 8/24/23, 8/31/23, and 9/7/23. On 8/20/25 at 12:34 PM review of Resident #126's Medication Administration Record and Treatment Administration Record from August 2023 revealed: - Order for: Location: Cleanse sacral wound with wound cleanser, and add 1 application of Santyl and cover with dry dressing and secure with adhesive boarder gauze every day shift for wound care- Order Date: 08/11/2023; D/C [discontinue] Date: 08/15/2023 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Order for: cleanse sacral wound with wound cleanser and add 1 application of Santyl and cover with dry dressing and secured with adhesive boarder gauze one time a day for wound healing- Order Date: 08/18/2023; D/C Date: 08/25/2023 - Order for: Location: Cleanse wound to right foot ankle with wound cleanser, apply Santyl and cover with dry dressing and secure every day shift for wound healing- Order Date 08/11/2023; D/C Date: 08/15/2023 - Order for: cleanse wound to right foot ankle with cleanser, apply Santyl and cover with dry dressing and secured with boarder gauze daily one time a day for wound healing- Order Date: 08/18/2023; D/C Date: 08/25/2023 For both wound treatment orders, there was a three day drop off of the orders; however, per the Wound NP's notes, the resident still had a sacral and ankle pressure ulcer that had not resolved. On 8/21/25 at 9:31 AM in an interview with Wound Nurse (WN #15) when asked when residents with pressure ulcers are assessed, she stated, For readmissions and admissions the nurse does their weekly skin checks, but the Wound NP also does a complete, head to toe skin assessment on residents when she comes in on the Tuesday after their admission. When asked why a wound treatment order would be discontinued and/or not reordered, WN #15 stated, The wound healed or resolved or if the resident was no longer with us. On 8/21/25 9:42 AM in an interview with the DON, the surveyor shared the concerns that for both the sacral and ankle pressure ulcer treatment orders, the order was discontinued and not reordered for three days despite the resident still having the wounds. She said she would look into it. Additionally, the surveyor requested all wound notes for Resident #126. On 8/21/25 at 1:09 PM in an interview with the DON she stated, I looked back in Resident #126's progress notes and orders and was unable to determine why the treatment orders fell off. It was not like a medication order that had a specific time frame. During the interview she stated that if a resident had a pressure ulcer, then they should have a treatment order and that education would need to be provided to the staff about this. The surveyor shared this was a concern and the DON verified and confirmed understanding. When asked how often a resident with a pressure ulcer would seen by the wound NP she stated, A resident with a pressure ulcer would be seen once a week by the Wound NP and then depending on the orders, the wound nurse might see the resident several times a week, but again it depends on the orders. In a dual observation with the DON, the surveyor showed that only three wound notes were provided and shared the concerns that the resident was not seen once a week during their admission. The DON verbalized understanding. 2) On 08/19/2025 at 11:10 AM, during an interview with Resident # 5's Responsible Party, he/she voiced concerns that the resident had a wound that was not healing. On 08/20/2025 at 8:14 AM, a record review revealed the following: -A Skin Check Weekly effective date of 07/22/2025 with a new pressure area to Resident #5's sacrum worsening. -A wound assessment report dated 08/07/2025 and signed by a Nurse Practitioner for a treatment to sacrum to Cleanse with 0.125% Dakin's solution Calcium alginate, Santyl, Skin prep surrounding tissue (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or peri-wound Bordered foam. -A wound assessment report dated 8/14/2025 and signed by Staff #14(Nurse Practitioner) for a treatment to sacrum to Cleanse wound with wound cleanser and pat dry Calcium alginate, Skin prep surrounding tissue or peri-wound, Medical grade honey Bordered foam. Continued review of Resident #5's Treatment Administration Record (TAR) revealed a physician's order for sacral wound care. The order, effective from 1:24 PM on 07/24/2025 to 6:38 PM on 8/18/2025, prescribed daily cleansing with Dakin's solution, calcium alginate, Santyl, skin prep, and secured by a border gauze dressing during the day shift. The record indicated treatment continued for four days after the wound Nurse Practitioner recommended a change in the treatment of the sacral wound, effective 08/14/2025. Upon further review, Resident #5's Treatment Administration Record (TAR) showed a physician order start date of 08/18/2025, at 6:38 PM. This was five days after the wound Nurse Practitioner's recommendation to cleanse wound with wound cleanser and pat dry Calcium alginate, Skin prep surrounding tissue or peri-wound, Medical grade honey Bordered foam. An X on the date of 08/18/2025, indicated treatment was not started until 08/19/2025. On 08/21/2025 at 9:34 AM, an interview with Staff #15 (Wound Care Nurse) stated the process for new wound treatment recommendations is completed right away on the same day after contacting the Primary Physician for approval. At this time concerns were shared with Staff #15 regarding delays in residents' wound care recommendations. 