STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215179	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manokin Nursing and Rehab	11974 Edgehill Terrace Princess Anne, MD 21853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility reported incident # 2602973, medical records, facility documentation, interview with facility staff, and observation, it was determined that the facility failed to 1) protect a cognitively impaired resident (Resident #50) from physical abuse by a resident (Resident #21) with a known history of verbal and physical aggression towards staff and residents. This was evident for 1 (Resident #50) of 4 residents reviewed for abuse during the annual survey. 2) In a separate occurrence, not Immediate Jeopardy, the facility also failed to prevent resident to resident physical abuse. This was evident for 1 of 3 (Resident #93) reviewed for behaviors during the annual survey. The Maryland Office of Health Care Quality (OHCQ) determined that the facility's failure to protect a cognitively impaired resident from physical abuse from another resident met the Federal definition of Immediate Jeopardy, and the facility was notified of Immediate Jeopardy at 2:50 PM on 9/25/2025. The facility developed a plan sufficient enough to remove immediacy which was reviewed and accepted by OHCQ after 4 attempts at 7:38pm on 9/25/2025 while surveyors remained onsite. The plan was verified on 9/26/25 and Immediate Jeopardy was abated on 9/26/25 at 3:12 pm. The findings include: 1) On 09/22/2025 at 11:12 AM a phone interview with the complainant for Resident #50 was conducted, and he/she stated that Resident #50 was attacked by another resident and that is how an injury was obtained. On 09/23/2025 at 11:23 AM in Review of Resident's #21's medical record revealed: On 02/03/2025 at 10:41 PM a Nurse Practitioner progress note stated Resident #21 was previously a resident at another Nursing Home Facility and was Emergency Petitioned (a form filed with the court that is for situations where a resident shows symptoms of a mental disorder and presents a danger to their life or safety or the safety of others, and cannot or will not voluntarily seek treatment.) to the hospital on 1/23/25 for homicidal ideations. He/she verbalized that he/she was going to kill everyone and noted it was because they pluck my last nerve. On 02/15/2025 a Physician Progress note, stated Resident #21 was sent to the emergency room from another facility secondary to making threats to kill other residents. On 4/23/2025 a Psychiatric Eval and Consultation report for Resident #21 stated, Increased behaviors including physical contact is reported. On 5/28/2025 at 5:40 PM a progress note indicated that Resident #21, expressed vulgar language towards other residents and staff for unknown reasons. On 6/2/25 at 2:04 PM a progress note revealed that Resident #21, upon assessment, verbal aggression with derogatory slander was heard from resident while punching his fists in own hands repeatedly, related to another resident coming into his/her room without permission. On the date of service of 6/6/2025 a Psychiatric evaluation and consultation for Resident #21 stated, low mood and low energy remain present, sleep disturbance. On 06/06/2025 at 9:17 PM a Nurse Practitioner Progress note stated, Resident #21 has been noted to be yelling out. He/she has been using derogatory slander. He/she has been punching his fists into the air and into his own hands repeatedly. He/she has been upset about other residents coming into his/her room without permission. Aggression does occur frequently. Under Assessment in Plan: Continue to monitor closely. On 6/17/2025 at 07:02 AM, a progress noted stated, Resident #21 was heard yelling at the roommate. Resident #21 continues yelling out. Staff attempting to redirect without success. Further (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	review of Resident #21's medical record revealed that there was no plan of care in place from the time of admission on [DATE] until 08/16/2025 for Resident #21's history of homicidal ideations, abusive behaviors, or aggression towards residents or staff. (A care plan is a document that summarizes health conditions, specific care needs, and current treatments. It should outline what needs to be done to manage the person & Resident #21's care needs.) On 09/23/2025 at approximately 11:30 AM in review of Resident's #50's medical record revealed the following: On 08/16/2025 at 6:50 PM a Change in Condition Evaluation revealed Resident #21 was heard yelling, when writer got to Resident #21's room, Resident #50 was on the floor in a puddle of blood on side with laceration above right eye. Resident #21 was yelling, I told him/her out of my bed and punching his/her fist in his/her hand in rage, separated from aggressor, Resident #50 was sent out by 911. On 08/16/2025 at 7:58 PM a Progress note, Resident heard yelling while this writer at nurses' station, med aide went into room came out yelling he had thrown resident in the floor. When this writer got to the room resident yelling I told her get him/her out of my bed so he/she got him/her out him/her self, in a wheelchair was punching his fist stating and I will do it again. The Nurse Practitioner (NP) was notified and came to see the resident to review medications. On 08/16/2025 at 8:42 PM an Emergency Provider Note indicated that Resident #50 presented to the emergency room after a fall, was pulled out of bed by another resident that resulted in a fall to the ground with a laceration. Right eyebrow laceration was 2.5 CM (centimeters) in length and required 3 sutures. On 08/16/2025 at 10:42 PM, an Emergency Department (ED) provider notes that stated Resident #50 included a history of severe dementia. Per Emergency Medical Services (EMS) Resident #50 walked into another resident's room into another resident's bed and was pulled out and fell to the ground and hit their head, was noted to have a laceration. The resident required 3 sutures to the right eyebrow. Further review of Resident #21's medical records revealed a care plan initiated on 8/16/25, with a focus of physically aggressive behavior: the resident is physically aggressive to other residents related to a post physical altercation of pulling another resident out of his/her bed. with interventions of 1) Administer medications as ordered. Monitor/document for side effects and effectiveness. 2) Medication review by MD. 3) Psych consult related to physical aggression. However, the care plan was only placed after the physical aggression occurrence involving injury of Resident #50 and did not include non-pharmacological interventions (methods that use non-medicinal approaches to manage distress, agitation, or inappropriate behaviors, focusing on environmental, social, and personal adjustments rather than medications) and/or de-escalation techniques for Resident #21's continued aggressive behavior. On 08/17/2025 at 1:26 AM, a Progress note for Resident # 50 indicated, came back from hospital with 3 sutures placed to forehead bruising noted to the right side of face and eye.On 09/23/2025 at approximately 11:40 AM review of Facility Reported Incident #2602973 on 08/16/2025, revealed the following: Resident #50 had a laceration above the right eye. The allegation of resident-to-resident abuse was verified by witness statements collected from staff present at time of the altercation. Resident #21 pulled Resident #50 out of Resident #21's bed without waiting for staff to assist and redirect Resident #21 prior to physical abuse towards Resident #50. Resident #50 was transferred to the hospital. Continued review of Facility Reported Incident #2602973 revealed the following witness statement: A handwritten statement by Staff # 18 revealed that Resident #21 went to the medication cart and told Staff #18 someone was in his/her bed. Staff #18 told Resident #21, she would get Resident #50 out of the bed, at this point Resident #21 was near Resident #50 and stated, there and yanked Resident #50 out of the bed by the shirt and pants.On 9/23/25 at 2:52 PM during a phone interview, Staff #18 confirmed the investigation statement, adding she was putting away medications when Resident #21 demanded Resident #50 be removed from his bed. Resident #21 then forcefully yanked Resident #50 from the bed, stating, I told you to get him/her out of my bed or I was going to. Staff #18 noted, In the last 6 months Resident's #21's anger has become worse. Further review of the facility reported incident revealed that there no evidence that staff on the unit where Resident #21 was located received education related to Resident #21's aggressive behaviors. On (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/23/2025, at approximately 11:45 AM, continued review of Resident #21's medical record revealed the following: On 08/17/2025 at 1:24 PM a Physician Progress note stated that in review of Resident #21's record, the response of Resident #21, was provoked and pushing Resident #50 out of his/her bed to the floor causing injury was excessive as he/she has been prone to aggressive behavior in the past. On 8/17/25 a Psychiatric report, revealed Resident #21, has exhibited episodes of aggression and agitation towards staff and peers. Resident #21 has been verbally abusive towards both staff and his peers. Plan: Melatonin 3 mg by mouth at bedtime.On 8/23/25 at 6:30 PM a progress note revealed, verbal aggression towards staff, generally aggressive demeanor, successfully verbally redirected and back in his room.On 9/07/25 at 12:26 PM a progress note revealed Resident #21, used profanity and derogatory language toward staff and other residents for no apparent reason.On 9/09/25 at 10:34 AM a progress note stated that. Resident #21 proceeded to use profanity and derogatory remarks upon assessment insulting staff stating, with that black a** baby inside of you b***h, to our pregnant staff member offering assistance. Further review of Resident's #21's medical record revealed a Care plan dated 9/09/25 with a focus of the resident has a behavior problem related to verbal aggression toward residents and staff. With one Intervention to assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. However, the care plan did not include additional non-pharmacological interventions or de-escalation techniques for Resident #21's continued aggressive behavior. Additionally, there was no evidence that staff had received training in behavior management. Such training would focus on assisting residents in developing more appropriate coping or interaction methods, and/or expressing their feelings suitably.On 9/10/25 at 7:24 AM a nurse's note stated, Resident #21 is sitting in the dining room threatening the staff and other residents. The resident is stating that he will beat everyone's ass one on one. Nursing staff was unable to redirect Resident #21. On 9/10/25 at 7:57 AM a nurses note stated, Resident #21 was attempting to self-transfer from a wheelchair to a regular chair, the resident started screaming I will do what I want to do bitch and if you stop me, I will have every cop and news station in this place. Resident attempted to be redirected with no success at this time. On 9/10/25 at 8:56 AM a nurse note stated, Resident #21 was educated again on the importance of asking for assistance, the resident then became irate and tried to flip to a table over in the dining room. The Resident threatened staff stating he was going to kill all of us. On 9/10/25 at 12:26 PM: a progress noted stated, Resident #21 attempted to stand up again without assistance. When the resident was asked to sit back down, the resident proceeded to say I will slit everyone's throat in here. On 09/10/2025 at 12:35 PM a nurse progress note stated, Responsible Party (RP) called and {was}notified a clinical social worker {was} sending {resident #21} out for a mental eval due to the resident having the intent and means to hurt someone.On 9/10/25 at 2:52 PM a Nurse Practitioner Note stated, seen today for an acute visit. Resident with extreme behaviors, including racial slurs, using profanity and vulgar language. The resident verbalized to several staff members that he was going to slit their throats as well as making gestures to insinuate strangling them around their neck. Resident #21 was unable to be calmed or redirected and could not care plan for safety. With a Plan of the resident sent to the emergency room for evaluation.On 9/11/25 at 2:54 PM a progress note that indicated Resident #21 was readmitted to the facility. On 9/11/2025 late entry at 2:55 PM a Nurse Practitioner Progress Noted revealed, Resident #21 was sent out to hospital due to extreme behaviors and threats. Resident #21 was Emergency Petitioned (EP) to the hospital but no new orders were given. Resident #21 continues to yell out racial slurs. On 9/15/25 at 12:35 PM a progress note stated, Resident #21 was making threats, using profanity and being vulgar toward staff while collecting trays. Resident #21's verbal abuse continued, yelling while standing and making threats then plopping back down into the chair unsafely. The resident states, come closer so I can beat your ass.On 9/17/2025 Psych Note stated: Resident # 21 seen at the request of the facility, due to increased aggression. Resident #21 has been verbally and physically abusive towards staff and residents. The plan is to start Risperdal (an atypical antipsychotic medication used to treat certain mental health conditions) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for aggression, titrate melatonin up. Continue to provide nonpharmacological interventions, monitor and document any increase or worsening behaviors, changes in mental status, and encourage participation in activities as tolerated.On 9/17/25 at 12:31 PM a progress note revealed, Resident #21 was trying to have another resident push him down the hall, and the resident was educated. After being educated, Resident #21 became very belligerent calling nursing staff ni**ers, and b***es and stating was going to kill everyone in this place. resident was attempted to be redirected with no success. On 9/17/25 at 2:34 PM a progress note revealed, Resident #21 continues to threaten staff stating, I will kill you all with a machine gun. Resident #21 then tried to flip the table in the day room. The resident was asked to calm down. Resident #21 then stated shouting I will f***ing hit every single one of you. On 09/18/2025 at 9:56 AM a progress note revealed, Resident #21 cursing and saying racial slurs at staff, unable to redirect, care continues. On 9/18/25 at 10:17 AM a progress note revealed, Resident #21 continues to curse and yell racial names at staff, care continues. On 9/19/25 at 3:02 PM a progress note revealed, Resident #21 continues with baseline behaviors of cursing and yelling at staff. On 9/20/25 at 2:45PM a nurse's progress note revealed, Resident #21 had an episode of cursing at staff this afternoon. On 9/22/25 at 11:30 AM a progress note revealed, Resident #21 is verbally aggressive using loud profanity and vulgar language towards staff in the middle of lunch time, standing up and plopping back down in a chair using punching motions punching his fits into his other hand repeatedly. On 9/22/25 at 1:58 PM a progress note revealed, Resident #21 was screaming and yelling obscenities and making accusatory remarks.On 9/23/25 at 2:30 PM in an interview with Staff #3, stated R #21 is frequently aggressive, requiring intervention. GNA #3 also mentioned witnessing the end of an occurrence with R#50 where R #21 threatened to kill the resident if he/she was to enter his room again. From 9/23/2025 to 9/24/2025 the surveyor interviewed 7 staff on the unit where Resident #21 is located regarding training that included abuse, behavior management, and homicidal/suicidal interventions they stated:-Geriatric Nursing Assistant (GNA) Staff #3, stated she has been employed at the facility for 5 years, she has not received any training since being hired.-Geriatric Nursing Assistant/Certified Medication Tech (GNA/CMA) Staff #18 did not have training, does not remember as it has been so long since having any training.-Licensed Practical Nurse (LPN), Staff #26 stated that she had not received any training since being hired and was hired in May of 2025.-Activities Assistant (AA) Staff #28 stated she has not received any training in the last couple years.-Registered Nurse (RN) Supervisor, Staff #19 stated she has not received any training.-Geriatric Nursing Assistant (GNA), Staff #29 stated she has not received any training through this facility.