STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215188	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvert County Nursing Ctr.	85 Hospital Road Prince Frederick, MD 20678

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical observations and staff interviews, it was determined the facility staff failed to provide nursing care within the standards of practice. This was evident for 4 (Residents #78, # 43, #83, and #15) out of 6 residents reviewed during the recertification and complaint survey process.The findings include: The administration of supplemental oxygen and prescribed nebulizer treatments to a resident, as ordered by a physician, to maintain adequate oxygen saturation and support respiratory function. Equipment, including oxygen tubing and humidifier bottles, is expected to be clean, dated, and labeled. Nebulizer masks and tubing are expected to be clean, dated, labeled, and stored in a clean plastic bag when not in use.On 03/22/2026, during Southern Shore unit rounds, surveyor observations revealed multiple unlabeled respiratory supplies as follows: at 7:50 AM, Resident #78 in bed with oxygen tubing in place; humidifier bottle empty and unlabeled; at 7:55 AM, oxygen tubing and nebulizer tubing on Resident #43's nightstand, unlabeled; at 8:10 AM, Resident #83 in bed with oxygen tubing in place; humidifier bottle present and unlabeled; and at 8:27 AM, Resident #15 with nebulizer mask and tubing on floor at bedside, unlabeled. On 03/22/2026 at 8:40 AM interview with Licensed Practical Nurse (LPN) #8 revealed oxygen tubing should be changed weekly and dated, masks should be dated and stored in a plastic bag when not in use. On 03/23/2026, during unit rounds on the Southern Unit, surveyor observations revealed the following: at 7:02 AM, Resident #83's nebulizer mask and tubing were observed on the nightstand without a label. At 7:05 AM, Resident #78 had oxygen tubing and a humidifier bottle at bedside; the bottle contained no water and was unlabeled. At 7:32 AM, Resident #43 had a nebulizer mask hanging on a gallon water bottle on the nightstand; no oxygen sign was observed at the resident's door. On 03/23/2026 at 7:40 AM interview with LPN #8, confirmed oxygen tubing should be changed weekly and dated; masks should be dated and stored in a plastic bag when not in use. The LPN further stated an oxygen sign should be present at the resident's door. Following surveyor intervention, LPN #8 placed an oxygen sign on the resident's door. On 03/23/2026 at 8:00 AM during unit rounds on the Southern Unit with Registered Nurse (RN)#9, surveyor observation revealed Resident #83 in bed receiving oxygen; oxygen tubing and humidifier bottle were unlabeled. Nebulizer tubing and mask were observed on the nightstand, unlabeled and not stored in a plastic bag. On 03/23/2026 at 8:06 AM, interview with RN #9 revealed that oxygen tubing and humidifier bottles should be labeled, and nebulizer masks and tubing should be stored in a plastic bag when not in use. He further confirmed that no labels were present for Resident #83. With the surveyor's intervention, RN #9 replaced and labeled the oxygen tubing, nebulizer tubing, and mask.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 record reviews and interviews, it was determined that the facility failed to ensure 1) Residents' immunization status was verified and 2) current vaccinations were offered. This was found to be evident for 4 (Resident #30, #45, #2, and #49) out of 5 Residents reviewed for infection control during the recertification and complaint survey. The findings include: Tuberculosis (TB) is a contagious, airborne bacterial infection primarily caused by Mycobacterium tuberculosis, which usually attacks the lungs but can affect other body parts like the brain or spine. It is preventable and curable yet remains a leading cause of death worldwide.According to Centers for Disease and Prevention (CDC) nursing home residents must undergo tuberculosis (TB) screening upon admission to identify latent or active infection, typically using a two-step tuberculin skin test (TST/Mantoux) or a single IGRA blood test. A two-step test is generally required, with the second step performed 1-3 weeks after the first. Influenza (the flu) is a contagious viral respiratory infection causing sudden fever, muscle aches, sore throat, and severe fatigue, lasting from a few days to two weeks. It spreads primarily via droplets from coughs/sneezes, often treated with rest, fluids, and antiviral drugs. Complications can include pneumonia and, in severe cases, death.Pneumococcal disease is a serious bacterial infection caused by Streptococcus pneumoniae, leading to illnesses like pneumonia, meningitis, and sepsis. It is highly contagious, spreading through respiratory droplets. Vaccination is the best prevention, particularly for young children, adults 65+, and those with high-risk health conditions.Severe acute respiratory syndrome (SARS) is a contagious