3) On 08/20/2025 at 8:30 AM, a review of Resident #5's medical records revealed an Engage Mini Nutritional assessment dated [DATE] at 2:10 PM, that indicated no nutritional intervention related to the sacrum wound that developed on 07/22/2025. On 08/20/2025 at approximately 12:00 PM during a phone interview with Staff # 11 (Dietician) stated the dietician is informed by the nurse about any new wounds and would evaluate the resident at the time a wound occurred. Stated, Resident #5 is due for a Quarterly Nutritional assessment and Staff Dietician #16 (onsite Dietician) assesses residents with new wounds at the facility. On 08/25/2025 at 9:00 AM, interview with Staff #16 (Dietician) stated she just started managing wounds in August of this year. She was not aware of the sacrum wound until 08/22/2025, was never notified or consulted for any intervention regarding Resident #5's sacrum wound in July of 2025. At this time Staff #16 verified that there was no nutritional intervention at the time the sacrum wound occurred and was only addressed with quarterly Nutritional Assessment signed on 08/21/2025 by Staff # 11 only after Surveyor intervention. 4) On 08/20/2025 at approximately 8:45 AM a review of Resident's #5 medical record revealed the following: -A Physician order dated 5/17/2025 at 6:46 PM Turn and Reposition every 2 hours and as needed to promote skin circulations every shift for skin care -A Physician order dated 5/18/2025 at 10:21 PM Pressure reducing/pressure redistribution low air loss mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further Review of Resident #5's sacral wound care plan, dated 05/31/2025, included interventions of applying zinc oxide after each incontinence episode and applying a wound treatment dressing as ordered 07/22/2025. However, the care plan interventions did not incorporate physician orders for turning and repositioning, using a pressure-reducing mattress, or changes in treatments. On 08/20/2025 at 10:47AM, an interview with Staff # 15 (Wound Care Nurse), stated staff should be aware of any interventions for new wounds, as these interventions are documented in the care plan. The care plan must be updated to reflect any changes in treatment or newly identified skin areas. At this time Staff # 15 validated Resident #5's care plan was not updated with interventions related to the sacrum wound. On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, it was determined the facility failed to adequately assess urinary incontinence and implement a care plan to restore continence to the fullest extent possible. This was evident for 1 (Resident #107) of 1 residents reviewed for Bladder and Bowel Incontinence during the recertification/complaint survey. The findings include:On 08/19/2025 at 9:08 AM, in an interview with Resident #107, stated he/she had been waiting for 2 to 3 hours since early morning and was completely soaked. The resident stated that the staff reported no one was there yet, and that waiting to be changed occurred often.On 08/26/2025 at 7:39 AM, a review of Resident #107's medical record revealed a Bowel and Bladder assessment dated [DATE], three days after the resident's admission to the facility. The direction to complete the assessment included; If resident is Continent of both Bowel and Bladder-evaluation Complete. If resident is Incontinent of either Bowel and/or Bladder-Continue with evaluation. However, the assessment was incomplete and indicated the resident was incontinent of bowel and bladder, addressing only Section A, questions one and two, and Section B, question one. Section B included 10 other questions to be completed, Section C, D, and G were blank that indicated incomplete.-Section A for Current Bowel and Bladder Status that included: the resident's current bladder and status. In Resident #107's assessment it was documented as Incontinence of bowel and bladder-Section B had 11 questions that indicated: gender, active diagnosis, medication, consciousness level, ability, primary language, physical assistance required, assistive devices required with toileting, and pain. However, only one question (gender) was answered.Further review of Resident #107 record review indicated that there was no plan of care related to incontinence.On 08/26/2025 at 8:35 AM during an interview, the Director of Nursing (DON) stated incontinent residents are to be on either a toileting program or a two-hour check and change schedule. Both a comprehensive bowel and bladder assessment and an incontinence-related care plan must be established.On 08/26/2025 at 12:21 PM during an interview with Staff # 19 (Unit Manager) stated that upon admission, a comprehensive Bowel and Bladder assessment is required. If the patient is continent, no further questions are necessary. However, if the patient is incontinent, additional questions must be completed, and a care plan addressing incontinence, including interventions, should be