-Certified Medication Tech (CMA) Staff #27 stated she has not received any specific training. Staff #27 stated that a form may be required for signature, simply stating the obligation to report abuse to a supervisor immediately. On 09/24/2025 at 2:20 PM, during an interview with the Director of Nursing (DON), stated that a resident specific care plan must be developed and updated to address any behavioral changes observed in residents. This plan should include resident-specific interventions and non-pharmacological interventions. On 9/25/25 at 9:31AM, in an interview with the Medical Director, he stated Resident # 21 poses a significant risk of harming other residents if triggers are not identified, as he has the means (fists) and a history of striking others. Staff require de-escalation training for behavior management. Our Psych Services are inadequate, and facilities suffer from the lack of Psych services across the Eastern Shore. These identified concerns were brought to the attention of the facility's Medical Director, Nursing Home Administrator(NHA), and the Director of Nursing(DON) on 09/25/2025 and an Immediate Jeopardy was called on 09/25/2025 at 2:50 PM related to failure to protect a cognitively impaired resident (R#50) from resident to resident abuse from a resident (Resident #21) with a known history of verbal and physical aggression towards staff and residents.The facility developed a plan sufficient enough to remove immediacy which was reviewed and accepted after 4 attempts at 7:38pm on 9/25/2025 while surveyors remained onsite. The facility's abatement plan was accepted by the OHCQ at 3:12 PM on 09/26/2025.The plan included:The following actions were taken to prevent Resident #21 from perpetrating additional (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abusive behaviors. (Alleged Completion Date: 9/25/25)Six Residents with care plan focuses of verbal or physical aggression were identified and 100% care plans were updated with person-centered non-pharmacological interventions and resident specific triggers and behavioral monitoring orders as applicable.Resident #21 has been on alert charting for aggressive behaviors since 9/18/25.Resident #21 received psych consultation, medication adjustment, and follow-up.Resident #21 was evaluated by psych provider on 9/17/25 and was started on anti-psychotic/hypnotic medication.Resident #21 has therapy scheduled with licensed mental health professionals.Behavior charting upgraded to 1:1 supervision 24:7 on 9/25/25 at 1609 until IDT assessment reviews and confirms a reduction in his behaviors during weekly risk meetings.Resident #21 has been moved from secured locked unit room [ROOM NUMBER]A to private room [ROOM NUMBER]B on 9/25/25 around 1530.IDT reviewed and revised care plans to identify patterns in resident's behaviors of profanity, racial slurs, punching his own fist, yelling, derogatory remarks, and threats on 9/25/25 at 1700. Facility implemented non-pharmacological interventions such as resident preferred food choices such as candy, tv imagery, providing personal space and the freedom to exhibit independence in his personal care on 9/25/25 at 1700. Care plan revisions and interventions communicated to front line staff caring for resident to include providing the Kardex on 9/25/25 at 1745 with new non-pharm interventions.Actions to Prevent Occurrence/Recurrence:The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 9/25/25)Abuse policies were reviewed/updated to include all sources of abuse, including residents to residents on 9/25/25 by the Chief Nursing Officer.The abuse investigation procedure and documentation process were reviewed and revised on 9/25/25 by the Chief Nursing Officer.Staff Development Coordinator educated, and knowledge checked with a quiz all current working Nurse Aides and Licensed Nurses on de-escalation techniques including abuse policies and procedures on 9/25/25 (19/97 nursing staff=19.6%). Nursing staff will be educated on abuse and de-escalation before clocking in on their next shift according to their working schedules in When to Work. PRN staff will be called in for education and quizzing and if unable to come to the facility they will be educated via phone and quizzed by nurse management. 100% of nursing staff will be educated by 09/25/2025. Ongoing behavior documentation will be monitored by the Director of Nursing and Nurse Management daily during clinical morning meetings, and care plans will be updated as indicated. Staff will be educated on new interventions either verbally or in written form by nurse management.Social Service Director to start discharge planning immediately for Resident #21 on 9/25/25, Resident accepted to another facility with transfer on 9/26/25.The Survey team confirmed the facility followed their abatement plan and the Immediate Jeopardy was abated on 09/26/2025 at 3:12 PM 2) On 09/22/2025 at 12:31 PM an observation of Resident #93 in his/her room lying on bed, no staff were present.On 09/24/2025 at 9:45 AM a review of Resident #93's medical record revealed the following progress notes:On 7/15/2025 at 3:54 PM a Progress Note revealed, Resident #93, keeps hitting female residents.On 7/25/2025 at 11:03 AM a progress note revealed, Resident #93, was sitting at table in dining room, asking another resident for his/her money, who declined to have his/her money, Resident #93 began hitting the resident in the neck, both residents separated.On 8/29/2025 at 4:51 PM a Nurse Practitioner Note stated of note, another resident was sitting in the dining room eating dinner. The resident was singing while sitting there, and Resident #93 told the other resident to shut up. The other resident did not stop singing, so Resident #93 slapped the other resident in the face with an open hand. No injuries were noted to either party.On 9/10/2025 at 2:26 PM a progress note stated, Resident #93 was observed hitting another resident in the dayroom. Resident #93 was observed to have another resident by the shirt smacking the other residents back with an open hand. Resident #93 stated that the other resident had his book. Residents were separated and assessed for any injuries. Further review of Resident #93's medical record revealed a care plan created on 07/25/2025 with a Focus of the resident has a behavior problem related to physical aggression towards other residents and staff. with an intervention initiated on 07/25/2025 that indicated, Resident will have 1:1 supervision. However, there was no evidence that the resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was under 1:1 supervision, nor was the plan of care revised to include new interventions aimed at preventing physical aggression toward other residents.On 09/24/2025 at 1:14 PM, in an interview, Staff #33 stated there were no current residents on a 1:1 Supervision on the unit where Resident #93 resided. Staff #33 clarified that a 1:1 supervision requires a completed form and presented Surveyor a form, titled Safety check log Employee #33 stated the form would be kept either in the resident's paper chart or electronic medical record. Staff #33 stated that this level of supervision mandates a staff member to remain with the resident, only being relieved by another staff member for breaks. During the interview, Resident #93 approached the nurses' station without being accompanied by any staff.On 09/24/2025 at 2:20 PM, in an interview the Director of Nursing (DON) stated, the 1:1 supervision staff would be with the resident and the process involves GNA/staff documentation of observations on a paper form, uploaded to the electronic medical record. Staff are informed via a form at the nurses' station and during shift changes, as it's a care plan intervention. Care plans are revised for behavioral changes or resolved if not applicable. A 1:1 intervention continues until the behavior no longer exists and then should be resolved from the plan of care. The Surveyor inquired about Resident #93's 1:1 documentation; the DON stated there was none and verified that the behavior care indicated an intervention for 1:1 supervision. At this time concerns were shared with the DON.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews with facility staff and review of pertinent documentation, it was determined that the facility failed to employ a qualified social worker on a full time basis in a facility licensed with more than 120 beds. The facility is licensed for 135 beds. This deficient practice was found to be evident during the facility's recertification/complaint survey and has the potential to affect all residents. The findings include:On 9/23/25 at 9:41 AM in an interview with Social Worker Designee (SWD #6) she stated she was not licensed or certified. During the interview she stated she had worked at the facility for 1 year, been in the Social Services position for 5 months, and that prior to this position she was a certified medicine aide.On 9/23/25 at 12:35 PM the surveyor requested SWD #6's degree and credentials qualifying her for the Social Worker position; however, by the exit of the survey team on this day, no documents were provided. On 9/23/25 at 5:25 PM review of SWD #6's employee file revealed an application for the Social Work Designee position. In the Record of Education section under college it revealed, Health as the course of study and that it was a certificate program. On 9/24/25 at 9:43 AM in an interview with the Director of Nursing she verified and confirmed that the facility does not have the qualifying degree/credentials to provide for SWD #6.The concern that there was not a qualified social worker on staff was reviewed with the Director of Nursing throughout the survey and again during exit on 9/25/2025.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to ensure staff received mandatory communication training. This was evident for 5 (GNA #3, GNA #18, GNA #22, LPN #33, RN #19) out of 5 direct care staff employees reviewed during the Extended Survey investigation portion of the facility's recertification survey. This deficient practice had the potential to impact all residents.The findings include:On 9/23/25 at 5:19 PM in an interview with the Human Resources Director (HRD #20), when asked about the training and education provided to facility staff, she stated the facility did not use an online learning platform like Relias. She stated that all new hires (clinical and non-clinical) completed tasks online for their onboarding and showed the surveyor a printed copy from a binder in her office. When asked for clarification of what it meant to complete a task, she stated the staff read the tasks and then signed off when they finished showing they read through all of them. She verified and confirmed there was no evaluation criteria, written or otherwise, of staff after reading the tasks. Additionally, she stated they completed a 4 hour orientation with her onsite at the facility where they reviewed the onboarding tasks. When asked to share a time estimate for each task, she stated, They [staff] probably just click through them which is why I review them at the orientation. She stated that there were some additional training and in-services provided, but that nursing would have those sign in sheets. On 9/24/24 at 9:35 AM HRD #20 provided the survey team with a copy of the required onboarding tasks, titled Mandatory Staff Education and had written on the first sheet, Onboarding tasks that are completed prior to hire. [5 hours estimated]. In an interview with HRD #20 she verified and confirmed that the 5 hour estimated time was for completion of all the onboarding tasks. Review of the tasks revealed the following topics:- Resident Rights- Abuse/Abuse Prevention/Abuse Reporting- HIPPA (Health Insurance Portability and Accountability Act)- Fire Safety- Infection Control- Bloodborne Pathogens- OSHA (Occupational Safety and Health Act) Right to Know - Read the Chemical Label- Incident Accident Prevention- Writing a Statement- Aggressive Behaviors- Employee Violence- Body Mechanics- Customer Service- Using the Telephone- Advanced Directives- Dementia Care Tips- Facts about Sexual Harassment- Elopement- Pain Assessment and Management- PoemThe review failed to reveal Communication as an onboarding task for employees in the facility.On 9/24/25 at 9:38 AM Geriatric Nursing Assistant (GNA #3's) employee file was reviewed. The review revealed she was hired on 1/19/24; however, failed to reveal evidence of communication training. On 9/24/2025 at 9:48AM GNA #18's employee file was reviewed. The review revealed she was hired on 11/7/05; however, failed to reveal evidence of communication training. On 9/24/2025 at 10:17 AM GNA #22's employee file was reviewed. The review revealed she was hired on 11/19/24; however, failed to reveal evidence of communication training. On 9/24/2025 at 10:27 AM Licensed Practical Nurse (LPN #33's) employee file was reviewed. The review revealed she was hired on 9/26/24; however, failed to reveal evidence of communication training. On 9/24/2025 at 12:17 PM Registered Nurse (RN #19's) employee file was reviewed. The review revealed she was hired on 12/24/24; however, failed to reveal evidence of communication training. Staff Educator (SE #23) was interviewed on 9/24/24 at 8:36 AM. The surveyor requested evidence of communication, QAPI, dementia, cognitive impairment/mental illness, and infection control training from 10/1/23 through present. On 9/24/25 at 10:21 AM in an interview with SE #23, HRD #20 and the Director of Nursing (DON), when asked what training she was involved with, HRD #20 stated she only handled the onboarding and 4 hour orientation for all staff. The DON and SE #23 confirmed that HRD #20 only handled the onboarding and 4 hour orientation. The remainder of the interview was conducted with SE #23 and the DON. During the interview when asked what the various methods were used to provide training, in-services, and education to staff, the DON stated outside of the onboarding and orientation, there was a 12 month calendar published by the CNO (Chief Nursing Officer, CNO #1) that ran from January to December. SE (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#23 and the DON verified and confirmed there was no online learning platform used by the facility to provide education/training to staff.When asked if there was any mandatory training all staff received, SE #23 stated for clinical staff, yes, and it was outlined on the 12 month calendar. When asked if there were any mandatory trainings that nonclinical staff received, SE #23 stated, Not that I provide. You can ask [DON's name]. The DON stated, The head of the departments would do the trainings if they had any. I am clinical so I would refer you to the department heads. When asked about Rehab (physical therapy, occupational therapy and speech therapy) participation in facility trainings, the DON and SE #23 stated that the Rehab staff do not participate in the 12 month calendar education. When asked about the process in place to track staff participation in the required trainings, SE #23 and the DON said, Sign in sheets. Additionally, SE #23 stated, I have not looked or seen them [sign in sheets], but I can get with [Assistant Director of Nursing's (ADON's) name] to find them because she was the facility's previous Staff Educator. SE #23 stated she had only been at the facility as the Staff Educator for about a month.The Activities Director was interviewed on 9/24/25 at 10:48 AM. During the interview she stated there was no mandatory training she provided for her staff. During the interview she stated, I know that HR does some, but no, I do not.The Director of Housekeeping/Laundry was interviewed on 9/24/25 at 12:50 PM. During the interview she stated there was no mandatory training that she provided for her staff. The Director of Rehab was interviewed on 9/24/25 at 1:19 PM. During the interview she stated there was no mandatory training that she provided for her staff. On 9/24/25 at 10:42 AM in an interview with the ADON when asked about evidence of staff trainings she stated, I was the Staff Educator, but only for like 2 weeks and [Licensed Practical Nurse (LPN #33)] was it for like a year. On 9/24/25 at 10:45 AM in an interview with LPN #33 when asked if she was the facility's previous Staff Educator, she stated she had never been the Staff Educator for the facility. During the interview she stated, I believe here that always fell with the ADON. On 9/24/25 at 10:51 AM in an interview with CNO #1 she stated, She [SE #23] was wrong, all staff do attend some of those trainings (and provided the Monthly Education Calendar 2025). [SE #23's name] checked off which trainings were [for] non-clinical [staff also]. When asked for evidence of staff participation in training, education, and in-services, CNO #1 provided the surveyor with 3 binders and 2 manilla folders. When asked for the duration of each training on the 12 month calendar, CNO #1 flipped to one of the pages in the binder, pointed to the line that read length, and stated that the times were listed on the attendance sheets. On 9/24/25 at 10:59 AM review of the Monthly Education Calendar (2025) revealed education on Effective Communication was scheduled for April and October. On 9/24/25 at 11:04 AM review of the 3 binders and 2 manilla folders of staff education, training, and in-services failed to reveal an attendance sheet or any further evidence of an Effective Communication training. On 9/24/25 at 2:06 PM in an interview with Activities Aide (AA #28), when asked if s/he had received any training in 2023, 2024, or 2025 s/he stated no. S/he stated when s/he was hired, s/he had completed some online training but verified and confirmed that s/he had not received any training in 2023, 2024 or 2025. Registered Nurse (RN #39) was interviewed on 9/25/25 at 8:54 AM. During the interview, when asked if s/he had communication training upon hire or since s/he had been employed the facility s/he stated, no. GNA #27 was interviewed on 9/25/25 at 9:05 AM. During the interview, when asked if s/he had communication training upon hire or since s/he had been employed the facility s/he stated, no. On 9/24/25 at 4:13 PM in an interview with SE #23 a dual observation of the 3 binders and 2 manilla folders was conducted. When asked if there was any further evidence of staff participation in educations, in services, or trainings, she stated, No, not to my knowledge and I asked the lady before me, and she did not have anything either. Another request was made to SE #23 to verify if there was any evidence of any communication training for employees and the duration for each training on the 12 month calendar. She said she would check. On 9/24/25 at 4:44 PM in an interview with the DON when asked if there was any further documentation/evidence of staff participation in education, in services, or trainings, she stated, No, there is no further documentation to provide for staff training. The surveyor shared this was a concern and the DON (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	confirmed understanding. On 9/25/25 at 9:29 AM in an interview with SE #23 she stated, [Nursing Home Administrator's name] and [CNO #1's] said we had a survey in 2023, and we do not have any evidence of the training you requested from 2024 or 2025. The surveyor shared this was a concern and SE #23 acknowledged understanding.