illness caused by a coronavirus disease (COVID). It's a disease that affects the lungs and airways, also called a respiratory illness.Nursing homes must offer Influenza, Pneumococcal, and SARS/COVID vaccinations to all residents, reinforcing their importance for infection control. Facilities are required to conduct active surveillance, including daily symptom checks, and implement measures like masking, testing, and antiviral treatments during outbreaks to manage respiratory virus transmission.During a review of Resident immunization records conducted on 03/26/26 at 9:21 AM, it was determined that Residents #30, #45, #2 medical records did not show their immunization status for TB, Influenza, SARS/COVID, and Pneumococcal. During a review of Resident #49's medical records conducted on 03/26/2026 at 9:38 AM, it was determined that the Resident received TB testing on 2/05/25 and 2/12/25 with education. However, there was no record of the immunization status for SARS/COVID, Pneumococcal, and Influenza. During an interview conducted on 03/26/2026 at 10:43 AM, the Infection Control Preventionist reported that she did not obtain the immunization status of Residents nor did she offer vaccines. She stated that the MDS Coordinator did that because she did not have time to commit to her Infection Control Preventionist role due to her fulltime role as the unit manager on the Western [NAME] Nursing Unit. ImmuNet is Maryland's secure, confidential, and HIPAA-compliant Immunization Information System (IIS). It is a web-based database used by healthcare providers, schools, and public health programs to store, track, and manage vaccination records for both children and adults across the state. It helps prevent over- or under-vaccination. During an interview conducted on 03/26/2026 at 10:53 AM, the MDS Coordinator advised that she viewed the immunization status of a resident on ImmuNet when she completed her assessment. However, she did not input the immunization status in the Resident's medical records. During an interview conducted on 03/26/26 at 11:00 AM, the Director of Nursing (DON) acknowledged that the Infection Control Preventionist did not have time to dedicate to Infection Control and as a result certain requirements for Infection Control were not currently getting done. He further explained that his goal was to put someone in the role of the Infection Control Preventionist that would be dedicated to Infection Control.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record reviews and interviews it was determined that the facility failed to ensure that geriatric nursing assistants (GNA) received at least 12 hours of in-service training annually. This was found to be evident for 5 (GNA #18. #19, #20, #21 & #22) out of 5 GNA's reviewed for training. The findings include:During an interview with the Nursing Home Administrator (NHA) on 03/25/2026 at 9:13 AM she reported the Director of Nursing (DON) handles training for staff.During an interview with the Director of Nursing on 3/25/2026 at 9:46 AM he reported education is completed throughout the year for GNA's via in-services and educational sheets. He reported the GNA's should be receiving 12 hours of mandatory training yearly. During a review of the training records for GNA's #18, #19, #20, #21 and #22 on 3/25/2026 at 11:45 AM it was discovered the records provided by the staffing manager were competency checkoff sheets and tests that had been completed by the GNA's. There was no documentation confirming the GNA's had 12-hours of annual training.During an interview with the DON on 3/26/2026 at 10:12 AM he advised he had just started employment with the facility three weeks ago and reported they have been unable to locate any documentation confirming the GNA's had completed their required 12-hour training so he was unable to confirm that the training requirement had been met for GNA #18, #19, #20, #21 and #22.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on a review of a complaint, staff interviews, and record reviews, it was determined that the facility failed to ensure the provision and use of a motorized wheelchair to promote and maintain the resident's independence and freedom of movement. This was evident for 1 (Resident #65) out of 1 resident reviewed during the recertification and complaint survey process. The findings include:A motorized wheelchair (power wheelchair) is a battery-operated mobility device used to assist residents with limited strength, endurance, or mobility. It is typically operated by the resident using a hand control and is intended to promote independence, safe mobility, and the resident's ability to move about the facility.On 03/26/2026 at 7:45 AM record review during the complaint investigation was conducted, Resident #65 reported that the motorized wheelchair has been nonfunctional since 2025. The resident stated that a vendor completed measurements for repair or replacement; however, no follow-up has been