implemented. At this time Staff #19 verified the bowel and bladder assessment was incomplete and there was no plan of care established related to incontinence.On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, resident interview, review of complaint intake #337241 and staff interviews, it was determined that the facility failed to 1) monitor a resident for pain and schedule an appointment for pain management following hospital discharge, and 2) ensure that a resident was given pain medication consistent with professional standards of practice. This was evident for 3 (Resident #107, #127, and #68) out of 76 residents reviewed during the recertification/complaint survey. The findings include: 1) On 08/19/2025 at 9:09 AM in an interview with Resident #107, the resident reported “I have pain from my feet to my thighs and have requested pain medication, but no one has responded yet.” On 08/21/2025 at 9:56 AM a review of Resident #107’s medical record revealed the following: -On 07/21/2025 at 5:42 PM, a Discharge Summary from Hospital documented that Resident #107 was recommended to follow up with his/her pain management clinic and spine specialist after discharge. -On 7/22/2025 at 11:59 PM a physician placed an order to follow up with his/her pain management clinic and spine specialist. -On 07/23/2025 at 12:07 PM a physician ordered a pain management consultation for chronic pain. Further review of Resident #107’s medical record revealed a pain care plan initiated on 07/21/2025. This plan indicated the patient experienced pain in the waist area and lower extremities. The review further showed interventions to monitor for signs and symptoms of pain. An additional review of Resident #107's MAR (medication administration record) for July and August, 2025, showed no evidence of pain being monitored or recorded every shift. 08/26/2025 at 9:00 AM, in an interview with resident #107 stated he/she had not seen their pain and/or spine specialist and was unaware of any scheduled appointments. The resident stated he/she was experiencing pain, that a recent injection had not provided relief, and expressed a desire to see their pain management MD. On 08/26/2025 at 9:30 AM, an interview with Staff #12 (Medical Record Director) stated upon admission from the hospital, nurses are responsible for reviewing the discharge summary for any required follow-up appointments, including pain management. They then provide a copy of the discharge summary to the Medical Record Director for scheduling and notify the resident and/or their responsible party of the appointment date. On 08/26/2025 at 9:39 AM during an interview with the Staff #19 (Unit Manager) stated that the Staff #12 schedules appointments based on discharge summaries. Nurses then updated physician orders with appointment details and informed residents. Staff #19 was unaware of any pain management appointment for the resident; stated such an appointment would have been noted in physician orders if scheduled. She verified there was no such order, and the resident was also unaware of any appointment. Staff #19 also stated that nurses record pain monitoring every shift in the treatment administration record. However, she verified there was no evidence of the resident being monitored for pain during July and August 2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/2025 at approximately 1:30 PM a document, titled Appointment and Transport request form for Resident #107, was given to the surveyor by Staff #19. It indicated a follow up from hospital discharge appointment with the pain physician for Resident #107 on September 11th, 2025 at 10:00 AM. Staff #19 confirmed that this appointment was arranged after surveyor intervention. On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns. 2) On 8/26/25 at 12:45 PM review of an attachment to a Complaint intake #337241 had that Resident #127 was getting pain medications when their pain level was at zero, and that nonpharmacological measures were not being implemented prior to medication administration. On 8/26/25 at 1:00 PM review of the physician’s order dated 10/31/23 read: “oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug*Give 1 tablet by mouth every 4 hours as needed for pain. Further review did not reveal an order for non-Pharmacological interventions. Review of the resident’s Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of November 2023 through January 2024 on 8/26/25 at 1:16PM did not indicate that nonpharmacological measures were being implemented. Further review revealed that Resident #127 got their pain medication on January 20, 2024, when their pain level was documented as zero, indicating no pain. On 8/27/25 at 9:12 AM In an interview with the Director of Nursing (DON) she was asked if a resident on a PRN (As Needed) pain medication should have a non-Pharmacological interventions put in place, and she said yes. She was asked if they should be getting pain medications when their pain level was at a zero, and she said no. She was made aware that Resident #127 got pain medications when their pain level was at zero with no nonpharmacological interventions implemented. She said she would follow up with more staff training. 