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to provide mandatory Quality Assessment and Performance Improvement training to staff. This was evident for 7 (GNA #3, GNA #18, GNA #22, LPN #33, RN #19, DA #41, HA #42) out of 7 employees reviewed during the Extended Survey investigation portion of the facility's recertification survey. This deficient practice had the potential to impact all residents.The findings include:Quality Assurance and Performance Improvement (QAPI) helps long-term care facilities improve the quality of life and care for residents by using a structured, data-driven process to identify issues, address the root causes of problems, and implement solutions. It involves ongoing monitoring, teamwork from all staff levels, and continuous review and revision of plans to ensure a safe, resident-focused environment, and adherence to regulations. As a facility's QAPI program involves input and collaboration from all staff, the term staff includes all new and existing facility staff (with direct and indirect care functions); individuals providing services under a contractual arrangement; and volunteers per the State Operations Manual.On 9/23/25 at 5:19 PM in an interview with the Human Resources Director (HRD #20), when asked about the training and education provided to facility staff, she stated the facility does not use an online learning platform like Relias. She stated that all new hires (clinical and non-clinical) completed tasks online for their onboarding and showed the surveyor a printed copy from a binder in her office. When asked for clarification of what it meant to complete a task, she stated the staff read the tasks and then signed off when they finished showing they read through all of them. She verified and confirmed there was no evaluation criteria, written or otherwise, of staff after reading the tasks. Additionally, she stated they completed a 4 hour orientation with her onsite at the facility where they reviewed the onboarding tasks. When asked to share a time estimate for each task, she stated, They [staff] probably just click through them which is why I review them at the orientation. She stated that there were some additional training and in-services provided, but that nursing would have those sign in sheets. On 9/24/24 at 9:35 AM HRD #20 provided the survey team with a copy of the required onboarding tasks, titled Mandatory Staff Education and had written on the first sheet, Onboarding tasks that are completed prior to hire. [5 hours estimated]. In an interview with HRD #20 she verified and confirmed that the 5 hour estimated time was for completion of all the onboarding tasks. Review of the tasks revealed the following topics:- Resident Rights- Abuse/Abuse Prevention/Abuse Reporting- HIPPA (Health Insurance Portability and Accountability Act)- Fire Safety- Infection Control- Bloodborne Pathogens- OSHA (Occupational Safety and Health Act) Right to Know - Read the Chemical Label- Incident Accident Prevention- Writing a Statement- Aggressive Behaviors- Employee Violence- Body Mechanics- Customer Service- Using the Telephone- Advanced Directives- Dementia Care Tips- Facts about Sexual Harassment- Elopement- Pain Assessment and Management- PoemThe review failed to reveal QAPI as an onboarding task for employees in the facility.On 9/24/25 at 9:38 AM Geriatric Nursing Assistant (GNA #3's) employee file was reviewed. The review revealed she was hired on 1/19/24; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 9:48AM GNA #18's employee file was reviewed. The review revealed she was hired on 11/7/05; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 10:17 AM GNA #22's employee file was reviewed. The review revealed she was hired on 11/19/24; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 10:27 AM Licensed Practical Nurse (LPN #33's) employee file was reviewed. The review revealed she was hired on 9/26/24; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 12:17 PM Registered Nurse (RN #19's) employee file was reviewed. The review revealed she was hired on 12/24/24; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 1:31PM Dietary Aide (DA #41's) employee file was reviewed. The review revealed he was hired on 6/5/25; however, failed to reveal evidence of QAPI training. On 9/24/2025 at 1:42PM Housekeeping Aide (HA #42's) employee (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	file was reviewed. The review revealed he was hired on 10/28/24; however, failed to reveal evidence of QAPI training. On 9/24/24 at 8:36 AM in an interview with Staff Educator (SE #23), the surveyor requested of evidence of QAPI, communication, dementia, cognitive impairment/mental illness, and infection control training from 10/1/23 through present. On 9/24/25 at 10:21 AM in an interview with SE #23, HRD #20 and the Director of Nursing (DON), when asked what training she was involved with, HRD #20 stated she only handled the onboarding and 4 hour orientation for all staff. The DON and SE #23 confirmed that HRD #20 only handled the onboarding and 4 hour orientation. The remainder of the interview was conducted with SE #23 and the DON. During the interview when asked what the various methods were used to provide training, in-services, and education to staff the DON stated outside of the onboarding and orientation, there was a 12 month calendar published by the CNO (Chief Nursing Officer, CNO #1) that ran from January to December. SE #23 and the DON verified and confirmed there was no online learning platform used by the facility to provide education/training to staff.When asked if there was any mandatory training all staff received, SE #23 stated for clinical staff, yes, and it was outlined on the 12 month calendar. When asked if there were any mandatory trainings that nonclinical staff received, SE #23 stated, Not that I provide. You can ask [DON's name]. The DON stated, The head of the departments would do the trainings if they had any. I am clinical, so I would refer you to the department heads. When asked about Rehab (physical therapy, occupational therapy and speech therapy) participation in facility trainings, the DON and SE #23 stated that the Rehab staff do not participate in the 12 month calendar education. When asked about the process in place to track staff participation in the required trainings, SE #23 and the DON said, Sign in sheets. Additionally, SE #23 stated, I have not looked or seen them [sign in sheets], but I can get with [Assistant Director of Nursing's (ADON's) name] to find them because she was the facility's previous Staff Educator. SE #23 stated she had only been at the facility as the Staff Educator for about a month.The Activities Director was interviewed on 9/24/25 at 10:48 AM. During the interview she stated there was no mandatory training she provided for her staff. During the interview she stated, I know that HR does some, but no, I do not.The Director of Housekeeping/Laundry was interviewed on 9/24/25 at 12:50 PM. During the interview she stated there was no mandatory training that she provided for her staff. The Director of Rehab was interviewed on 9/24/25 at 1:19 PM. During the interview she stated there was no mandatory training that she provided for her staff. On 9/24/25 at 10:42 AM in an interview with the ADON when asked about evidence of staff trainings she stated, I was the Staff Educator, but only for like 2 weeks and [Licensed Practical Nurse (LPN #33)] was it for like a year. On 9/24/25 at 10:45 AM in an interview with LPN #33 when asked if she was the facility's previous Staff Educator, she stated she had never been the Staff Educator for the facility. During the interview she stated, I believe here that always fell with the ADON. On 9/24/25 at 10:51 AM in an interview with CNO #1 she stated, She [SE #23] was wrong, all staff do attend some of those trainings (and provided the Monthly Education Calendar 2025). [SE #23's name] checked off which trainings were [for] non-clinical [staff also]. When asked for evidence of staff participation in training, education, and in-services, CNO #1 provided the surveyor with 3 binders and 2 manilla folders. On 9/24/25 at 10:59 AM review of the Monthly Education Calendar (2025) revealed education on QAPI was scheduled for January and July. On 9/24/25 at 11:04 AM review of the 3 binders and 2 manilla folders of staff education, training, and in-services failed to reveal an attendance sheet or any further evidence of QAPI training. On 9/24/25 at 2:06 PM in an interview with Activities Aide (AA #28), when asked if s/he had received any training in 2023, 2024, or 2025 s/he stated no. S/he stated when s/he was hired, s/he had completed some online training but verified and confirmed that s/he had not received any training in 2023, 2024 or 2025. GNA #27 was interviewed on 9/25/25 at 9:05 AM. During the interview, when asked if s/he had QAPI training upon hire or since s/he had been employed the facility s/he stated, No, I do not know what that is. On 9/24/25 at 4:13 PM in an interview with SE #23 a dual observation of the 3 binders and 2 manilla folders was conducted. When asked if there was any further evidence of staff participation in educations, in services, or trainings, she stated, No, not (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to my knowledge and I asked the lady before me, and she did not have anything either. Another request was made to SE #23 to verify if there was any evidence of any QAPI training for employees. She said she would check. On 9/24/25 at 4:44 PM in an interview with the DON when asked if there was any further documentation/evidence of staff participation in education, in services, or trainings, she stated, No, there is no further documentation to provide for staff training. The surveyor shared this was a concern and the DON confirmed understanding. On 9/25/25 at 8:37 AM in an interview with SE #23 when asked if there was evidence of QAPI training provided to the staff in 2024 or 2025 she stated, If it is not on the [attendance] sheets, I was not here then so I cannot confirm that. On 9/25/25 at 9:29 AM in an interview with SE #23 she stated, [Nursing Home Administrator's name] and [CNO #1's] said we had a survey in 2023, and we do not have any evidence of the training you requested from 2024 or 2025. The surveyor shared this was a concern and SE #23 acknowledged understanding.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, it was determined that facility staff failed to treat residents with dignity. This was evident for 2 (#214, #97) of 27 residents that resided on the memory care unit and for 13 residents on the memory care unit that were in the dining/activity area on 1 of 3 days observed during a revisit survey. The findings include:On 12/1/25 from 1:30 PM to 2:20 PM observation was made on the Chase memory care unit of 13 residents sitting in the dining/activity area of the unit. There were no activities at the time. There was no music on, the television screen was on with a still photo of channels and there was no sound. One resident was crying, and one resident was complaining. None of the residents had any type of activity such as books, coloring books, music, videos, or any type of interaction with the staff on the unit. The residents were sitting and staring at each other. There were 5 nursing staff members standing and sitting around the nurse's station. Resident #213 said to the surveyor, they won't turn the tv on and that bothers me.After the surveyor left the common area observation was made on 12/1/25 from approximately 2:00 PM to 2:04 PM of Staff #10 (Activity Assistant) sitting in a chair at the bedside of Resident #214, who resided on the memory care unit. The surveyor walked in the resident's room and stood in front of Staff #10. Staff #10 was sleeping in the chair with activity material on her lap. The surveyor looked at Resident #214, who was lying in bed. Resident #214 shrugged his/her shoulders and stared at the surveyor. The surveyor then walked to the other side of the room which was around a wall where another bed was located and then opened the bathroom door and looked into the bathroom. The surveyor shut the door and stood at the entrance doorway and then walked back to Staff #10. The surveyor stood in front of Staff #10 and made a noise. Staff #10 opened her eyes, and the surveyor informed Staff #10 that she was sleeping. Staff #10 confirmed and stated that she had a bad headache. Review of Resident #214's care plan documented, resident is dependent on staff for activities, meeting emotional, intellectual, physical, and social needs. The care plan was revised on 11/17/25 with the intervention added, The resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. On 12/2/25 at 8:26 AM observation was made on the Chase unit of Staff #32 (GNA) standing to feed Resident #97 breakfast in the resident's room while the resident was lying in bed. Staff #32 did not hear the surveyor walk in the room as she was talking on a cell phone in another language while standing to feed Resident #97. The surveyor walked up to Staff #32 and asked her what she was doing, and she said she was talking to her sister because she needed money. At that time Staff #33 walked into the room and the surveyor informed her what was going on. LPN #33 stated that it was a dignity issue and then walked out of the room. On 12/2/25 at 9:15 AM the Director of Nursing (DON) and the Nursing Home Administrator (NHA) were informed of the observations. The NHA stated that the behavior of the staff was unacceptable.On 12/2/25 at 9:45 AM an interview was conducted with the Director of Activities. She stated that they had planned activities on the memory care unit (Chase). She was informed of the observations and of the observation of Staff #10 in the resident's room. She stated that Staff #10 normally did not work on that unit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, it was determined that the facility failed to maintain a homelike environment for the residents, this was evident for 2 of 3 units observed during the recertification/complaint survey.The findings include,On 9/22/2025 at 9:39 AM during the initial tour of the facility, observations were made of the following rooms/bathrooms:RM 200: The bedroom door was scraped up all the way to the handle and needed replacement covers.room [ROOM NUMBER]B: the wall trim at the head of the bed was missing from bed A to bed B. Also observed behind the head of the bed on the B-side were lots of paint scrapings on the wall.room [ROOM NUMBER]: The bathroom door had holes about 6 x 5 inches long; there were paint scraps on the wall opposite the toilet measuring about 12 x 5 inches. The wood on the bathroom door was scraped off towards the bottom section in two areas measuring about 3 x 2 and 7x 5 inches long.room [ROOM NUMBER]A: The wall paint by the bed was peeled off about 10 x 9 inches, and the vent in the bathroom ceiling was hanging loose, about to fall off.room [ROOM NUMBER]: The bathroom ceiling had holes measuring about 2 x 4 inches and another brown circular stains on four different areas about 4 x 5 inches long.room [ROOM NUMBER]-The bathroom ceiling had two big brown circular stains, one measuring about 10 x10 inches and the other 4 x 3.5 inches. The soap dispenser was broken, and the cover was missing.Rom 504 B-2: The nightstand had worn out edges all around it.room [ROOM NUMBER]A-A: The wheelchair arm rest was torn and the resident sitting on it was picking on the foam and string.room [ROOM NUMBER]B-2: The nightstand had worn out edges.On 9/24/2025 at 1:01 PM in an Interview with Staff #17, the regional maintenance director who has oversight over the building, he stated that the prior maintenance director was terminated at the end of August and it's just the maintenance assistant doing all the work. He was asked if maintenance do rounds on the floors, and he said that they have tasks in the TELs System that are supposed to be completed weekly, monthly, quarterly and semiannually which they check off once done. He was asked how issues that need fixing are brought to their attention and he said that anyone with Point Click Clear (PCC)access can create a report that comes directly to their cell phones and computers through their TELs system and that Issues are fixed based on their urgency.He was asked about their wheelchair maintenance process, and he said that the Physical therapists are responsible for putting in orders for their repairs. As for residents on wheelchairs who do not go for therapy, he stated that maintenance has a monthly inspection for all wheelchairs. On 9/24/2025 at 1:38 PM the nursing home administrator, the regional maintenance director and the surveyor did a walk through and the surveyor pointed out the above concerns. The regional maintenance director said he will get started on some of the repairs right away.