received regarding the status of the equipment. The resident further reported that the lack of a functioning motorized wheelchair has limited mobility within the facility and has impacted independence.On 03/26/2026 at 8:30 AM interview conducted with the Physical Therapy Director (PTD). She explained that the process involves taking the resident's measurements, obtaining a vendor estimate, and submitting it to the Business Office Manager (BOM) for processing, and stated she was unsure of the timeframe. The PTD confirmed that the initial motorized wheelchair assessment was completed on 08/18/2025 by Freedom Mobility (vendor), and the estimate was forwarded to the Administrator due to the absence of a Business Office Manager.On 03/26/2026 at 9:09 AM, an interview was conducted with the Business Office Manager (BOM), who stated she has been in her position since December 2025.The BOM stated she became aware of the resident's wheelchair issue on 01/16/2026. She further reported that she contacted Freedom Mobility on 01/16/2026 and was informed that authorization/approval had been received from Telligen on 10/10/2025.On 03/26/2026 at 9:34 AM during an interview with the Administrator she confirmed that the facility did not have a Business Office Manager (BOM) from July 2025 through December 2025. She stated that during this period, she assumed responsibility for Business Office functions, which resulted in a breakdown in follow-up and tracking of the authorization process.The Administrator acknowledged that the facility failed to follow up on the approved request, resulting in a delay in providing the resident with the necessary equipment to support mobility, as well as a failure to update the resident regarding the status. The Administrator further stated, I am going to talk to Resident #65 right now.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that residents were offered written information regarding advance directives. This was evident for 4 (Resident#6, # 10, 89, and #90) out of 6 residents reviewed for advance directives during the recertification and complaint survey process. The findings include:An advance directive is a written instruction, such as a living will or durable power of attorney for healthcare, that is completed by a resident to outline their preferences for medical care in the event they are unable to make decisions for themselves.In a long-term care facility, an advance directive guides staff and providers in honoring the resident's choices regarding treatment, life-sustaining measures, and designation of a representative to make healthcare decisions on their behalf, in accordance with the resident's rights.On 03/23/2026 at 9:05 AM medical record review revealed no documentation to indicate that the facility provided information or education regarding advance directives to Residents #6, #10, #89, and #90 and/or their resident representatives. On 03/23/2026 at 8:01 AM interview conducted with the Social Worker (MSW) revealed that residents or their responsible party are asked upon admission whether an advance directive is in place. The MSW stated that if an advance directive is not in place, the facility provides the Maryland Attorney General's Office Advance Directive packet. When asked how the offering of advance directives to the resident or Responsible Party (RP) is documented, the MSW stated documentation is inconsistent, stating, sometimes I document, sometimes I don't. On 03/24/2026 at 8:19 AM, the surveyor and the Social Worker (MSW) conducted a record review of Residents #6, #10, #89, and #90's charts and electronic health records (EHR). The MSW confirmed that there was no documentation to indicate that information or education regarding advance directives had been provided to the residents and/or their Responsible Parties (RPs).

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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 interview and record review, it was determined that the facility failed to ensure that a resident who is unable to carry out activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was evident for 1 of 1 resident (Resident #118) reviewed for ADL care.The findings include:Activities of Daily Living (ADLs) are defined as basic self-care tasks, including bathing, dressing, toileting, transferring, eating, and personal hygiene, that are necessary to maintain a resident's health and well-being.On 03/23/2026 at 12:34 PM, this surveyor conducted an interview with Resident #118's family member, who reported concerns that the resident's ADL care was not being carried out on 11/09/2025.On 03/23/2026 at approximately 1:00 PM, this surveyor conducted a record review of Resident #118's electronic health record. Review of the Minimum Data Set (MDS), completed on 10/03/2025, revealed the resident was assessed as dependent for oral hygiene, toileting hygiene, shower/bath self, upper body dressing, lower body dressing, personal hygiene, and