3) Review of Resident #68’s clinical records on 8/21/2025 at 10:37 AM revealed the resident was re-admitted to the facility in July 2023 with medical diagnoses that include but not limited to Opioid dependence, uncomplicated, Chronic pain syndrome, non-pressure chronic ulcer of bilateral lower leg, Peripheral vascular disease, chronic embolism and thrombosis of unspecified deep veins of bilateral lower extremity. On 8/21/2025 11:17 AM Review of physician orders revealed the following active orders: - Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) : Give 1 tablet by mouth every 4 hours as needed (PRN) for pain, start date 11/12/2024, and - Tylenol Oral Tablet 325 MG (Acetaminophen): Give 2 tablet by mouth every 4 hours as needed for Pain, start date 4/18/2025 [of note, there are no parameters/pain scale indicated for administration of the above PRN pain meds]. On 8/21/2025 at 11:21 AM, record review revealed that Resident # 68's pain was not managed consistently: A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025 was completed. Staff documentation revealed that the resident was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given: 1) PRN Tylenol 325mg (2 tabs) ordered without parameters for pain management, for a pain score of 6 on 8/18/2025 at 0641 (6:41 AM). 2) PRN Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 4 hours as needed for pain was given on the following dates/times: - On 8/1/2025 at 7:39 (7:39 AM) and at 1749 (5:49 PM) for pain score of 6…. - On 8/3/2025 at 0008 (12:08 AM) for pain score of 6, at 0723 (7:23 AM) for pain score of 7, and at 1925 (7:25 PM) for pain score of 1. - On 8/5/2025 at 0052 (12:08 AM) for pain score of 7, at 1049 (10:49 AM) for pain score of 5, and at 2001 (8:01 PM) for pain score of 6 - On 8/18/2025 at 1703 (5:03 PM) for pain score of 8, etc. More so, there was no documentation of non-pharmacological interventions (NPIs) attempted prior to these PRN pain meds administration. On 8/25/2025 at 9:05 AM, an interview was conducted with Registered Nurse (RN #24) regarding administration of PRN pain medications: RN #24 stated that prior to giving any pain medication, he will assess the resident's pain and choice of pain med to be given will be based on physician orders/ordered parameters. He stated that each PRN pain med order must have a pain scale/parameters for administration: mild pain 0 -4, moderate pain 5-7, and severe pain 7-10. When asked what pain med to give a resident that has both Acetaminophen (Tylenol) and Oxycodone ordered, RN #24 stated that he would give Acetaminophen for mild pain and Oxycodone for moderate to severe pain. He added that he would attempt non-pharmacological interventions (NPIs) such as relaxation technique, distraction, massage etc. prior to administering any PRN pain medication. RN #24 further stated that it was not appropriate to administer Oxycodone 10mg for a pain score of 1. RN #24 stated that he would educate the resident regarding pain management and if the resident insists on the Oxycodone, he (RN 24) would call the Physician and get a one-time order for the Oxycodone and document it. On 8/26/2025 at 3:04 PM, in an interview with the Director of Nursing (DON), she stated that PRN pain meds should be given following physician orders and the PRN pain med order should have parameters (at least mild, moderate, severe pain) for administration. Regarding non-pharmacological interventions (NPIs) prior to PRN pain med administration, DON stated that staff were expected to document in their progress notes that they attempted NPIs prior to PRN pain med administration. Surveyor reviewed with the DON Resident #68’s MAR and TAR for August 2025 regarding staff PRN pain med administration (Tylenol and Oxycodone). DON verified that the PRN orders failed to have parameters/pain scale for administration. She validated that the resident’s pain was not consistently managed and it was not appropriate to give Tylenol for a pain score of 6 and Oxycodone for a pain score of 1. However, she stated that she was going to look at the nurses' progress notes to see if they documented the reason for administering the above pain meds and/or NPI's that were attempted. On 8/27/2025 at 7:30 AM, in a follow up interview with the DON, she stated that she could not find any nursing progress notes that indicated that NPI's were attempted prior to administering the above (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN pain meds to Resident #68. She added that there were no notes indicating why the Tylenol was given for a pain score of 6 and the Oxycodone for a pain score of 1.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of employee files and staff interview, it was determined that the facility failed to perform annual performance reviews for the Geriatric Nursing Assistants (GNA). This was identified for 3 (GNA #38, GNA#43, and GNA #44) of 5 GNAs reviewed during a recertification / complaint survey.The findings include:Review of GNA #38, GNA #43, and GNA #44's employee files on 8/28/2025 at 8:52 AM revealed no performance appraisals were included for the years 2022 and 2023.On 8/28/2025 at 9:26 AM, an Interview was conducted with the Human Resources Manager, staff # 33, who confirmed that the annual GNA performance appraisals for 2022 and 2023 were missing. Staff #33 stated that if the performance appraisals were not in the GNA files, then they were not done.The Director of Nursing (DON) stated on 8/28/2025 at 11:00 AM that the GNAs should have an annual performance evaluation. The DON agreed that the missing performance appraisals for year 2022 and 2023 were a concern.