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record reviews and interviews, it was determined that the facility staff failed to provide appropriate care to residents when they had abnormally elevated blood pressure (BP). This was evident in 1 (Resident #6) out of the 45 residents reviewed for their care during this recertification/complaint survey.The findings include:On 9/22/25 at 2:38 PM, the review of Resident #6's medical record revealed that the resident had transferred to the hospital on 8/13/25 due to elevated blood pressure; the systolic blood pressure went over 200 mm Hg.Further review of Resident #6's vital signs from 8/14/25 to 9/23/25 revealed that the resident had elevated blood pressure, with systolic BP measured over 190 mm Hg, 14 times during the period. The highest record was 215/88 mm Hg on 9/12/25. However, there was no documentation to support that Resident #6's medical conditions were notified to the physician or that specific care was provided to the resident related to managing the symptoms.During an interview with Staff #13 (Licensed Practical Nurse) on 9/23/25 at 11:35 AM, she stated that if a resident's blood pressure is abnormally elevated, it should be notified to the provider, rechecked, and medication gotten per the provider's order (if still high). Staff #13 said, All communication should be documented in the system; also, a change in condition form is required to be completed.In an interview with the Director of Nursing (DON) on 9/24/25 at 11:48 AM, she reviewed Resident #6's blood pressure and stated that the resident had a history of high blood pressure and had been taking several hypertension medications. Also, she explained that Resident #6 was followed up with a cardiologist. The surveyor requested documentation to support how the resident's elevated blood pressures were cared for by the facility staff.On 9/24/25 at 12:00 PM, the surveyor reviewed Resident #6's most recent cardiologist follow-up note. The note showed that the last visit was on 7/31/25 for a regular follow-up and no new orders at that time. Also, the most recent facility's attending physician's note was on 7/07/25 without new orders.In an interview with the Medical Director on 9/25/25 at 9:39 AM, he confirmed that even though a resident was followed up by a specialist (such as a cardiologist), their current changed condition should be notified and assessed by the attending physician. The surveyor asked to review Resident #6's blood pressures. The Medical Director stated that those elevated blood pressures should be notified to the physician, and interventions recommended.During an interview with the Director of Nursing (DON) on 9/25/25 around 10 AM, the surveyor shared the above concerns, and she validated them.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of employee files and interviews with facility staff, it was determined that the facility failed to conduct required performance reviews of Geriatric Nursing Assistants (GNAs) at least once every 12 months. This was found to be evident for 2 (GNA #3, GNA #18) out of 2 GNA employee files reviewed during the Sufficient and Competent Nurse Staffing facility task for the facility's recertification survey. The findings include:Performance reviews are to be completed for each GNA at least every 12 months to identify specific, in-service education based on the outcome of those individual performance reviews. On 9/24/25 at 9:38 AM GNA #3's employee file was reviewed. The review revealed she was hired on 1/19/24; however, failed to reveal a performance review was conducted in 2025. On 9/24/2025 at 9:48AM GNA #18's employee file was reviewed. The review revealed she was hired on 11/7/05; however, failed to reveal a performance review was conducted in 2023 or 2024. On 9/24/25 at 1:44 PM an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) when asked if performance reviews were conducted for GNAs, the DON stated yes. During the interview when asked how frequently they were conducted, the DON stated, Let me verify. The ADON stated, I think it is 12 months. When asked who conducted the performance reviews, the DON stated the ADON or DON. When asked where they were stored, the DON stated, HR has them in their employee files. The surveyor shared that there were no performance reviews for GNA #18 from 2023 or 2024 and there was no performance review for GNA #3 in 2025 observed in their employee files. On 9/24/25 at 1:56 PM in an interview with GNA #3 when asked how long s/he has worked at the facility s/he stated on and off for years. During the interview when asked if s/he has had a performance review she stated, No, never.On 9/24/2025 at 2:25 PM the surveyor requested the performance reviews for GNA #3 and GNA #18. On 9/24/25 at 2:32 PM in an interview with the DON and ADON, the DON stated if the Director of Human Resources did not have the performance reviews in their employee files, then they did not have them. The surveyor shared this was a concern and the DON acknowledged understanding.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of records and interview with facility staff, it was determined that the facility failed to 1) ensure that drug records were maintained in a manner that allowed for reconciliation of dispensed and administered medication, and 2) complete controlled medication counts with two nurses. This was evident for four (Resident #44, #79, #96, #35) out of the six residents reviewed for administration of narcotic medication during this recertification/complaint survey.The findings include:A Controlled Medication Utilization Record (count sheet) is a form used to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original container, including the date, time, the dose given, the signature of the nurse administering the medication, the amount remaining, the amount wasted, and the signature of the individual who checked.A shift count sheet in a nursing home is a form used at the end of a nursing shift to document the inventory of controlled substances, particularly narcotics, ensuring accuracy and accountability. 1) On 9/22/25 at 3:10 PM, the surveyor reviewed randomly selected residents' Medication Administration Records (MARs) and count sheets. The review revealed the following discrepancies:a. Resident #44 was prescribed Morphine Sulfate 100mg/5ml (liquid) 0.25 ml by mouth every 4 hours as needed for breakthrough pain. The MAR showed that he/she received the medication four times between August 2025 and September 2025. However, the count sheet documented fifteen administrations during that period, meaning eleven administrations were not reconciled.b. Resident #79 was prescribed Alprazolam 0.5 mg tablet orally every 8 hours as needed for anxiety for 14 days, starting 8/05/25. The MAR showed that the resident received this medication on 8/11/25, 8/14/25, and 8/18/25. However, the count sheet documented that Resident #79 took the medication thirteen times from 8/01/25 to 8/29/25. This included ten additional administrations not documented in the MAR. Furthermore, the MAR showed no active order for the medication from 8/01/25 to 8/04/25 and 8/20/25 to 8/29/25.c. Resident #96 was prescribed pain medication with Oxycodone 10 mg by mouth every 4 hours as needed. The MAR showed that he/she received the medication on 9/19/25 at 3 PM. However, the count sheet documented that the medication was removed on 9/19/25 at 6 AM, which does not match the administration time. d. Resident #35 was prescribed Zolpidem 5 mg by mouth every 24 hours as needed for insomnia. The count sheet documented that the resident received the medication every night from 9/16/25 to 9/22/25. However, the MAR lacked documentation for 9/16/25 and 9/18/25.During an interview with the Director of Nursing (DON) on 9/24/25 at 1:57 PM, she explained that nurses should document controlled medication use on both the MAR and the count sheet. The surveyor reviewed medical records for Resident #44, #79, #96, and #35 with the DON. She confirmed that the documentation was not reconciled between the MAR and the count sheet.2) During an investigation of the narcotic box and count sheets for each unit on 9/22/25 at 3:10 PM, it was revealed that the facility nurses failed to complete shift count sheets with two nurses. The sheet has columns for date, time of day, a Yes or No section for EDK (Emergency Drug Kit) box sealed, a Yes or No section for count correct, the on-duty nurse's signature, and the off-duty nurse's signature.a. The review of shift count pages for the 100s unit on 9/22/25 at 3:34 PM revealed incomplete nurse signatures on the following shifts: 9/11/25 Day shift (missing off-duty signature). 9/15/25 Evening shift (missing on-duty signature). 9/15/25 Night shift (missing off-duty nurse's signature). Furthermore, the form had incomplete answers for the questions regarding the EDK box sealed and count correct for 34 out of 49 columns from 8/29/25 to 9/22/25.b. The review of shift count pages for the Dementia unit on 9/22/25 at 3:52 PM revealed: * Missing on-duty nurse's signatures on 9/18/25 and 9/20/25. The next line of the 9/22/25 day shift documentation had an off-duty nurse's signature without other information.During an interview with Staff #13 (Licensed Practical Nurse) on 9/22/25 at 3:10 PM, she stated that two nurses, one going on duty and one going off duty, were required to count narcotic medications and document them with a signature.In an interview with Staff #32 (Licensed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse) on 9/22/25 at 3:28 PM, she stated that signing the shift count meant they had responsibility for those medications. She added that answering each question was not required.In an interview with the Director of Nursing (DON) and the Infection Preventionist (IP) on 9/24/25 at 1:57 PM, they confirmed that the shift count sheet should be completed with both on- and off-duty nurses, and all questions need to be answered. The surveyor shared the shift count sheets from the two units with the DON. She verified that the documentation was not completed in full.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, it was determined that the facility failed to date and label drugs when opened with an open date. This was evident for 3 of 6 medication carts reviewed on the nursing units during the recertification/complaint survey.The findings include:On 9/24/2025 at 8:36 AM, the medicine (Med) cart on the short hall was reviewed with staff #12 a License practical Nurse (LPN) and staff #11 a unit manager and revealed medications opened with no dates on them to indicate when they were opened. These medications include:1-Fluticasone Propionate (Flonase) nasal spray 50mg-2-Clopatadine drops-Pataday 0.1%According to the manufacturer's instruction, open bottles of Flonase nasal spray which is used to treat seasonal allergies should be discarded after 2 months or when the number of sprays indicated on the bottle has been used or whichever comes first. This is due to reduced effectiveness and contamination risks. Also, the Clopatadine (olopatadine)eye dops use to treat allergic reactions should be discarded after 4 weeks (28 days) per manufacturer's instructions.On 9/24/2025 at 8:49 AM on the 200 unit, the long hall med cart was reviewed with nursing staff, and some medications were also found opened with no open dates, these medications were confirmed with Staff #12 a License practical Nurse (LPN) and included:1--lactulose10gm/15 (237ML) bottle x 22-Magnisium Citrate sol Lemon bottle (10 FL oz-296ml) 3-Fluticasone Propionate nasal spray 50mcg x 3On 9/24/2025 at 10:07 AM an observation of the chase long hall med cart on the-500s Unit /locked unit revealed meds opened, and undated to include:1- Sodium polystyrene sulphonate liquid 120 ml bottle2-Imodium oral solution 8fl oz- house stock bottle3-lactulose sol 473 ml liquid bottle4- Valproic acid oral solution USP 250ml/5ml -16fl oz-bottle Staff #27 a Certified Medication Aide (CMA) was there to confirm the findings and stated that they are confused and not sure if they should go by the manufacture's expiration date or the date the bottles was opened.In an interview with Staff #12 a License Practical Nurse (LPN) on 9/24/25 at 8:43 AM, she was asked about the process for dating open medications. She stated that open medications are supposed to be dated on the day they were opened. She took out the medications stating she would discard them and order new ones.On 9/24/2025 at 10:30 AM in an interview with the director of nursing (DON), she was asked about the policy for medication storage in relation to opened nasal sprays, eye drops, liquid meds or multi dose medications. She stated that when meds are open, they should be dated with open dates. She was made aware of the above findings, and she stated she would follow up.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview with facility staff, it was determined that the facility failed to 1) ensure food items were stored under sanitary conditions by labeling and dating food items and 2) maintain proper freezer temperature for food items on the units. This deficient practice had the potential to affect all residents who consume food in the facility and was evident during the recertification/complaint survey.The findings include:1) On 09/21/2025 at 8:29 AM during the kitchen tour with the food service director (Staff #25), the surveyor observed the following items in the freezer that were not labeled: a bag of fish, sliced cheese in a container, 1-gallon open jars of ranch dressing, golden Italian dressing, creamy [NAME] dressing, and BBQ sauce.During an interview with Staff #25 on 9/21/2025 at 8:31 AM, when asked about labeling of food items, he/she stated that items are labeled with a receive date and a use by date. Staff #25 stated that the items observed should have been labeled. Surveyor shared the concern that these items were open and used and not labeled. 2) On 09/24/2025 at 10:23 AM the surveyor conducted a check of the refrigerator temperature logs on the unit. The normal degree temperature ranges indicated on the log must be 33 F - 40 F for the refrigerator and of 10 F to -0 F for the freezer. The temperature log for the Chase Unit for the month of September 2025 noted the freezer temperature checked at 7AM and 7PM: 9/1/25-9/3/25= 15 F; on 9/4/25= 20 F; 9/5/25- 9/15/25= 15 F; 9/16/25-9/17/25=20F; 9/18/25-9/19/25=18 F; and 9/20/25-9/24/25= 0 F. There were no actions taken in the column of the log tilted If out of range, what did you do. the surveyor checked the temperature of the freezer which registered -5 F at that time. An interview was conducted on 9/24/2025 at 10:30 AM with the Infection Preventionist (IP) staff #23 who was cleaning the refrigerator. When surveyor asked about the temperature log, staff #23 stated that he/she will educate staff on how to properly read the thermometers in the freezer and that he/she cannot account for what was written on the log. The surveyor made staff #23 aware that this was a concern. On 9/24/2025 at 11:37 AM, the surveyor shared the finding of the temperature log with the Director of Nursing (DON) and shared the concern. The DON stated that she was also concerned and stated that she would have maintenance inspect the refrigerator and freezer to ensure it was working properly and maintaining the within range temperatures. The DON was also made aware of the concern from the kitchen.