tub/shower transfer. The MDS defines dependent as staff performing all of the effort, with the resident completing none of the activity, or the assistance of two or more staff members required for the resident to complete the activity.On 03/25/2026 at approximately 3:00 PM, this surveyor conducted a record review of ADL documentation for 11/09/2025. Record review revealed no documented evidence of ADL care provided during the 1500-2300 and 2300-0700 shifts. There was no documentation for bathing, bed mobility, bowel care, dressing, oral hygiene, personal hygiene, toileting, toileting hygiene, or transfers.On 03/26/2026 at 10:44 AM, this surveyor conducted an interview with the Director of Nursing (DON) regarding the lack of documented ADL care for the identified shifts. The DON acknowledged the concern.

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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 interviews and record review it was determined that the facility failed to ensure a Resident was free of accidents. This was found to be evident for 1 (Resident #2) out of 1 Resident reviewed for accidents during the recertification and complaint survey. The findings include: During an interview conducted on 03/22/2026 at 8:46 AM, Resident #2 reported that during incontinent care Geriatric Nursing Assistant (GNA) #7 raised the bed to a high position and rolled the Resident on their right side. The GNA told the Resident that she needed to get a washcloth and that she would be right back. The GNA left the Resident on his/her right side and the bed in a high position. The Resident reported that he/she rolled off the bed onto the floor and hit his/her head. The Resident reported that he/she was not injured. The Minimum Data Set (MDS) 3.0 is a standardized, federally mandated assessment tool for nursing home residents, implemented by CMS to improve care quality. It collects comprehensive data on functional, cognitive, and health status (e.g., mobility, pain, medications) at scheduled intervals to guide care planning, quality monitoring, and reimbursement.During a review of Resident #2's MDS assessment conducted on 03/25/2026 at 8:59 AM, it was discovered that the Resident was assessed as dependent for incontinent care requiring 2 staff assistance. According to MDS a dependent resident relies on the helper to make all the effort. The Resident does none of the effort to complete the activity. The dependent Resident requires assistance from 2 or more helpers to complete the activity.ˆDuring an interview conducted on 03/25/26 at approximately 9:15 AM, the Nursing Home Administrator (NHA) confirmed that GNA #7 left Resident #2 unattended, on his/her right side with the bed raised to a high position. As a result, Resident #2 fell off the bed to the floor. During an interview conducted on 03/25/26 at approximately 10:30 AM, the Director of Nursing (DON) confirmed that Resident#2's MDS assessment identified the Resident as being dependent and required 2 staff assistance when care was provided. The DON reported that he had started an in-service education on providing appropriate care for dependent residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews it was determined that the facility failed to store medications to ensure medications remained safe and effective. This was evident for 1 (Western [NAME] Unit) out of 3 Refrigerators used for medication storage.The findings include:During an observation of the medication storage refrigerator on the Western [NAME] Unit on 3/23/2026 at 10:09 AM with Licensed Practical Nurse (LPN) #11 it was observed that the medication storage refrigerator was at 64 degrees Fahrenheit. The refrigerator had several medications stored inside that included insulin: Mounjaro autopens, Lispro autopens, Humulin 70/30 autopens, Lantus; suppositories: Acetaminophen and Bisacodyl; and Tuberculosis Purified Protein Derivatives (PPD).During an interview with Licensed Practical Nurse (LPN) #11 on 03/23/2026 at 10:09 AM she reported night shift checks the refrigerator temperatures and records them in a log nightly.During a review of the Refrigeration Monitoring Quality Assurance Record log for the Western [NAME] Unit medication refrigerator on March on 03/23/2026 at 10:10 AM it revealed there was no documentation for the medication refrigerator being checked on the night shift of 3/22/2026.During an observation with the Western [NAME] Unit Manager on 3/23/2026 at 10:16 AM she confirmed the temperature in the refrigerator was too high. She reported that the medication refrigerator should be checked nightly and documented in the Refrigeration Monitoring log. She confirmed it was not signed off as being checked on 3/22/2026 and advised it should have been signed off by the night nurse.During a review of the facility Storage and Expiration Dating of Medications and Biologicals medication storage policy on 03/23/2026 at 1:41 PM it revealed that Facility should ensure medications and