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review and interview, it was determined the facility staff failed to ensure a resident was free from unnecessary medications. This was evident for 1 (Resident #49) of 74 residents reviewed during a recertification/complaint survey.The findings include:On 8/20/2025 at 8:55 AM, a review of Resident #49's medical record revealed an Annual MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 5/26/2025 that indicated under Section M (skin conditions) that the resident had no pressure ulcer and/or skin issues. On 8/20/2025 at 10:10 AM review of weekly skin sheet documentation from May 2025 through August 2025 revealed Resident #49's skin was intact, No wounds present.On 8/20/2025 at 10:22 AM, review of nursing progress note dated 7/15/2025 at 14:12 (2:12 PM) revealed the following documentation: Note Text: Skin sweep completed by [Name] wound CNP (Certified Nurse Practitioner), no areas noted. RP and MD notified.On 8/20/2025 at 10:26 AM, review of physician orders revealed an active order with a start date of 11/2/2024 for Prostat three times a day for Wound healing, give 30ml.On 8/20/2025 at 10:30 AM, review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025 revealed staff documentation that Resident #49 was being given Prostat 3 times a day for wound healing [of note: Resident #49 has no wounds].On 8/20/2025 at 10:35 AM, in an interview with Resident #49's nurse, Licensed Practical Nurse (LPN #9), she confirmed that the resident did not have any wounds.On 8/20/2025 10:40 AM, an interview was conducted with the Acting Unit Manager, Licensed Practical Nurse (LPN #10) who confirmed that Resident #49 had no wounds. LPN #10 reviewed the resident's medical records with the surveyor that revealed a wound assessment report dated 5/7/2025 that indicated resident's sacral wound was healed/resolved.Surveyor reviewed resident's MAR and TAR for August 2025 with LPN #10: He verified and confirmed that Resident #49 should not have been getting Prostat for wound healing as the resident did not have any wounds. LPN #10 immediately discontinued the order.On 8/20/2025 at 10:49 AM, in an interview with the Wound Nurse, LPN #15, she validated that Resident #49 did not have any wounds.On 8/20/2025 at 11:40 AM, in an interview with the Director of Nursing (DON), surveyor reviewed Resident #49's MAR and TAR for August 2025 and shared concerns regarding the resident getting an unnecessary medication (Prostat for wound healing). DON stated that she was going to follow up with the staff.

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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 observation and interview it was determined facility staff failed to safely store medications and dispose of expired medications and patient supplies. This was evident on 2 of 3 nursing units observed for Medication Storage and Labeling during a recertification survey.The findings include:On 8/25/2025 at 9:45 AM, A review of Medication cart #1 on Unit 2 was conducted in the presence of Licensed Practical Nurse (LPN #26), for Medication Storage and Labeling observation. The following items were found to be expired:- 1 opened box of COVID-19 At home Test kit (Rapid antigen test for ages 2 and up) with expiration date of 4/14/2025 noted on the box. There were 3 test packs in the box, one of them opened. The packs each had an expiration date of 5/11/2025.- 1 bottle of Pro-Stat Wild Cherry Punch that was about a third full: expired on 8/6/2025.LPN #26 verified and confirmed that the above items were expired. She removed them and stated that she was going to discard them. On 8/25/2025 at 10:15 AM Observation of Med-cart #2 on Unit 2 in the presence of Registered Nurse (RN #25), for Medication Storage and Labeling was completed. The following observations were made:- A bottle of Pro-Stat concentrated liquid Protein Medical food that expiration on 7/10/2025- A sticky bottle of Valproic Acid solution 250/5ml that was about a third full. The label on the bottle was faded and there was no resident name and/or expiration date visible on it. RN #25 stated the medication belonged to one of the resident's on the unit but she was unable to identify the resident it belonged to. Part of the solution (sticky substance) was on the outside of the bottle and in the med cart where the bottle was found. RN #25 confirmed that the sticky substance was spillage from the bottle containing the Valproic acid solution and the medication should have been discarded and/or re-labeled.On 8/27/2025 at 12:10 PM Observation of the Medication Storage room behind the nurses' station on Unit 1 was conducted in the presence of