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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 medical record review and staff interviews, it was determined that the facility failed to implement an effective infection control program and the staff failed to follow infection control practices and guidelines to prevent the development and transmission of disease by failing to complete tuberculosis (TB) screening for newly admitted residents. This was evident for 4 (Resident #17, #8, #3, and #77) of five residents for TB screening during this recertification/complaint survey.The findings include:Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. Each resident must have a health assessment upon admission, including significant past or present infectious diseases and signs and symptoms of tuberculosis (TB).Skin tests should be administered to all new residents and employees as soon as their residency or employment begins unless they have documentation of a previous positive reaction. A two-step procedure (administering 2nd skin test within 1-3 weeks) is advisable for the initial testing of residents and employees. Each skin test should be administered and read by appropriately trained personnel and recorded (in mm induration) in the person's medical record. [Center for Disease Control and Prevention]On 9/24/25 at 3:27 PM, the surveyor reviewed randomly selected residents' immunization records. The review revealed as below: Resident #17 was admitted in October 2024. The TB skin test was completed on 10/22/24. However, there was no documentation for the second test. Resident #8's initial admit date was in May 2024. However, there was no documentation for his/her TB test upon the admission. Resident #3 was admitted in March 2025. The 2-step skin test was completed on 3/05/25 and 3/12/25. However, there was no result documented for the second test. Resident #77 was admitted in February 2024. However, there was no documentation for the TB test upon the admission.During an interview with Staff #23 (Infection Preventionist) on 9/24/25 at 4:05 PM, she stated that the 2-step TB skin test should be completed for residents and documented in residents' medical records. On 9/24/25 at 4:53 PM, the surveyor reviewed medical records for Resident #17, #8, #3, and #77 with the Director of Nursing (DON). She verified that the TB test should be completed in 2 steps. The above residents' TB tests were not completed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review and staff interview, it was determined that the facility staff failed to assess and document residents' vaccination status for influenza and pneumococcal vaccines and failed to provide education regarding the benefits and risks of the vaccines. This was evident for two (Resident #17 and #3) of the five residents reviewed for immunizations during the recertification/complaint survey. The findings include:The pneumococcal vaccine helps prevent pneumococcal disease, which is any type of illness caused by Streptococcus pneumoniae bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for adults age [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention: Vaccines and Preventable Disease)Influenza (Flu) is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications. Influenza (Flu) vaccines can prevent this disease. (Centers for Disease Control and Prevention: Vaccines and Preventable Disease)On 9/24/25, at 3:27 PM, the surveyor randomly selected five residents to review their immunization status. The review revealed the following:a. The electronic medical records for Resident #17, who is a candidate for the pneumococcal vaccine, showed that the resident was admitted in October 2024. The resident refused the Flu vaccine when it was offered on 10/23/24, however there was no evidence to support the facility staff provided education regarding the vaccine to the resident. Additionally, there was no documentation for the pneumococcal vaccination status in the system.b. Resident #3 was admitted in March 2025. There was no documentation for the resident's Flu vaccine.During an interview with Staff #23 (Infection Preventionist) on 9/24/25, at 4:05 PM, she stated that residents' immunization status, including COVID-19, Flu, and pneumococcal, should be assessed and documented in their medical record. She said, Since I have been here just a month, I haven't reviewed them yet. Also, she confirmed that if a resident refused the vaccination, the proof of declination and education should be documented in the system.In an interview with the Director of Nursing (DON) on 9/24/25, at 4:53 PM, the surveyor reviewed the selected residents' medical records. She verified that the vaccination status and education should be documented in the system for any resident who refused a vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review and staff interview, it was determined the facility failed to maintain residents' and staff's COVID-19 vaccination status in their medical records. This was evident for five (Resident #3, #8, #17, #27, and #77) of 5 residents and one (Staff #19) out of five facility staff members reviewed for COVID-19 vaccinations status during this recertification/complaint survey.The findings include:1) Resident RecordsOn 9/24/25, at 3:27 PM, the surveyor randomly selected five residents to review their immunization status. The review revealed Resident #3, #8, #17, #27, and #77 did not have their COVID-19 vaccination status in their medical records.During an interview with Staff #23 (Infection Preventionist) on 9/24/25 at 4:05 PM, she stated that the facility staff should maintain residents' COVID-19 vaccination status and update them in the medical records.In an interview with the Director of Nursing (DON) on 9/24/25 at 4:53 PM, the surveyor reviewed residents' immunization records with her. The DON verified that there was no information for COVID-19 vaccination status for those five residents.On 9/25/25 around 11 AM, the facility staff submitted copies of five residents' (Resident #3, #8, #17, #27, and #77) COVID-19 vaccination status from Immunet (Maryland's confidential Immunization Information System). However, those were printed on 9/25/25 after the surveyor's intervention. There was no evidence to support the facility staff monitored residents' COVID-19 vaccination status timely. 2) Staff RecordsOn 9/24/25 at 1:40 PM, the surveyor reviewed five randomly selected employees' files for health records. The review revealed that Staff #19, a direct resident care staff member who was hired in December 2024, did not have any health records, including COVID-19 vaccination status, in her file.In an interview with the Infection Preventionist (IP) on 9/24/25 at 2:48 PM, she stated that the facility was supposed to obtain employees' immunization records from Immunet (Maryland's immunization information system) and the IP should review the data. The IP said, I started this position a month ago. I haven't actually been involved in monitoring employees' immunization status yet. However, the IP verified that employees should fill out all necessary documentation in their onboarding system, and the IP should monitor them. She also confirmed that the documentation was supposed to be in their health file.During an interview with the Director of Nursing (DON) on 9/24/25 at 4:53 PM, the surveyor reviewed Staff #19's employee health file with her. The DON said she would search for the documentation. However, no further documentation was provided to the surveyor until the survey was completed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview, it was determined the facility failed to ensure the kitchen's freezer was in working order. This was evident during a revisit survey.The findings include:On 12/1/25 at 10:43 AM a tour of the kitchen was conducted. In the freezer, which was accessed through the refrigerator, observation was made as the door was opened of plastic curtain sleeves that had significant ice and frost build-up and ice build-up on the door. There were chunks of ice approximately 6 inches by 2 inches on the floor and 8 inches by 2 inches going up the poles of the storage carts. There were small mounds of ice built up on the ceiling above the compressor fans. There was ice on top of boxes that were stored in the freezer. The surveyor had the Dietary Manager, Staff #38 come into the freezer to confirm the findings. Staff #38 stated that they had the freezer worked on a month or two ago. He said he would call the company to come look at it. On 12/2/25 at 11:45 AM an interview was conducted with Staff #6, the maintenance director who stated, I was made aware of the freezer yesterday. There was no work order prior to yesterday. My assessment was the door wasn't always closed, and it did not freeze properly and there was ice built up around the door. I cleared it yesterday. On 12/3/25 at 10:50 AM an interview was conducted with Staff #20, Regional Director of Maintenance. Staff #20 stated that they had the freezer previously worked on. The surveyor informed him of the findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 surveyor observations, interviews with residents and facility staff, and review of pertinent documentation, it was determined that the facility failed to maintain an effective pest control program. This was found to be evident during the facility's recertification survey.The findings include:During the survey several observations were made of flies and gnats in the building. On the first day of the survey on 9/22/25 at 8:35 AM, surveyors were placed in the facility's conference room with multiple gnats and flies observed in the room. Throughout the survey conducted from 9/22/25 through 9/25/25, there were observations made each day of gnats and flies in the conference room and hallways of the facility. On 9/22/25 at 8:39 AM the surveyor observed flies flying around in the dining room.On 9/23/25 at 2:35 PM the surveyor observed several flies flying around room [ROOM NUMBER] and landing on Resident #72. When asked if flies were an issue s/he stated, Yes, that white thing [pointed to the wall behind his/her] is supposed to catch them, but it does not work. An interview was conducted with the Maintenance Director on 9/23/24 at 3:53 PM. During the interview he stated he was the Regional Maintenance Director and had been at the facility about 3-4 weeks because the onsite Maintenance Director was terminated about 3-4 weeks ago. When asked if he did rounds, he stated yes. When asked how frequently he stated, Whenever I can get here. He then stated that since June [2025] he has come at least once a month. When asked if the facility had a preventative insect/pest control program he stated Yes, Allstate comes here every other week. When asked if the facility had an issue with insects and/or pests he stated, Flies for sure are the biggest concern recently. When asked what interventions have been put in place as the current ones do not seem to be fixing the issue he stated, The Attorney General was here in June [2025] and they noted it as an issue, so we started putting up more traps like the vectors. The surveyor requested insect/pest logs from the past 3 months. On 9/23/25 at 4:21 PM review of the Allstate Pest Management logs revealed the following staff observations:- 6/1/25 ants/flies on Chase unit (room [ROOM NUMBER])- 6/15/25 ants on [NAME] unit (room [ROOM NUMBER])- 6/17/25 beetle on [NAME] unit- 6/23/25 ants on [NAME] unit (room [ROOM NUMBER])- 6/25/25 roaches on Chase unit (room [ROOM NUMBER])- 6/30/25 ants on Chase unit- 7/7/25 ants on [NAME] unit (room [ROOM NUMBER])- 7/11/25 spiders on [NAME] unit (room [ROOM NUMBER])- 8/1/24 ants, roaches on Chase unit (room [ROOM NUMBER])- 8/4/24 ants on Chase unit (room [ROOM NUMBER])- 8/6/25 roaches on [NAME] unit (Rooms 405, 407)- 8/14/25 roaches in office on desk by door button- 8/18/25 spiders on Chase unit (Medical Director's office)- 8/18/25 roaches all over the kitchen- 8/25/25 small roaches office- 8/28/25 roaches service hallOn 9/25/25 at 9:01 AM review of the Allstate Service Inspection Reports conducted by Allstate technicians revealed the following:- On 6/10/24 Unable to sign logbooks on Chase due to it being missing. Several staff members including kitchen dietary director report about fly activity throughout the facility. Kitchen seeing fly activity because it is located right next to loading door which is not just used for deliveries. Employees use the door all day long to smoke in back of building and come in and out of facility. Employees also use emergency exit door near nursing station on [NAME] and on Antioch.- On 6/23/25 Hallways-fly activity. Treated problem hallways, service hallway, lobby, smoking area exit, and atone exit door frames. Observed heavy activity in service hallway by loading dock, door and front entry doors to facility.Also recommend keeping better sanitation around dumpster area to remove attractions.- On 6/24/25 Loading dock and dumpsters-flies.Observed trash bind right up against building right outside of loading dock door entrance. Observed tons of flies in and around bins due to employees' trash and food residue. Recommend removing bins altogether to get rid of attractions for flies. Also recommend only using door for deliveries. Employees use this door as an employee entrance and to go out and smoke all day long. Due to door getting a lot of foot traffic flies are using this as a main point of entrance.- On 9/16/25 Inspected and treated dish machine electrical box for roaches. Observed minor (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activity.On 9/25/25 at 5:02 PM in an interview with the Director of Nursing (DON), the surveyor shared the concern of pests in the facility. The DON verified and confirmed understanding.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to ensure staff received compliance and ethics training. This was evident for 5 (GNA #18, GNA #22, RN #19, DA #41, HA #42) out of 7 employees reviewed during the Extended Survey investigation portion of the facility's recertification survey. This deficient practice had the potential to impact all residents.The findings include:On 9/23/25 at 5:19 PM in an interview with the Human Resources Director (HRD #20), when asked about the training and education provided to facility staff, she stated the facility does not use an online learning platform like Relias. She stated that all new hires (clinical and non-clinical) completed tasks online for their onboarding and showed the surveyor a printed copy from a binder in her office. When asked for clarification of what it meant to complete a task, she stated the staff read the tasks and then signed off when they finished showing they read through all of them. She verified and confirmed there was no evaluation criteria, written or otherwise, of staff after reading the tasks. Additionally, she stated they completed a 4 hour orientation with her onsite at the facility where they reviewed the onboarding tasks. When asked to share a time estimate for each task, she stated, They [staff] probably just click through them which is why I review them at the orientation. She stated that there were some additional training and in-services provided, but that nursing would have those sign in sheets. On 9/24/24 at 9:35 AM HRD #20 provided the survey team with a copy of the required onboarding tasks, titled Mandatory Staff Education and had written on the first sheet, Onboarding tasks that are completed prior to hire. [5 hours estimated]. In an interview with HRD #20 she verified and confirmed that the 5 hour estimated time was for completion of all the onboarding tasks. Review of the tasks revealed the following topics:- Resident Rights- Abuse/Abuse Prevention/Abuse Reporting- HIPPA (Health Insurance Portability and Accountability Act)- Fire Safety- Infection Control- Bloodborne Pathogens- OSHA (Occupational Safety and Health Act) Right to Know - Read the Chemical Label- Incident Accident Prevention- Writing a Statement- Aggressive Behaviors- Employee Violence- Body Mechanics- Customer Service- Using the Telephone- Advanced Directives- Dementia Care Tips- Facts about Sexual Harassment- Elopement- Pain Assessment and Management- PoemThe review failed to reveal compliance and ethics as an onboarding tasks for employees in the facility.On 9/24/2025 at 9:48AM GNA #18's employee file was reviewed. The review revealed she was hired on 11/7/05; however, failed to reveal evidence of compliance and ethics training. On 9/24/2025 at 10:17 AM GNA #22's employee file was reviewed. The review revealed she was hired on 11/19/24; however, failed to reveal evidence of compliance and ethics training. On 9/24/2025 at 12:17 PM Registered Nurse (RN #19's) employee file was reviewed. The review revealed she was hired on 12/24/24; however, failed to reveal evidence of compliance and ethics training. On 9/24/2025 at 1:31PM Dietary Aide (DA #41's) employee file was reviewed. The review revealed he was hired on 6/5/25; however, failed to reveal evidence of compliance and ethics training. On 9/24/2025 at 1:42PM Housekeeping Aide (HA #42's) employee file was reviewed. The review revealed he was hired on 10/28/24; however, failed to reveal evidence of compliance and ethics training. On 9/24/25 at 10:21 AM in an interview with SE #23, HRD #20 and the Director of Nursing (DON), when asked what training she was involved with, HRD #20 stated she only handled the onboarding and 4 hour orientation for all staff. The DON and SE #23 confirmed that HRD #20 only handled the onboarding and 4 hour orientation. The remainder of the interview was conducted with SE #23 and the DON. During the interview when asked what the various methods were used to provide training, in-services, and education to staff the DON stated outside of the onboarding and orientation, there was a 12 month calendar published by the CNO (Chief Nursing Officer, CNO #1) that ran from January to December. SE #23 and the DON verified and confirmed there was no online learning platform used by the facility to provide education/training to staff.When asked if there were any mandatory training all staff received, SE #23 stated for clinical staff, yes, and it was outlined on the 12 month calendar. When asked if there were any mandatory trainings that (continued on next page)