biologicals are stored at their appropriate temperatures and identified the refrigeration storage temperature should be 36 - 46 degrees Fahrenheit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and interviews it was determined that the facility failed to have a medication error rate of less than 5% during the medication observation facility task. This was evident for 2 medication errors out of 37 opportunities which resulted in a medication error rate of 5.41%.The findings include:1. During an observation of Certified Medication Aide (CMA) #10 on 3/23/2026 at 8:49 AM she completed her medication administration to Resident #83.During a review of the Medication Administration Record (MAR) for Resident #83 on 3/23/2026 at 8:56 AM it was discovered that the Resident also had an order to receive eye drops that had not been given. The order was for Carboxymethylcellulose Sodium Ophthalmic Liquid (Carboxymethylcellulose Sodium (Ophth)) Instill 1 drop in both eyes four times a day for dry eyes on drop in each eye four times a day.During an interview with CMA #10 on 3/23/2026 at 8:58 AM she reported that she had given all the medications due to Resident #83 at that time and advised that she didn't see an order for eye drops for Resident #83.During an observation of CMA on 3/23/2026 at 9:01 AM she confirmed the Resident had an active order and Resident #83 was due to get the eye drops listed in the order. She returned to administer the medication to Resident #83.2. Oxycodone is an immediate-release, short-acting opioid medication used for acute pain, while OxyContin is a brand-name, extended-release version of oxycodone designed for long-term, around-the-clock pain management. Oxycodone acts in 4-6 hours, whereas OxyContin works over 12 hours.During an observation of Licensed Practical Nurse (LPN) #3 on 3/24/2026 at 8:46 AM she was gathering medication to administer to Resident #2. While collecting the medication for Resident #2 she came to an order for OxyContin Oral Tablet ER 12 Hour and instead of OxyContin 10 mg she added Oxycodone 10 mg to the medication cup to be given to Resident #2.During an interview with LPN #3 on 3/24/2026 at 8:48 AM she reported that Resident #2 had run out of Oxycontin yesterday, so she was giving him/her Oxycodone in place. She reported that she did not notify the doctor to advise Resident #2 was out of Oxycontin and did not obtain an order to administer Oxycodone in place of the Oxycontin. She administered Oxycodone 10 mg to Resident #2 in place of Oxycontin 10 mg.During a review of the MAR for Resident #2 on 3/24/2026 at 9:52 AM it was discovered that he/she was receiving Oxycodone 10 mg until 3/07/2026 when it was discontinued and replaced with Oxycontin 10 mg. The Resident had no active order for Oxycodone 10mg. Additional review of the MAR showed that the Oxycontin 10 mg was signed off as given by LPN #3 although it was Oxycodone that was administered.During an interview with the Director of Nursing (DON) on 3/24/2026 at 10:12 AM he advised the nurse should have notified the doctor to make aware of the unavailability of the Oxycontin and requested an order for the Oxycodone 10 mg as a replacement.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews it was determined that the facility failed to ensure food was prepared and served on sanitary pans, dishes and utensils. This was found to be evident for 1 out of 1 commercial dishwasher observed during the recertification and complaint survey. The deficient practice has the potential to affect all residents who consume liquids and food. The findings include: 3-bay Compartment Sinks maintains proper sanitization. Each sink bowl (bay) serves a different role, one for rinsing, washing, and sanitizing. During an observation conducted on 03/22/26 at 8:49 AM, the Surveyor observed Dietary Aide #13 rinsing silver metal pans in the 3-bay compartment sink. The Surveyor observed one bay with water, the bay for washing and sanitizing was empty. The Surveyor asked why the other 2 bays weren't filled, the Dietary Aide replied that he was rinsing the pans before placing them in the dishwasher so there was no need to fill the other 2 bays. Center of Medicaid and Medicare Services (CMS) requirements for hot water dishwashers in facilities like nursing homes mandate that high-temperature machines must achieve a wash temperature of at least 150 degrees Fahrenheit (F) and a final sanitizing rinse of 180 degrees (F) to effectively kill bacteria. For stationary rack, single-temperature machines, the requirement is a minimum of 165 degrees (F). During an observation conducted on 03/26/2026 at 8:48 AM in the kitchen, the Surveyor and Certified Dietary Manager (CDM) observed the hot water dishwasher not meet the required final rinse of 180 degrees (F). The CDM ran 5 trays through the dishwasher with the final rinse ranging between 138-140 degrees (F). The CDM reported that she would notify the Maintenance Director. The Surveyor and CDM