Unit Manager (UM #19). The following items were found to be expired:- 5 ESwab Collection and Transport System (for Wound Culture), expired on 12/29/2024- 1 Port Access Infusion Set [22G x 1 (25mm)] Lot # P101Y21, expired on 7/31/2025The following items were observed in an unlocked bottom cabinet behind the nurses' station on Unit 1 next to the med-storage room:- 2 Disposable Virus Specimen Collection Tubes, expired on 8/1/2022- 4 Sterile Normal Saline collection tubes (Lot # MSY2203), expired on 1/13/2023.UM #19 verified and confirmed that the above items were expired. She immediately removed them and stated she was going to discard them.On 8/27/2025 at 2:58 PM a review of the facility's policy on Medication Labeling and Storage revealed the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personal have access to keys. Under Medication Storage 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3) If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 4) Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Under Labeling: 2)The Medication labels includes, at a minimum .d) Expiration date, when available, e) resident's name; .8) If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. On 8/27/2025 at 3:18 PM during survey exit with the Nursing Home Administrator, Director of Nursing, and Regional Clinical Educator, Surveyor shared concerns regarding the above findings made during Medication Storage and Labeling observation on 8/25/2025 on Unit 2 and 8/27/2025 on Unit 1. They provided no additional information.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record reviews and interviews, it was determined that the facility failed to assist the resident in making appointments and arranging transportation to and from the dental services locations. This was evident for 2 (Resident #5 and Resident #10) of 3 residents reviewed for dental services during the recertification/complaint survey. The findings include: 1) On 08/20/2025, at 10:45 AM, a review of Resident #5's Physician orders revealed that there was no indication of an appointment scheduled for a dentist. Further review of Resident #5's medical record revealed that progress note documented as below: -On 8/10/2025 at 10:59 PM, Resident #5 complained of pain in the right mouth gum, which interfered with eating. The doctor was notified and ordered a dental consult. -On 8/10/2025 at 11:05 PM, the primary physician placed an order as Dental consult in AM. -On 8/11/2025 at 20:32 (8:32 PM), a progress note stated, Resident #5 reported right mouth gum pain, which interfered with eating. -On 08/14/2025 at 9:34 PM a progress note stated, upon assessment, it was noted that the resident's lower dental implants were detaching from the gums. The physician was notified and ordered an urgent dental consultation. -On 8/15/2025at 1:42 PM a Nursing Progress note documented that the resident reported tooth pain. During the assessment, it was observed that the resident's lower dental implants were detaching from the gums. The physician was informed and ordered an urgent dental consultation. -On 8/18/2025 at 8:35 PM a care plan note: Eight days after the initial dental consultation for tooth pain, and four days after a physician ordered an urgent dental consult, a progress note indicated: unit secretary was looking for a dentist for implants due to the resident lacking dental insurance. On 8/20/2025 at 1:20 PM, in an interview with Staff # 12 (Medical Record Director), she explained the procedures of consultation: the physician provided an order to the nurse, which was then sent to medical records. Medical records subsequently schedule the appointment. If the patient did not have dental insurance, the facility would cover the cost. On 8/20/2025 at approximately 2:30 PM a document, titled Appointment and Transport request form for Resident #5, was given to the surveyor by Staff #12. It indicated a dental appointment for Resident #5 scheduled on August 21, 2025, at 1:30 PM. On 08/26/2025 at 10:43 AM during an interview with Staff # 19 (Unit Manager) she stated an urgent dental consultation would mean as soon as possible, and the appointment, scheduled for August 21, 2025, was delayed because the resident lacked insurance. Staff #19 confirmed that eleven days later, and only after surveyor intervention, an appointment was made for August 21, 2025, at 1:30 PM for Dental. (continued on next page)