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nonclinical staff received, SE #23 stated, Not that I provide. You can ask [DON's name]. The DON stated, The head of the departments would do the trainings if they had any. I am clinical, so I would refer you to the department heads. When asked about Rehab (physical therapy, occupational therapy and speech therapy) participation in facility trainings, the DON and SE #23 stated that the Rehab staff do not participate in the 12 month calendar education. When asked about the process in place to track staff participation in the required trainings, SE #23 and the DON said, Sign in sheets. Moreover, SE #23 stated, I have not looked or seen them [sign in sheets], but I can get with [Assistant Director of Nursing's (ADON's) name] to find them because she was the facility's previous Staff Educator. SE #23 stated she had only been at the facility as the Staff Educator for about a month.The Activities Director was interviewed on 9/24/25 at 10:48 AM. During the interview she stated there was no mandatory training she provided for her staff. During the interview she stated, I know that HR does some, but no, I do not.The Director of Housekeeping/Laundry was interviewed on 9/24/25 at 12:50 PM. During the interview she stated there was no mandatory training that she provided for her staff. The Director of Rehab was interviewed on 9/24/25 at 1:19 PM. During the interview she stated there was no mandatory training that she provided for her staff. On 9/24/25 at 10:42 AM in an interview with the ADON when asked about evidence of staff trainings she stated, I was the Staff Educator, but only for like 2 weeks and [Licensed Practical Nurse (LPN #33)] was it for like a year. On 9/24/25 at 10:45 AM in an interview with LPN #33 when asked if she was the facility's previous Staff Educator, she stated she had never been the Staff Educator for the facility. During the interview she stated, I believe here that always fell with the ADON. On 9/24/25 at 10:51 AM in an interview with CNO #1 she stated, She [SE #23] was wrong, all staff do attend some of those trainings (and provided the Monthly Education Calendar 2025). [SE #23's name] checked off which trainings were [for] non-clinical [staff also]. When asked for evidence of staff participation in training, education, and in-services, CNO #1 provided the surveyor with 3 binders and 2 manilla folders. When asked for the duration of each training on the 12 month calendar, CNO #1 flipped to one of the pages in the binder, pointed to the line that read length, and stated that the times were listed on the attendance sheets. On 9/24/25 at 11:04 AM review of the 3 binders and 2 manilla folders of staff education, training, and in-services revealed two attendance sheets with Compliance & Ethics listed as the Topic of In-service; however, there were only 12 signatures total. Furthermore, there were only 2 out of 7 employees observed on the attendance sheets. On 9/24/25 at 4:13 PM in an interview with SE #23 a dual observation of the 3 binders and 2 manilla folders was conducted. When asked if there was any further evidence of staff participation in educations, in-services, or trainings, she stated, No, not to my knowledge and I asked the lady before me, and she did not have anything either. The surveyor pointed out the two Employee Education Attendance Record sheets with Compliance & Ethics listed as the Topic of In-service. There were 12 staff signatures who had signed that they attended between 11/4/24 through 11/13/24. The surveyor shared the concern that only 2 of the 7 staff reviewed were identified on the attendance sheet and only 12 total signatures (although there were 9 pages of employees in the employee contact list provided by the facility) were observed. SE #23 acknowledged understanding. On 9/24/25 at 4:44 PM in an interview with the DON when asked if there was any further documentation/evidence of staff participation in education, in services, or trainings, she stated, No, there is no further documentation to provide for staff training. The surveyor shared this was a concern and the DON confirmed understanding. On 9/25/25 at 9:29 AM in an interview with SE #23 she stated, [Nursing Home Administrator's name] and [CNO #1's] said we had a survey in 2023, and we do not have any evidence of the training you requested from 2024 or 2025. The surveyor shared this was a concern and SE #23 acknowledged understanding.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interviews it was determined that facility staff failed to honor the wishes of the guardian of Resident #21. This finding was evident for 1 out of 3 residents reviewed for behaviors during the recertification/complaint survey.The findings include:Review of the clinical record for Resident #21 revealed an order of court -consent that ordered [NAME] County Department of social Services as guardian of person for Resident #21. Review of the clinical record for Resident #21 revealed a discharge form dated 9/26/25. The form documented for the signature of the patient/representative verbal consent.Further review of the clinical record for Resident #21 revealed a discharge planning instruction sheet completed on 9-26-25, that documented under the person receiving instructions verbal consent with the initials of a staff member. Under Relationship to the Resident, it was documented facility staff member.Review of the clinical record revealed no evidence that a 30 day involuntary discharge notice was issued.On 9-29-25 a complaint submitted by the guardian of Resident #21 revealed that facility staff contacted the guardian on 9/25/25 and stated they wanted to transfer the resident to a sister facility in another county. The guardian stated they did not consent to the transfer of the resident, asked that other placements be considered, and that questions regarding their concerns be answered. The guardian documented that on 9/26/25 (the next day) when they contacted the facility, facility staff informed them that the resident had been moved earlier that day. On 9-30-25 interview with the guardian of Resident #21 revealed that facility staff transferred the resident without their consent and despite their objection to the transfer. The guardian also stated that no 30 day discharge notice was issued. On 9-30-25 interview with the administrator provided no additional information.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed to inform the responsible party on three separate dates when a new medication was ordered for a resident. This was evident for 1 (Resident #72) of 5 residents reviewed for unnecessary medications during the facility's recertification survey.The findings include:The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at S483.45(c)(3), as any drug that affects brain activities associated with mental processes and behavior (CMS, 2023). These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. These medications can have serious potential risks, including side effects, drug interactions, and the possibility of neuroleptic malignant syndrome (a rare but potentially life-threatening condition) or tardive dyskinesia (a movement disorder that can develop if you take an antipsychotic medication), therefore, requiring careful consideration and monitoring.On 9/22/25 at 9:22 PM review of Resident #72's medical record revealed s/he was admitted to the facility on [DATE]. Further review of the medical record revealed s/he was ordered the following psychotropic medications:- Depakote Oral Tablet Delayed Release 500 mg (milligrams) with an order date of 3/28/25. - Lumateperone Tosylate Oral Capsule 42 mg with an order date of 4/23/25. - Trazodone HCl Oral Tablet 50 mg with an order date of 5/19/25 - Sertraline HCl Oral Tablet 50mg with an order date of 10/16/24.On 9/22/25 at 9:37 PM review of Resident #72's medical record revealed his/her spouse was listed under the Contact Type section of the resident's profile as the Responsible Party (RP), AR (Accounts Receivable) Guarantor (RP in the process of collecting outstanding medical bills), and Emergency Contact #1.On 9/22/24 at 9:52 PM review of Resident #72's medical record failed to reveal evidence that Resident #72's RP was informed prior to him/her starting depakote, lumateperone, and trazadone.On 9/23/25 at 2:26 PM in an interview with the Director of Nursing (DON) when asked if a resident's RP should be informed in advance of the risks and benefits of a medication, the treatment alternatives or other options and be able to choose the option s/he preferred she stated if a resident has a RP, they should be notified by a doctor or the floor nurse prior to starting a new medication. The surveyor requested evidence from the medical record that Resident #72's RP was informed prior to starting him/her on depakote, lumateperone, and trazadone.On 9/23/25 at 3:34 PM in an interview with the DON when asked if she had the requested documentation of Resident #72's RP being informed of the three most recently prescribed psychotropic medications she stated, My ADON (Assistant Director of Nursing) is going over that now.On 9/24/25 at 9:43 AM in an interview with the DON she stated she did not have any evidence that Resident #72's RP was informed/notified prior to starting him/her on depakote, lumateperone, and trazadone. The surveyor shared this was a concern as the RP was not informed of the risks and benefits of the medications, treatment alternatives/other options, or given the opportunity to to choose the option they preferred. The DON acknowledged understanding.

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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 medical record review and interviews with facility staff, it was determined the facility staff failed to notify the physician and the responsible party in a timely manner of a resident's significant change in condition. This was evident for Resident #113, one of the three closed records reviewed during this recertification/complaint survey.The findings include:Agonal breathing is an abnormal, involuntary reflex that signals a severe medical emergency, such as cardiac arrest. It is not effective breathing and cannot sustain life. Though the person is still alive, this reflex indicates that the brain is not receiving enough oxygen and that death is imminent without immediate intervention.On 9/23/25 at 8:10 AM, the surveyor reviewed the three system-selected residents for the closed records review. The review revealed the following:7/16/25 at 11:03 AM: A nurse wrote a progress note stating, Resident has agonal breathing, RR (respiration rate) is 4, does not appear to be in any pain or discomfort, care continues. 7/19/25 at 2:55 AM: A progress note was written by the ADON (Assistant Director of Nursing) stating, This RN called to assess resident. No heart or lung sounds noted on assessment. No pulse palpable. Resident DNR (Do Not Resuscitate) per MOLST, resident CTB (ceased to breathe) at 2:55. Postmortem care provided.However, there were no detailed notes from 7/16/25 to 7/19/25 documenting Resident #113's changing condition.Further review of Resident #113's medical records on 9/23/25 at 8:38 AM revealed that the resident was under palliative care since June 2025 and received narcotics frequently for pain management. The MOLST (Medical Orders for Life-Sustaining Treatment) form was dated 7/22/25 and signed as DNI (Do Not Intubate).During an interview with the Director of Nursing (DON) on 9/24/25 at 10:27 AM, she confirmed that there was no further documentation regarding Resident #113's condition between 7/16/25 and 7/19/25.In an interview with the Medical Director on 9/25/25 at 9:47 AM, he reviewed Resident #113's progress notes concerning the agonal breathing. He stated that the resident's decreased condition was expected due to their health status and use of narcotics for pain. However, he emphasized that the resident's change in condition should have been documented in the system and the attending physicians should have been notified.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview with residents and interviews with facility staff, it was determined that the facility failed to ensure that an allegation of abuse was reported to the State Survey Agency, the Office of Health Care Quality (OHCQ), in a timely manner. This was evident for 1 (Resident # 72) of 4 residents reviewed for abuse during the facility's recertification survey. The findings include:The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report).On 9/22/25 at 9:16 AM in an interview with Resident #72 s/he stated s/he felt abused whenever the aides (Geriatric Nursing Assistants, GNAs) yell at her, which happens at least once a week. During the interview s/he stated, They just push and push when trying to clean me up or give me a bath in my bed. Instead of saying would you please do this, they just grab me and forcefully move me. I do not know their names because most of them do not wear name tags or introduce themselves to me. On 9/22/25 at 12:17 PM in an interview with the Director of Nursing (DON), the surveyor informed her of Resident #72's allegation of abuse. The DON stated, I will look into that. On 9/22/25 at 4:49 PM in an interview with the DON, when asked if the initial self- report was submitted to OHCQ, she stated that she went and talked to Resident #72 and that abuse was not substantiated. When asked the facility's process for investigating allegations of abuse she stated she did an investigation and Resident #72 said there was a misunderstanding. When asked what the reporting time was for any allegation of abuse, the DON stated within 2 hours. When asked if she reported Resident #72's allegation of abuse within 2 hours she stated no. The surveyor shared that it was a concern and the DON verified and confirmed understanding. On 9/23/25 at 12:15 PM in an interview with the DON when asked the process for investigating allegations of abuse she stated, I can get you the policy. When asked again to clarify the facility's process for investigating allegations of abuse she stated, I spoke with you yesterday. I investigate it, report it, and do the follow up report. We put orders in for alert charting and do education to staff. During the interview when asked what the reporting time to OHCQ was for any allegation of abuse she stated 2 hours. Additionally, when asked what the reporting time to OHCQ was for submission of the follow up report, she stated 5 days. When asked when an investigation was considered completed, she stated, Whenever we obtain all the information and get all the statements. It is a whole team effort during the investigation. She then stated, When the 5 day follow up has been submitted the investigation would be considered complete. On 9/26/2025 at 3:00 PM during the exit conference with the Nursing Home Administrator, DON, and other facility staff, no further information was provided to validate the reporting of an allegation of abuse.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interviews it was determined that facility staff failed to appropriately discharge Resident #21. This finding was evident for 1 out of 3 residents reviewed for behaviors during the recertification/complaint survey.The findings include:Review of the clinical record for Resident #21 revealed an order of court -consent that ordered [NAME] County Department of social Services as guardian of person for Resident #21. Review of the clinical record for Resident #21 revealed a discharge form dated 9/26/25. The form documented for the signature of the patient/representative verbal consent.Further review of the clinical record for Resident #21 revealed a discharge planning instruction sheet completed on 9-26-25, that documented under the person receiving instructions verbal consent with the initials of a staff member. Under Relationship to the Resident, it was documented facility staff memberReview of the clinical record forResident #21 revealed no evidence that a 30 day involuntary discharge notice was issued.On 9-29-25 a complaint submitted by the guardian of Resident #21 revealed that facility staff contacted the guardian on 9/25/25 and stated they wanted to transfer the resident to a sister facility in another county. The guardian stated they did not consent to the transfer of resident, asked that other placements be considered, and that questions regarding their concerns be answered. The guardian documented that on 9/26/25 (the next day) when they contacted the facility, facility staff informed them that the resident had been moved earlier that day. On 9-30-25 interview with the guardian of Resident #21 revealed that facility staff transferred the resident without their consent and despite their objection to the transfer. The guardian also stated that no 30 day discharge notice was issued. On 9-30-25 interview with the administrator provided no additional information.