reviewed the dishwasher temperature log for the month of March. Each day from 3/1/26-03/26/26 showed the wash temp was 150 degrees (F) and the final rinse was 180 degrees (F). The CDM reported that she realized that the temperatures were the same for each day since 3/1/26 were unlikely since the final rinse was failing to meet 180 degrees (F). She further reported that she would immediately conduct education for the dietary staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, it was determined that the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee consisted of the minimum required members. This deficient practice had the potential to affect all residents. This was identified during the QAPI/QAA facility task during the annual/complaint survey.The findings include:On 03/26/2026 at 10:11 AM, the Administrator provided the QAPI (Quality Assurance and Performance Improvement) binder for review. The Administrator reported that there were impacts to QAPI meetings due to unfilled clinical staff positions. On 03/26/2026 at approximately 11:00 AM, this surveyor conducted a record review of the QAPI binder, including QAA committee meeting attendance and signatures. Record review revealed that for the QAPI meeting dated 10/23/2025, there was no documented attendance or signature for the Administrator or Infection Preventionist. For the meeting dated 11/17/2025, there was no documented attendance or signature for the Infection Preventionist. For the meeting dated 12/19/2025, there was no documented attendance or signature for the Infection Preventionist.On 03/26/2026 at 11:36 AM, this surveyor conducted an interview with the Administrator regarding QAPI meeting attendance. The Administrator confirmed that there was no documented attendance or signature for the Administrator or Infection Preventionist on 10/23/2025, and no documented attendance or signature for the Infection Preventionist on 11/17/2025 and 12/19/2025.On 03/26/2026 at 11:52 AM, during continued interview, the Administrator reported that there were issues with attendance and confirmed that the facility did not ensure the minimum required members were present at each QAPI meeting. The Administrator acknowledged the concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to provide a safe and sanitary environment. This was found to be evident for 2 (Resident #2 & #130) out of 20 Residents observed for Infection Control during the recertification and complaint survey. The findings include: 1) A Foley catheter bag collects urine from a flexible tube (catheter) inserted into the bladder, typically holding 600–900 mL (leg bags) or up to 2000 mL (bedside bags). Always keep the bag below waist level to use gravity for draining and prevent infection. Empty the bag every 3-4 hours or when it is 1/2 to 2/3 full. During an interview conducted on 03/22/2026 at 8:42 AM, the Surveyor observed Resident #2's bed in the lowest position with the foley catheter bag attached to the right side of the bed and lying on the floor. On 03/22/26 at 9:17 AM the Surveyor reported the observation to the assigned License Practical Nurse (LPN) #3. The Surveyor observed the LPN raise the resident's bed from the lowest position to a position that allowed the foley bag to no longer touch the floor. During an interview conducted on 03/22/26 at 9:19 AM, LPN #3 acknowledged that the foley bag should never touch the floor because of Infection Control concerns that could cause the resident to contract a urinary tract infection. She stated that she would speak with the unit manager for directions on deciding if the foley catheter bag should be replaced. 2) During an observation of Licensed Practical Nurse (LPN) #3 on 3/24/2026 at 8:46 AM it was observed that she used a portable blood pressure cuff and a pulse ox on Resident #2. When she was finished using the equipment she left the Resident's room and placed the cuff and pulse ox on top of her medication cart without being cleaned. During an observation of Licensed Practical Nurse (LPN) #3 on 3/24/2026 at 9:12 AM it was observed that she took the portable blood pressure cuff and pulse ox from the top of her medication cart and used the devices on Resident #130. When she finished using the cuff and pulse ox she left the Resident's room and placed the cuff on her medication cart without cleaning the equipment. During an interview with LPN #3 on 3/24/2026 at 9:26 AM she reported that she should have cleaned the equipment after using them on Resident #2 and #130. During an interview with the Director of Nursing on 3/24/2026 at 3:10 PM he confirmed that the blood pressure and pulse ox should have been cleaned after each use and before using on another Resident.