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	215178	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns. 2) On 08/19/2025 12:01 PM Resident #10 reported to the surveyor that I have a broken tooth and its hurting. I have a few broken teeth. I have been seen by a dentist, and they said I might have to get some of the teeth pulled out. It's been about 2 years since I've seen the dentist. On 08/20/2025 at 1:20 PM, in an interview with Staff #12, she explained that she was responsible for scheduling resident's appointments, if a consult was ordered while the resident was in the facility, the doctor would give nurse an order- then order goes to medical records, then she would schedule the appointment. For dental insurance Medicaid would cover dental, if they had no dental insurance facility will pick up the cost. She stated that the dentist that comes into the facility would see the resident if asked, no matter their insurance. For tooth aches the dentist would see them and make recommendations, usually middle of the month. Staff #12 was asked if she was aware of any dental concerns for Resident #10 and if he had any scheduled dentist appointment and she stated that she was not aware of any dental appointment for Resident #10. On 08/20/2025 at 2:06 PM, a review of Resident #10's dental exam completed on 9/21/2024 revealed that the resident presented with missing restoration on tooth #30 with poor restorability and mobility on tooth #12 and #13. Referral Date: September 21, 2024. Reason For Referral: Extraction tooth #30, #12 and #13. On 08/20/2025 at 2:13 PM, a review of the 10/3/2024 progress notes in Resident #10's chart revealed that the resident had a referral for dental consult at the University of Maryland Medical Center, for oral and maxillofacial surgery and for extraction of tooth #30, #12 and #13. Medical records department has been contacted for follow up. The Physician and resident were both informed. However, there was no documented evidence to support that resident #10 was scheduled for dental services as recommended. On 08/20/2025 2:34 PM, in an interview with RN#13, he was asked to explain the medical referral process. He stated that when a referral is made by a provider in-house the referral would be flagged in the physical chart and the nurse would be notified by the provider. The unit manager would then take a copy of the written referral and send it to Staff #12 who was responsible for the scheduling of procedures and the transportation to and from the appointment. Once the transportation is scheduled Staff #12 would usually post the schedule in every unit and the unit managers would also receive a copy of the schedule. After getting report from the out-going floor nurse, the resident's nurse would be responsible for reviewing the appointment schedule posted in the nursing station in order to prepare the resident for their appointment. The surveyor noted that a weekly transportation scheduled posted in unit 3 's nursing station and in the unit managers office. 08/20/2025 3:30 PM, in an interview with RN#13, he stated that he spoke to Staff #12 they were both looking for the corresponding document for the 9/21/2024 referral. He explained that the facility changed management company and therefore some documentations were not easily accessible and as a result they were trying to recover the documentation related to this referral. RN #13 was notified by the surveyor that the lack of follow-through with this referral was a concern, and he acknowledged the issue. On 08/21/2025 9:12 AM, the surveyor notified the Nursing Home Administrator (NHA) of the concerns regarding Resident #10's dental consult and referral made on 9/21/2024; however, there was no (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation to support that the facility followed-up with the referral. The NHA stated that he will investigate it. The NHA later provided a new dental referral form date 08/21/2025 for which resident will be scheduled for a follow-up visit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview with facility staff, it was determined the facility failed to ensure food items were stored under sanitary conditions. This deficient practices was observed in the dry storage area during the recertification/complaint survey.The findings include:On 8/19/25 at 8:17 AM the surveyor observed 2 big bins in the dry storage area. The bins were lined with a white plastic bag. Each of the bags had areas that were ripped and soiled with brown and black stains. Neither bin was labeled with what the item was nor any date. On 8/19/25 at 8:21 AM in an interview with the Dietary Director (DD #2), during a dual observation, when asked what the food items in the bins were, she stated flour and sugar and that she knew they were not labeled. During the interview, she stated that she had just put them in there this morning and forgot to come back and label them. The surveyor pointed to the plastic bags and when asked if she would say the bags/bins were clean, she stated no. When asked why she put brand new bags of flour and sugar into dirty containers, DD #2 stated, I was just trying to get it all done.