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interviews it was determined that facility staff failed to provide the guardian of Resident #21 with a notice of transfer or discharge 30 days prior to the transfer or discharge. This finding was evident for 1 out of 3 residents reviewed for behavior during the recertification/complaint survey.The findings include:Review of the clinical record for Resident #21 revealed an order of court -consent that ordered [NAME] County Department of social Services as guardian of person for Resident #21. Review of the clinical record for Resident #21 revealed a discharge form dated 9/26/25. The form documented for the signature of the patient/representative verbal consent.Further review of the clinical record for Resident #21 revealed a discharge planning instruction sheet completed on 9-26-25, that documented under the person receiving instructions verbal consent with the initials of a staff member. Under Relationship to the Resident, it was documented facility staff member.Review of the clinical record for Resident #21 revealed no evidence that a 30 day involuntary discharge notice was issued.On 9-29-25 a complaint submitted by the guardian of Resident #21 revealed that facility staff contacted the guardian on 9/25/25 and stated they wanted to transfer the resident to a sister facility in another county. The guardian stated they did not consent to the transfer of resident, asked that other placements be considered, and that questions regarding their concerns be answered. The guardian documented that on 9/26/25 (the next day) when they contacted the facility, facility staff informed them that the resident had been moved earlier that day. On 9-30-25 interview with the guardian of Resident #21 revealed that facility staff transferred the resident without their consent and despite their objection to the transfer. The guardian also stated that no 30 day discharge notice was issued. On 9-30-25 interview with the administrator provided no additional information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview it was determined that the facility failed to ensure comprehensive care plans were developed and implemented. This was found to be evident for 2 (Residents #3 and #4) out of 6 residents reviewed for care plans during this recertification/complaint survey.The findings include:1) On 09/22/2025 at 11:20 AM, Resident #4 stated that he/she was getting antibiotics but did not know for how long. Medical record review on 09/24/2025 at 11:08 AM noted an order written on 6/20/2025 to give Cephalexin 500 mg capsule, one capsule by mouth twice daily for UTI for 6 days. Additional orders found for Ketoconazole 2 % Cream, apply topically to facial rash twice a day for seborrheic dermatitis, and Triamcinolone Acetonide 0.1 % Cream apply topically to right leg rash twice daily for stasis dermatitis written on 6/22/2025. There was no care plan documented for the focus, goal, or intervention for the use of these medications.An interview was conducted on 09/24/2025 at 11:49 AM with the Infection Preventionist (IP) Staff #23 who stated that part of the Antibiotic Stewardship program were to have a line listing of the resident on antibiotic and to ensure that the resident had an updated care plan for antibiotics. Staff #23 provided an antibiotic surveillance log dated June 2025 that listed that Resident #4 had orders for antibiotic. On 9/24/2025 at 12:01 PM, an interview with the unit manager, Staff #11 confirmed that there was no care plan written for antibiotic medications for Resident #4.The Director of Nursing was made aware of the concern on 9/24/2025 at 12:14 PM. 2) During the screening interview on 09/22/2025 at 12:34 PM, Resident #3 stated that he/she went out to dialysis on Mondays, Wednesdays, and Fridays.A review of Resident #3's medical record on 09/23/2025 at 12:32 PM noted an order for dialysis scheduled one time a day every Monday, Wednesday, and Friday written on 8/18/2025.On 9/23/2025 at 12:35, a further record review revealed that the resident had no care plan for dialysis.An Interview was conducted on 9/23/2025 at 1:15 PM with unit manager, Staff #11, who stated that resident went off site to dialysis. When asked if resident should have a care plan for dialysis, Staff #11 stated yes. Staff #11 also reviewed the residents' medical record and agreed that there was no care plan for dialysis.On 09/23/2025 at 2:31 PM, surveyor informed the DON that there were no care plan for dialysis for Resident #3, and that this was concern. The DON agreed that Resident #3 should have had an individualized dialysis care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to hold interdisciplinary team care plan meetings for residents concurrent with their quarterly care plan revisions. This deficiency was observed in 2 (Resident #88 and #10) of 2 residents reviewed for care plan meetings during this recertification/complaint survey. The findings include: Care plans are essential guides for the care residents receive within the facility. They must be developed within seven days of a resident's comprehensive admission Minimum Data Set (MDS) assessment and revised at least quarterly (or more frequently as needed). The facility is required to have these care plans developed and revised by an interdisciplinary team, which includes the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative, as practicable. 1) On 9/23/25 at 11:01 AM, the surveyor reviewed Resident #88's medical records. The review revealed that the resident was re-admitted to the facility in July 2024. The MDS assessments were completed quarterly on 9/24/24, 12/28/24, and 3/30/25, and an annual assessment was completed on 6/28/25. However, there was only one care plan meeting summary documented on 6/28/25. During an interview with Staff #10 (Social Worker) on 9/23/25 at 9:52 AM, she stated that the care plan meeting is held by social workers quarterly and is documented in the care plan summary in the medical record system. In an interview with the Director of Nursing (DON) on 9/25/25 around 10 AM, she reviewed Resident #88's care plan meeting documentation and confirmed that the meetings were not completed after each MDS assessment. 2) A review of Resident #10's clinical record on 9/23/25 at 1:35 PM revealed the facility failed to hold two interdisciplinary team care conferences for the resident. There was a care plan meeting held on December 30, 2024. No evidence for one held in March 2025, in June 2025 and in September 2025. This surveyor requested on 9/23/25 evidence of care conferences being held in March, June, and September 2025. A review of the clinical record on 9/24/25 revealed that a care plan summary was added to the electronic health record on 9/23/25 at 2:24 PM. The care plan meeting was held on 9/2/25. The last care plan meeting attendance sign in sheet for care conference was dated 12/30/24. There was no sign in sheet for a care conference for either March or June 2025. This surveyor interviewed the Director of Nursing on 9/26/25 at 1:00 PM. This surveyor asked if the care conferences were held and if she had any evidence that they were held. She replied that social work handles care plan conferences and if they have not brought them in then they were probably not done. She confirmed that this surveyor had asked for evidence earlier in the week.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview with staff, and medical record review, it was determined the facility failed to provide the level of assistance needed with feeding for dependent residents. This was evident for 3 (Resident #50, #55, and #97) of 7 residents reviewed for Nutrition during the recertification/complaint survey.The findings include:Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility.1)On 09/22/2025 at 12:22 PM, during a phone interview with the complainant for Resident #50, concerns were expressed regarding Resident #50 eating with his/her fingers.On 09/23/2025 at 8:16 AM during a dining observation, Resident #50 was observed eating breakfast at a table in the dining area. The meal consisted of oatmeal and ground meat, which Resident #50 was eating with his/her fingers. Only a fork and knife were present on the meal tray, and no staff member was present assisting Resident #50 with the meal.On 09/23/2025 at 9:55 AM, in a review of Resident # 50's medical record revealed: An Activities of Daily Living (ADL) care plan initiated on 11/22/2021 with a focus of, The resident has ADL self-care deficit related to Alzheimer's with behaviors., with an intervention for eating of Supervised meals Date Initiated: 11/22/2021.2) On 09/23/2025 at 8:31AM during a dining observation Resident #55 was observed eating breakfast at a table in the dining area. The meal consisted of oatmeal and eggs, which Resident #55 was eating with his/her fingers. There were no staff present assisting Resident #55 with the meal.On 09/23/2025 at 10:06 AM, in a review of Resident # 55 medical record revealed:An ADL care plan initiated on 08/20/2025 with a focus of, The resident has ADL self-care deficit related to Dementia history of falls, Gait Dysfunction However, there was no intervention related to assistance level for eating. 3) On 09/23/2025 from 8:31 AM to 8:59 AM during an observation of dining, Resident # 97 was observed eating breakfast in the dining area. The meal, consisting of pureed food, no utensils were present, and a meal ticket that stated instructions for feeding assistance. Resident #97 observed repeatedly using their right hand to bring food to his/her mouth while simultaneously chewing on a wet white washcloth held in their left hand. No staff were present during the meal.On 09/23/2025 at 9:38 AM a review of Resident #97's medical record revealed the following: An ADL care plan initiated on 10/10/2019 with a focus of, The resident has ADL self-care deficit related to Dementia with behaviors, Alzheimer's The intervention for eating as Needs Supervision and verbal cueing, date Initiated: 06/16/2021.On 09/23/2025 at 8:22 AM, during an interview with Geriatric Assistant (GNA) Staff #3, stated Residents #50, #55, and #97 always eat with their hands. They should have finger foods but can only work with what the kitchen offers. 09/23/2025 at 9:01 AM, during an interview with Registered Nurse (RN) Staff #9, stated residents should be provided with appropriate utensils for eating. Food should not be placed in front of a resident unless staff are available to assist with feeding. If a resident eats with their hands, staff should help or consider a referral to therapy for specialized utensils. Staff #9 verified Resident #97's meal ticket at this time of feeding assistance.On 09/23/2025 at 12:30 PM the Surveyor requested from the Director of Nursing (DON) a current list of residents in the facility that require assistance with feeding. On 09/23/2025 at 12:36 PM, during an interview with the Director of Nursing (DON) stated staff are expected to provide feeding assistance to residents observed eating with their hands. Residents should be provided with utensils, and if residents require assistance with meals, it would be noted on the Resident's meal ticket. The Director of Nursing defined supervision within the care plan as the presence of a staff member during meals.On 09/26/25 at 12:10 PM, the DON provided the Surveyor with meal tickets for current residents requiring assistance with feeding. Residents' #50, #55, and #97 were among those with instructions on meal tickets that stated, feeding assistance. Concerns were communicated to the DON at this time.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, staff interview, and medical record review it was determined that the facility staff failed to provide 1 to 1 resident-centered activities to improve or maintain the resident's mental and psychosocial well-being. This was evident for 1 (Resident # 3) of 6 residents reviewed for activities during the recertification/complaint survey. The findings include:During the screening phase of the survey on 9/22/2025 at 10:15 AM when surveyor asked Resident #3 if he/she participated in activities, resident stated, you tell me. The surveyor asked if activities are done in the room, resident stated, no.On 9/22/2025 at 1:12 PM, Resident #3 was observed in bed with the television off. When surveyor asked if he/she were engaged in any bedside activity, the resident stated no.A record review of the care plan on 9/23/2025 at 11:46 AM, noted that the resident is dependent on staff for activities, meeting emotional, physical, social needs related to (if dependent) Immobility, Physical Limitations, and that the resident needed 1:1 bedside/in-room visits and activities if unable to attend out-of-room events initiated on 07/18/2025. Further record review on 9/23/2025 at 12:32 PM revealed the resident preferences: How important is it to you to listen to music you like? Somewhat important. How important is it to you to keep up with the news? Very important. How important is it to you to do your favorite activities? Very important. How important is it to you to go outside to get fresh air when the weather is good? Somewhat important. How important is it to you to participate in religious services or practices? Very important. An activity progress note dated 6/4/2025 documented that Resident #3 prefer to remain in room at the present time. He/she is encouraged to participate in activities of his choice and to come to planned activities in the dining room. He will watch TV programs, current events and receive 1:1 visit.The Activities Director (Staff #2) was interviewed on 9/23/2025 at 1:35 PM who stated that on admission all residents get an activity assessment, and their activities are planned based on preferences. Residents who are bedbound and those who do not want to leave their rooms are provided with a 1:1 bedside activity. When surveyor asked about activities conducted with Resident #3, Staff #2 stated that resident would close his/her eyes when activity staff went into the room. The Surveyor asked for documentation of activities offered to the resident and Staff #2 stated that a copy of the resident's activities log will be provided. On 9/23/2025 at 2:48 PM, Staff #2 provided documentation of a quarterly activities assessment completed on 6/4/2025 and stated that there was no documentation of daily activities. Surveyor informed staff #2 and the Director of Nursing that this was a concern. Staff #2 acknowledged the concern and stated that moving forward the staff will document activities provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, and staff interview it was determined that the facility staff failed to ensure medications were not left unattended on the locked unit. This was evident for 1 (#10) out of 45 residents that were part of the survey sample during the recertification/complaint survey.The findings include:On 9/22/25 at 9:00 AM, the surveyor observed the room of Resident #10 which was located on the locked unit which houses residents with some form of dementia and/or a psychiatric diagnosis. On the bedside table was an open bottle of Greer's goo (a compound medication to treat skin irritation and to act as a moisture barrier), a near empty container of Greer's goo on nightstand with a do not use past 9/4/25 date, and another container of Greer's goo on the nightstand as well. This surveyor told Staff #3 (a geriatric nursing assistant - GNA) on 9/22/25 at 9:08 AM about the findings and showed her what was observed. She said the nurse must have done a treatment earlier. She then said she would move the creams. This surveyor interviewed Staff #14 (the nurse on the unit) on 9/22/25 at 9:20 AM. This surveyor informed her of the observations and asked if it was normal to have medications in the residents' rooms. She replied that the resident received care that morning and that it was normal to have medications at bedside. The Director of Nursing (DON) was interviewed on 9/23/25 at 8:38 AM. This surveyor asked if a resident could have medications by their bedside even ones on the locked, dementia unit. She replied that it was not usually allowed. This surveyor asked, you said ?usually' does that mean that someone could have an order? She replied, you'll have to take it up with the Medical Director. The resident's clinical record was reviewed on 09/23/2025 at 9:24 AM. The review of the clinical record revealed that there was no physician order for leaving medication at the bedside. The DON was interviewed again on 09/23/2025 at 12:37 PM. This surveyor informed the DON that an order for resident to have medications by the bedside could not be found. The DON said if it wasn't in the chart then there probably isn't an order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review and interviews. It was determined that the facility failed to label and date oxygen tubing to indicate when it was last changed. This was evident for 2 (Residents #66 and #41) of 2 residents reviewed for respiratory care during the recertification/complaint survey.The findings include:On 9/22/25 at 8:30 AM and 8:42AM during the initial round on the unit, Residents #66 and #41 were observed in their respective rooms, both residents were receiving oxygen (O2) via a nasal cannula (NC) which is a tubing used to deliver oxygen to the nares. The NC was connected to an O2 humidifier, a medical device that provides supplemental O2 at the bedside. Continuous observation revealed that both O2 tubing were not labelled with a date to indicate when they were last changed.A second observation was made on 9/23/2025 at 1:19 PM. Resident #66 was sitting in the A/B day room with two family members with a portable O2 tank, the O2 tubing was not labelled with a change dated. Review of the physician's orders on 9/24/25 at 13:00 PM revealed an order for Resident #66 placed on 9/6/25 that read Oxygen 2 LPM via nasal cannula to maintain saturation above 92% every 12 hours for 02 sat. Further review did not reveal an order for the 02 tubing to be changed.Review of the Physician's order for Resident #41 also revealed an order placed on 7/16/24 that read O2 at 2lpm via nasal cannula continuously every 12 hours. There was a second order placed on 1/2/24 that read 02-Change O2 tubing and sterile water weekly. Label and date every night shift every Tue.In an interview on 9/22/2025 at 1:38 PM with Staff #13, a licensed practical Nurse (LPN). She was asked about the process for labelling O2 tubing, and she said that 02 tubing are supposed to be changed weekly by night shift and that the humidifier and NC tubing should have dates on them to indicate when it was last changed. She confirmed that both were not dated and stated that she would change and label them. On 9/24/25 at 2:00 PM, the director of nursing (DON) was made aware of the concerns, she confirmed that O2 tubing should have an order to change them weekly and that staff should label them with a date to indicate when it was last changed.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview, it was determined the physician failed to enter progress notes and order medications in a timely manner for a resident (Resident #6). This was evident for 1 of 3 residents reviewed during a revisit survey.The findings include:Review of Resident #6's medical record on 12/2/25 revealed the Resident was admitted to the facility in 2021 with diagnosis to include hypertension. Hypertension, or high blood pressure, is a condition where the force of blood against artery walls is consistently too high, which can lead to serious health problems like heart attack and stroke.Further review of Resident #6's medical record revealed the last physician/nurse practitioner note was on 10/20/25.During interview with the Director of Nursing (DON) on 12/3/25 at 8:15 AM, the DON confirmed there are no physician/nurse practitioner notes for Resident #6 since 10/20/25. The DON stated she contacted the Physician (Staff #31) and the Physician stated he had seen the Resident in November but had not put in the progress note in the medical record yet.After Surveyor intervention, on 12/4/25 the DON provided the Surveyor with the Physician's progress note from 11/27/25 and stated it is now in the Resident's medical record.Review of the Physician's progress note dated 11/27/25 revealed the Physician documented for the Resident's resistant blood pressure to start the Resident on Isosorbide Dinitrate 20 mg twice a day, HCTZ 12.5 mg daily and Folic Acid 5 mg daily.Review of Resident #6's physician orders revealed the Isosorbide Dinitrate, HCTZ and Folic Acid were not ordered until 12/3/25.Interview with the Director of Nursing on 12/4/25 at 8:46 AM confirmed Resident #6's Physician did not document his 11/27/25 progress notes in the medical record until 12/3/25 and did not place medication orders from the 11/27/25 visit until 12/3/25.