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews it was determined that the facility failed to maintain an antibiotic stewardship program. This was found to be evident for 5 out of 5 Antibiotic stewardship line listings during the recertification and complaint survey. This deficient practice has the potential to affect all residents.The findings include:Antibiotic Stewardship Program (ASP) requires a facility to develop and implement policies, procedures and/or protocols to optimize the selection, dosage, route and duration of antibiotic therapy. This is to improve Resident outcomes, reduce the risk of residents having adverse reactions to antibiotics, receiving them unnecessarily and/or developing antibiotic-resistant organisms.An Infection Preventionist (IP) is responsible for the facility's Infection Prevention and Control Program. This position requires specialized training in infection control.Based on a review of a certificate of completion from the Centers for Disease Control and Prevention on 3/24/2026 at 1:27 PM it reported the Unit Manager for the Western [NAME] Unit had completed the Nursing Home Infection Preventionist Training Course on 3/06/2026.During an interview with the Unit Manager of the Western [NAME] Unit on 3/25/2026 at 12:33 PM she reported she was the full time Unit Manager of the Western [NAME] Unit and was assigned the role of Infection Preventionist (IP). She confirmed the monitoring of the antibiotic usage is the role of the facility IP.Line listing is a detailed list used by a team of clinicians to identify, track, and monitor suspected infections to ensure appropriate treatments. It is a table where each row represents a single case of disease (a person) and each column represents a specific variable, such as demographic information, clinical symptoms, or exposure history. During an additional interview with the Unit Manager of the Western [NAME] Unit on 3/26/2026 at 10:37 AM she provided documentation of the Line listings for the Antibiotic Stewardship for October through March. She reported that the Line Listings for October and November 2025 was incomplete.During a review of the Line Listings provided by the Unit Manager on 3/26/2026 at 12:25 PM it was discovered that the months October through February was incomplete for several residents. The site of infection was missing for some Residents, it was not identified if some Residents diagnosed with pneumonia had a chest x-ray which was a column to be completed, for Residents that had a chest x-ray completed there was no date of when it was completed. In addition, the column for Healthcare Acquired or Community Acquired infections was not documented on most residents.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews of the facility records, it was determined that the facility failed to designate an Infection Preventionist at least part time to be responsible for managing its Infection Prevention and Control Program. This was evident during the recertification survey. This deficient practice has the potential to impact all residents in the building. The findings include:An Infection Preventionist (IP) is responsible for the facility's Infection Prevention and Control Program. This position requires specialized training in infection control.Based on a review of a certificate from the Centers for Disease Control and Prevention on 3/24/2026 at 1:27 PM it reported the Unit Manager for the Western [NAME] Unit had completed the Nursing Home Infection Preventionist Training Course on 3/06/2026.During an interview with the Unit Manager of the Western [NAME] Unit on 3/25/2026 at 12:33 PM she reported she was the full time Unit Manager of the Western [NAME] Unit and was assigned the role of Infection Preventionist (IP). When asked about her role as an IP with the facility she reported, she doesn't have a lot of time to dedicate to the position due to her Unit Manager position. During an additional review with the Unit Manager of the Western [NAME] Unit on 3/26/2026 at 10:37 AM she reported that she was in the position as IP last year from March through April, then in April the Director of Nursing (DON) at that time took over the IP position, the Assistant Director of Nursing later took it over from the DON and now the IP position was given back to the Unit Manager of the Western [NAME] about three months ago and she reported she didn't have the time to complete the required duties of an IP due to being full time in the Unit Manager PositionDuring an interview with the Administrator on 3/26/2026 at 11:56 AM she confirmed that the Unit Manager was full-time in that position and had the IP role added to that duty.