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on a record review and staff interviews, it was determined that the facility failed to collect all the necessary information for monitoring its antibiotic stewardship program. This was evident in the review of all seven months of antibiotic stewardship records during this recertification/complaint survey.The findings included: Antibiotic stewardship requires a facility to develop and implement policies, procedures and/or protocols to ensure residents who need antibiotics are treated appropriately. This is to reduce the risk of residents having adverse reactions to antibiotics, receiving them unnecessarily and/or developing antibiotic-resistant organisms. A facility-wide process must be in place to monitor the use of antibiotics so the results/feedback can be reported to nursing staff and prescribing clinicians.On 8/27/25 at 8:10 AM, the surveyor reviewed facility's antibiotic stewardship program from January 2025 to July 2025. The review revealed that the facility used spreadsheets for monitoring antibiotic use with resident name, infection type diagnosis, last treated, organism identified, Rx (prescribed) date, Rx duration, antibiotic name, dose, and meet minimum criteria. However, the form did not contain detailed information for infection type diagnosis, last treated, organism identified, and met minimum criteria.During an interview with the Director of Nursing (DON, also Infection Preventionist) on 8/27/25 at 9:32 AM, she stated that the facility has been holding weekly antibiotic stewardship with qualified staff to discuss use of antibiotics. The surveyor reviewed the facility's antibiotic stewardship spreadsheet with the DON. The surveyor stated that the documentation did not have all necessary information to monitor antibiotic use. The DON stated that she had other documentation used when they discussed at the antibiotic stewardship meeting.On 8/27/25 at 10:52 AM, the DON and Staff #3 (Regional educator) brought copies of documentation named 'order listing report' from the electronic medical records. The report had residents' name, order summary of antibiotic, order category (as pharmacy), revision date, and supply last order date. However, the report did not have details of criteria, organism identified, start date and end date. The surveyor informed the DON and Staff #3, their antibiotic stewardship did not adequately monitor their use of antibiotics. They validated the concerns.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on a review of clinical records and staff interviews, the facility failed to offer a resident a pneumonia vaccine upon admission. This was evident for one resident (Resident #68) out of the five reviewed for immunizations during this recertification/complaint survey.The findings included: On 8/26/25 at 11:44 AM, the surveyor reviewed five residents' electronic medical records for their immunizations. The review showed that Resident #68, admitted in October 2022, had no record of the pneumococcal vaccine.In an interview with Staff #19 (unit manager) on 8/27/25 at 1:12 PM, she stated that all unit managers are supposed to monitor residents' immunization status for influenza, pneumonia, and COVID-19 upon admission.On 8/27/25 at 1:16 PM, Staff #3 (Regional Clinical Educator) submitted Resident #68's vaccine declination form, which was dated 10/10/24. The form documented the resident's refusal of the influenza, Pneumovax23, and COVID-19 vaccines for personal reasons. Staff #3 stated that facility staff had reviewed Resident #68's paper chart and found this form.The surveyor asked for additional documentation to support that the facility offered the pneumonia vaccine upon Resident #68's admission in October 2022. Staff #3 responded, [Staff #20, unit manager] handed me declination form dated 10/10/24; I will look more for the 2022.The surveyor followed Staff #3 to review Resident #68's paper chart. There was no additional evidence to support that facility staff offered the pneumonia vaccine in 2022. Also, Staff #20 was not able to indicate where she found the vaccination decline form from Resident #68's paper chart.The surveyor shared their concerns with Staff #3, and she validated them.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review and staff interview, it was determined the facility failed to 1) document providing education regarding the benefits, risks, and potential side effects of receiving the COVID-19 vaccine to residents, and 2) maintain documentation related to COVID-19 vaccination status for staff. This was evident for 1 (Resident #2) of 5 residents and two (Staff #36 and #38) of five staff reviewed during this recertification/complaint survey. The findings include:A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2, the virus that causes coronavirus disease.1) A surveyor reviewed five residents' immunization records on 8/26/25. The review found that Resident #2, who was admitted in July 2025, refused the COVID-19 vaccine on 7/18/25. However, the resident's record showed no for the education provided session.When interviewed on 8/27/25 at 1:12 PM, Staff #19, a unit manager, stated she had offered and educated the resident's family about the vaccine but failed to document it by not clicking box for the education. The Nursing Home Administration validated this finding on 8/28/25.2) On 8/27/25 at 8:07 AM, a surveyor reviewed immunization records for five selected staff. The review revealed that Staff #36 (hired in November 2024) and Staff #38 (hired in September 2024) did not have COVID-19 vaccination records in their health files. The Director of Nursing (DON) and the HR director (Staff #33) confirmed that this documentation was required for new hires. When interviewed, Staff #33 admitted , I just missed them. The surveyor shared concerns that 2 out of 5 employees' health file did not have their COVID-19 vaccination status. Staff #33 validated it.