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on a medical record review and interview, it was determined that the facility staff failed to monitor and document residents' behavior for those who had mental disorders. This was evident for one (Resident #11) of the three residents reviewed for behavioral issues during this recertification/complaint survey.The findings include:On 9/24/25 at 10:12 AM, the surveyor reviewed Resident #11's medical records. The review revealed that the resident was admitted in April 2025 with diagnoses of schizoaffective disorder, major depressive disorder, and anxiety disorder. The resident had been administered several medications for the mental disorder, including those addressing symptoms of verbal or physical aggression. However, there was no order for behavior monitoring.During an interview with the Director of Nursing (DON) on 9/24/25 at 1:53 PM, she confirmed that Resident #11 had several mental disorders, including aggressive behavior. The surveyor asked the DON about the care for residents who had behavior issues. She stated the facility nursing staff should monitor their behaviors and document them in the Treatment Assessment Records under the electronic medical records. The DON verified that there was no documentation for Resident #11's behavior monitoring. She validated the concern.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of the medical record, interview with facility staff and review of facility policy, it was determined that the facility failed to ensure the physician reviewed and documented on the monthly pharmacy reviews and responded to the recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #72) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include:The Medication Regimen Review (MRR) is a thorough review of the medication regimen (plan) of a resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. Irregularity refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences.The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at S483.45(c)(3), as any drug that affects brain activities associated with mental processes and behavior (CMS, 2023). These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. These medications can have serious potential risks, including side effects, drug interactions, and the possibility of neuroleptic malignant syndrome (a rare but potentially life-threatening condition) or tardive dyskinesia (a movement disorder that can develop if you take an antipsychotic medication) therefore requiring careful consideration.Gradual dose reduction (GDR) is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.N-terminal pro-B-type natriuretic peptide (NT-proBNP) is a hormone released by the heart in response to stress or damage. Elevated levels of NT-proBNP can indicate heart failure or other underlying medical conditions. On 9/22/25 at 9:42 PM review of Resident #72's medical record revealed the following medication regimen reviews: 7/15/2025 Irregularities Found (see consultant pharmacist report) 8/17/24 Irregularities Found (see consultant pharmacist report) 5/24/2024 Irregularities Found (see consultant pharmacist report)The Director of Nursing (DON) was interviewed on 9/23/25 at 8:14 AM. During the interview when asked about the facility's process for the monthly MRR she stated, the pharmacist sends a list of all residents reviewed and his recommendations via email. For residents with a monthly pharmacy recommendation, the facility's expectation would be that the provider reviewed the recommendation and approved or denied it. If the provider denied the recommendation, they would write a rationale for why, and then it would be signed and dated. Additionally, she stated, I approved them all through the Medical Director. I would print them out from the email and physically hand them to [Medical Director's name] and at times the pharmacist would send emails to [Medical Director's name] as well. When asked who discontinued or put in new orders based off the monthly recommendations, the DON stated, If [Medical Director's name] was in the building, he changed the orders. If he was not and I sent them to him via email, I would put the orders in that [Medical Director's name] approved. Also, if [Medical Director's name] was not available, then Nurse Practitioner (NP #34) would be in the building, and I would physically hand the recommendations to her. She would address them and change the orders. The DON said that after any of the abovementioned processes, she would email the signed recommendations back to the pharmacist. Finally, the recommendations would have been scanned into the resident's medical records under the Miscellaneous tab. The facility's policy Addressing Medication Regimen Review Irregularities was reviewed on 9/23/25 at 4:15PM. The review revealed, Policy: It is the policy of this (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. Further review of the policy revealed, The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the medical record.On 9/23/25 at 8:43 AM the surveyor requested the consultant pharmacist reports from the three above dates for Resident #72. 1) On 9/23/25 at 11:46 AM review of the consultant pharmacist reports revealed Pharmacist #36 conducted a MRR on 5/24/24 and noted, This resident has been taking the following medications.[Ordered] 10/29/23: Sertraline 50mg (milligrams) Q AM (every morning) for bipolar[Ordered] 5/26/23: Depakote 500mg BID (twice a day) for bipolarPlease evaluate the current dose and consider a dose reduction. There were boxes that could be checked that stated the following: - Condition stable: Attempt dose reduction to Depakote 250mg by mouth BID for bipolar.- Resident with good response, maintain the current dose.- Previous dose reduction failed: Date of failed GDR:_____- Condition is not well controlled. IMPORTANT: Please add resident specific documentation to support the above action or check below if information was added to the physician progress notes.- Document clinical rationale here: _____- See physician progress notes for clinical rationale. None of the abovementioned boxes were checked. There was no physician signature or date.Review of Resident #72's medical record on 9/22/25 at 9:22 PM revealed the following active physician orders for psychotropic medications:- Depakote Oral Tablet Delayed Release 500 mg (milligrams). - Sertraline HCl Oral Tablet 50mg.The facility's policy, Gradual Dose Reduction of Psychotropic Drugs, reviewed on 9/23/25 at 11:52 AM revealed, Policy: Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Further review of the policy revealed, 1. Reducing the need for and maximizing the effectiveness of medications shall be considered for all residents who use psychotropic drugs. Therefore, dose reductions and behavioral interventions are part of medication management. 2. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated. 3. After the first year, a GDR will be attempted annually, unless clinically contraindicated. 5. GDR will be documented on the pharmacy recommendation form.On 9/23/25 at 12:06 PM in an interview with the DON a dual observation of the 5/24/24 MRR was conducted, it was noted that the provider had not responded, signed, or dated the recommendation and when asked if there was evidence that the provider had reviewed the pharmacy recommendation, the DON stated, No, we don't have the signed original. Additionally, she stated, This is the note that the doctor still wanted to continue the sertraline (and pointed to a progress note from the Medical Director).Upon review of the Medical Director's progress note dated 5/29/24 when asked if the note referenced Depakote, she stated no. When asked if there was evidence from the medical record that this monthly pharmacy recommendation was reviewed by the physician, with his response documented on the pharmacist's report, and that it was responded to by the physician, she stated, No ma'am it was not. It was not done for this monthly recommendation. 2) On 9/23/25 at 11:46 AM review of the consultant pharmacist reports revealed Pharmacist #35 conducted a MRR on 7/15/25 and noted, This resident [Resident #72] has a high NT-proBNP reading of 166. Please evaluate and monitor resident. In the Physician/Prescriber Response section, the Agree box was checked. Additionally, the provider, NP #34, signed and dated the form on 8/14/25. On 9/23/25 at 12:06 PM in an interview with the DON a dual observation of the 5/24/24 MRR was conducted and the surveyor requested evidence from the medical record that Resident #72 was evaluated and monitored after the provider agreed with the pharmacist's monthly recommendation to do so. On 9/24/25 at 7:53 AM the surveyor again requested evidence that Resident #72 was evaluated and monitored. On 9/24/25 at (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:34 PM in an interview with the DON she stated there was no documentation to provide for Resident #72's July 2025 pharmacy recommendation. The surveyor shared this was a concern as the provider had agreed with the pharmacist's recommendation to evaluate and monitor the resident and there was no evidence from the medical record to provide this was responded to. The DON acknowledged understanding.

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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 clinical record review and staff interview it was determined that the facility staff failed to ensure a resident received medication as ordered. This was evident for 1 (Resident #10) out of the 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include:A review of Resident #10's clinical record was conducted on 09/23/2025 at 1:35 PM. It was revealed that the resident's primary physician ordered on 5/22/25 Acetaminophen 325 mg to be administered with two tablets every six hours as needed for mild pain (1-3). The resident told staff that they had pain that was rated as 6 on 9/4/25, as 8 on 9/7/25, and as 10 on 9/22/25. There was no evidence that the physician was contacted with instructions on how to address pain levels higher than the 1-3 reflected in the orders for the first two incidents of pain rated greater than 3. The physician wrote an order on 9/10/25 for Tramadol 50 mg to be administered by mouth every 8 hours as needed for severe pain (7-10) for 14 days. This medication was not administered at all even on 9/22/25 when the resident's pain level was 10. Also, there was no order to address pain at moderate levels (4-6). The Director of Nursing was interviewed on 09/26/2025 at 9:33 AM. This surveyor showed her the Medication Administration Record (MAR) and the order for Acetaminophen to be administered as needed for pain levels of 1-3. She was then shown the pain levels of 6,8, and 10 with the notation that the nursing staff administered it. She replied that she would expect staff to call the doctor and get an order for something else. This surveyor then showed the order for Tramadol and asked why they administered the Tylenol not the Tramadol. She replied, I don't know why but they should have.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, review of the medical record, and interviews with facility staff, it was determined the facility failed to screen/evaluate a resident for rehabilitative services. This was evident for 1 (Resident #72) of 2 reviewed for Rehab and Restorative services during the facility's recertification survey. The findings include:On 9/22/25 at 9:31 AM in an interview with Resident #72 s/he stated, I am supposed to get therapy, and they do not give it to me. Review of Resident #72's medical record on 9/22/25 at 1:35 PM revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Parkinson's disease, muscle weakness (generalized), abnormal posture, and muscle wasting and atrophy.On 9/22/25 at 9:18 PM review of Resident #72's medical record revealed, Care Plan Conference Summary dated 7/3/25. In the Summarize Discussion of Care Plan Conference section it had documented, Family would like some type of therapy ordered for her. Goal is for [Resident #72's name] is to participate more in activities, emotional support and try daily routines.On 9/23/25 at 10:20 AM in an interview with the Director of Rehab (DOR) when asked when residents were evaluated for therapy she stated usually for a new admission within 72 hours and for long term care (LTC) residents if the resident had a change in condition such as a fall or we go by the MDS (Minimum Data Set) calendar, so approximately every 90 days. During the interview when asked if residents were reevaluated for therapy, the DOR stated LTC residents are picked up every 90 days. She stated, Every 90 days we do a screen or evaluation for LTC residents. Everyone is started as a screen and then based on the clinician's findings and/or residents' input, they would either be evaluated or not put on caseload with documentation stating why. When asked if Resident #72 was on caseload, the DOR stated, No, his/her quarterly assessment comes up at the end of the month. Usually, I would check to see what discipline saw her last and we'd pick them up like that. During the interview when asked when Resident #72 was last on caseload, the DOR stated s/he was last on caseload for physical therapy (PT) from 12/20/24-2/6/25 and was last evaluated on 3/27/25 by OT but s/he refused services at that time. When asked about the facility's process for a resident's refusal of services, the DOR stated, We try to educate them to be picked up by therapy to work on any deficits they might have, but it is up to the patient. We usually try to call the family to let them know. When asked if a resident had a responsible party (RP) and refused, would they be notified she stated, No, that is not the process all the time. Resident #72's quarterly assessment was not due until the end of September; however, the DOR did not provide any documentation that a screening or evaluation was completed 90 days prior during the month of June.On 9/25/25 at 9:53 AM in an interview with the DOR, when asked would a resident's RP requesting therapy being ordered be enough to trigger the resident to be screened/evaluated, she stated yes. During the interview when asked the timeline for the screening/evaluation to be completed, she stated, I do not have full time evaluating staff, but I do have PRN (as needed) staff, so I usually try to get it done within a couple days. On 9/25/25 at 5:02 PM in an interview with the Director of Nursing (DON), the surveyor shared the concern that Resident #72's RP had requested therapy during his/her care plan meeting on 7/3/25 and the resident had not yet been screened/evaluated. The DON acknowledged understanding and provided no further documentation at the exit conference on 9/26/25 at 3:00 PM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview, it was determined the facility staff failed to maintain a medical record in the most accurate form. This was evident for 1 (Resident #100) of 6 residents reviewed for medical record accuracy during the recertification/complaint survey.The findings include:During a record review on 09/23/2025 at 09:20 AM of a Facility Reported Incident, it was noted that Resident #100 had an Emergency Petition (EP) transfer to the hospital for suicidal ideation on 9/9/2025. Upon further review of the record, the surveyor found a progress note dated 9/17/2025 documented as This visit was conducted with the use of an interactive audio and video telecommunication system with real-time communication between the patient and the provider. On 09/23/2025 at 9:23 AM, an interview with the unit manager, Staff #11 revealed that the resident was not in the facility on 9/17/2025 and could not explain why that progress note was written in the resident's medical record.An interview was conducted on 09/23/2025 at 10:17 AM with the medical record director, Staff # 7. When surveyor asked if the medical record entry notes are reviewed for correct dates, Staff # 7 said no, but if there was a late entry note, the note must indicate late entry and if note is written in error, it will indicate such lines drawn through the note. Staff #7 reviewed the progress note written on 9/17/2025 and could not find where a late entry annotation or a written in error indication were documented as part of the entry. The Director of Nursing (DON) was made aware of the concern on 9/23/2025 at 11:30 AM, who confirmed that the resident was not in the facility on 9/17/2025 to have a virtual visit with the physician.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on medical record reviews and staff interviews, it was determined that the facility failed to have key essential personnel present during their monthly quality assurance (QA) meetings. This was evident during a review of the facilities quality assurance program activities during the recertification/complaint survey.The findings include:On 9/26/2025 at 11:02 AM the surveyors requested for the January to August of 2025 quality assurance (QA) monthly meeting sign in sheet from the facility.Review of the QA agenda/meeting sign in sheet from January to August 2025 on 9/26/25 at 11:10 AM revealed that in the months of July and August, certain key personnel did not attend the monthly meetings. For instance, in the month of July, the medical director, the social worker and the Infection preventionist were absent during the meeting and in the month of August the social worker, dietitian and the infection preventionist did not attend the meeting.On 9/26/2025 at 11:20 AM in an interview with the nursing home administrator who oversees QA. He was asked if he was aware that certain key personnel are required to be present during each QA monthly meeting and he said yes. He was asked why their presence was imperative and he said it's to help address issues that might come up requiring their expertise. He was made aware of the months when key personnel were absent during the meetings. He said he will be more consistent going forward.