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews it was determined that the facility failed to maintain a safe, functional and sanitary environment. This was evident in the Laundry Washer Room and the Laundry Folding Room during the recertification survey. This practice has the potential to affect all Residents.The findings include:1. During an observation of the Laundry Washer Room on 3/23/2026 at 1:56 PM a leak was discovered dripping from a pipe in the ceiling and running down the wall in the corner near the dryer room. Additional observation revealed a large area of black staining along the wall and on top of the Ecolab dispensing system box where the water was leaking. Further observation showed a red bucket below the pipe that collected the dripping water.During an interview with Laundry Aide #14 on 3/23/2026 at 1:58 PM she reported the leak from the ceiling had been leaking off and on for a couple of months. She advised maintenance was aware and had worked on the leak.During an interview with the Maintenance Director on 3/23/2026 at 2:09 PM he reported he didn't know the Laundry Washer Room had a leak and began cleaning the wall while other maintenance staff worked on the leak reported to be coming from the kitchen. During a repeat observation of the Laundry Washer Room on 3/24/2026 at 8:08 AM it was revealed that the wall had been cleaned and the black staining was removed. There was no active leak present.During an interview with Maintenance Technician #15 on 3/24/2026 at 8:40 AM he reported that the leak was coming from the kitchen and looks like it's been going on for a while, but I didn't know about it. He advised the maintenance staff would be verbally notified by Laundry if there was an issue and he was not aware if this was done. During an interview with Laundry Aide #17 on 3/24/2026 at 9:57 AM she reported the leak in the corner of the laundry room near the dryer room was coming from the kitchen and it's been going on for a while. She advised she had reported the leak and maintenance was looking at it last week.During an interview with the Maintenance Director on 3/25/2026 at 10:50 AM he reported that each wing in the building had a book labeled maintenance requests to report any concerns, but the kitchen and Laundry relied on verbal notification to notify maintenance. He was unable to confirm if any of his maintenance personnel were aware of the leak from the ceiling since there was no documentation and he was not made aware of the concern. He reported that the leak into the laundry room was from a kitchen drain, the drain wasn't sealed, the seal wasn't good, it was old.During a repeat observation of the Laundry Washer Room on 3/26/2026 at 9:26 AM a leak was noted coming from the ceiling in the same area as the previous leak. The floor was wet and the red bucket under the leak from the ceiling had water inside.During an interview with the Nursing Home Administrator (NHA) on 3/26/2026 at 10:08 AM she reported that after discussing the concern of the leak from the ceiling with the Maintenance Director they concluded the current maintenance reporting system for the Laundry area was not working so they would add a binder for staff to report maintenance concerns, and it would be kept at the front desk.2. During an observation of the Laundry Washer Room on 3/23/2026 at 1:56 PM it was observed that the ceiling had large areas of peeling paint hanging from the ceiling and heating ducts. Additional observation revealed an overhead pipe that had an outer insulation casing which was torn with insulation exposed and hanging out.During an interview with the Maintenance Director on 3/25/2026 at 11:36 AM he reported the ceiling needed to be repainted and the pipe needed to be rewrapped.3. During an observation of the Laundry Washer Room on 3/23/2026 at 1:56 PM the vent ducts were noted to have large particles of visible dust, dust was also observed on the top of the washing machines and the hoses behind the washing machines.During an interview with the Director of Environmental on 3/24/2026 at 9:50 AM she reported that the laundry room should be cleaned daily and agreed the visible dust should not be on the vents, washing machines or the washing machine hoses.4. During an observation of the Laundry Washer Room on 3/24/2026 at 9:40 AM the UniMac washer on the left side of room was noted to be leaking with a large puddle behind the machine and a blanket had been laid under the leak at the back (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the machine.During an interview with the Maintenance Director on 3/24/2026 at 9:46 AM he reported the Laundry staff was to notify maintenance verbally if there were any issues that needed to be repaired. He advised he was not notified of the leak and was not aware of the leak coming from behind the washer.During an interview with Laundry Aide #17 on 3/24/2026 at 9:59 AM she advised the washer had been leaking every now and again but could not advise how long it had been leaking.During an interview with the Maintenance Director on 3/25/2026 at 10:50 AM he reported two leaks were discovered that needed to be repaired on the washing machine. He reported that each wing in the building had a book labeled maintenance requests to report any concerns, but the kitchen and Laundry relied on verbal notification to notify maintenance. He was unable to confirm if any of his maintenance personnel were aware of the leak from the ceiling since there was no documentation and he was not made aware of the concern.