

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/26/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Calvert Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1881 Telegraph Road Rising Sun, MD 21911	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and resident record review, it was determined that the facility failed to prevent an avoidable accident with injury to Resident #15 during a transfer from the wheelchair to the bed. The facility failed to implement interventions, including adequate supervision that was consistent with the resident's needs, care plan and current professional standards of practice to reduce the risk of an accident. As a result, Resident #15 suffered a fall with harm (femur fracture). This was evident for 1 (#15) of 3 residents reviewed for accidents during the recertification survey. The findings include: A sit-to-stand lift is a specialized mobility device designed to help individuals with limited leg strength safely transition from a seated position to a supported, standing posture. It allows caregivers to easily transfer a patient between two seated surfaces, such as moving from a bed to a wheelchair, or from a chair to a toilet. To ensure quality care and accurate reimbursement, Centers for Medicare and Medicaid Services (CMS) mandates the use of the Minimum Data Set (MDS), which is a comprehensive clinical assessment tool used for all residents. The Brief Interview for Mental Status (BIMS) is a specific cognitive screening test conducted within Section C of that broader MDS assessment. Based on the interview performance, residents receive a score where 13 to 15 points indicates they are cognitively intact, while 8 to 12 points signifies moderate impairment. On 5/18/2026 at 9:30 AM, Resident #15 was interviewed during the initial screening process of the recertification survey and stated they had a fall in January 2026. The fall resulted in them having to go to the hospital where they were told they had fractured their leg. Resident #15 stated that they believe their bed was too high and their legs were not secured in the sit-to-stand lift when transferring from their wheelchair to their bed. Resident #15 stated they had to wear a leg brace for a month and a half and cannot use their left leg as well as before fall. Resident #15 stated it was a Geriatric Nursing Assistant (GNA) using the sit-to-stand lift during the fall and named GNA #25. Resident #15's medical record was reviewed on 5/19/2026 at 10:19 AM. Resident #15 was admitted to the facility on [DATE] with a BIMS score of 14 on their MDS dated [DATE]. Per medical record documentation, the fall occurred on 1/19/2026. Review of Resident #15's care plan prior to the fall showed, Transfer-Stand-up Lift with 2 Assist was initiated on 12/6/2022 and revised on 9/2/2025. Review of the resident's Kardex dated 1/19/2026 showed Transferring: Transfer-Stand-up Lift with 2 Assist. A progress noted dated 1/19/2026 at 5:55 PM stated, status post fall with left limb shortened and externally rotated. Patient stating pain 10/10 on assessment. Transferred to Emergency Department for further evaluation. Care plan reviewed. All interventions current and appropriate, will continue. The discharge summary from the hospitalization was reviewed and showed Resident #15 was diagnosed with an acute left distal femoral fracture. On 5/19/2026 at 1:53 PM, the facility's Handling and Transfer policy was reviewed. Under Compliance guidelines section 4 it stated, Mechanical lifts may (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 0689 Level of Harm - Actual harm Residents Affected - Few	include equipment such as full body Hoyer lifts or sit to stand lifts. Under section 10 it stated, Two staff members must be utilized when transferring residents with a mechanical lift. On 5/20/2026 at 1:35 PM, the facility's internal incident report dated 1/19/2026 at 5:20 PM was reviewed. Under Nursing Description it stated, Witnessed fall in room during transfer with sit-to-stand device. Resident was in sit to stand device in standing position. [Resident #15] became unable to support [themselves] and began sliding downward. Nurse and GNA present lowered [them] to the floor, one staff supporting head. Noted to have shortened left limb with outward rotation. Additional review of the incident report did not identify staff members involved. Resident #15 and their roommate (Resident #45) were interviewed on 5/20/2026 at 9:46 AM. Resident #45 had a BIMS of 12 on their MDS with Assessment Referral Date (ARD) of 11/11/2025. Resident #15 stated there was only one staff member (GNA #25) in the room when they fell during transfer. Resident #45 confirmed that there was only one staff member in the room at the time of the fall. Both residents stated that a Registered Nurse (RN) came into the room after the fall. Resident #15 stated that the RN that came in was RN #23. On 5/20/2026 at 12:00 PM, the staffing assignment for 1/19/2026 was reviewed. GNA #25 and RN #23 were assigned to Residents #15 and #45 on 1/19/2026 for the 3-11 PM shift. During an interview on 5/21/2026 at 10:43 AM, GNA #25 stated that they were the GNA assigned to Resident #15 during the fall. The GNA stated they were assisting the resident using the sit-to-stand lift to transfer between Resident #15's wheelchair and their bed when the resident was unable to hold their stance and started to slide downward. GNA #25 stated that they initiated the lift transfer by themselves and were the only staff member in the room prior to the resident starting to fall. On 5/22/2026 at 10:25 AM, the Director of Nursing (DON) was made aware of surveyor concerns regarding Resident #15's fall and lack of a 2 person assist during the transfer process using the sit-to-stand lift. The DON stated this is the first time they have heard that only one staff member started the transfer process, and stated that it's the facility's expectation that the transfer would be conducted by two staff members per facility policy.		

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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, facility policy review, and staff interview, it was determined that the facility failed to maintain nutrition room refrigerators in a sanitary manner as evidenced by the facility failing to maintain safe cold-storage temperatures and failing to discard expired resident food. This was found to be evident in 1 (South Unit) of 2 unit nutrition rooms observed. This deficient practice created the potential for foodborne illness. The findings include: On 05/18/2026 at 1:38 PM, the South Unit nourishment room refrigerator was observed. The thermostat inside the refrigerator read 50 F. The May temperature log was observed not to be filled out on dates 5/8, 5/10, 5/13, and 5/17. On 05/19/2026 at 9:23 AM and 12:09 PM, consecutive follow-up observations confirmed the temperature remained at 50 F. On 05/19/2026 at 12:56 PM, an audit of the refrigerator contents revealed the following expired and unlabeled items: 1) A To Go food container for room [ROOM NUMBER]B dated 5/9/2026 (10 days old). 2) An egg salad sandwich for room [ROOM NUMBER]A dated 5/9/2026 (10 days old). 3) A To Go container with food for room [ROOM NUMBER]-B dated 5/13/2026 (6 days old). 4) [NAME] Callender's Macaroni and Cheese meal stored in the refrigerator instead of the freezer, which lacked a name and date label. On 05/19/2026 at 12:48 PM, a review of the facility's Outside Food Policy was conducted. The policy stated: The prepared food must be consumed by the residents within 3 days of the labeled date. On 05/19/2026 at 2:00 PM, the Director of Nursing (DON) joint-reviewed the South Unit nourishment refrigerator with the surveyor. The DON confirmed the thermometer read 50 F, the temperature log was incomplete, and items exceeded the 3-day storage policy. The DON stated staff would immediately discard the outdated food items and contact maintenance to service the refrigerator.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and staff interviews, it was determined that the facility failed to ensure that the residents' call bell system was functioning properly as evidenced by the call bell system monitor being turned off at the nurses' station. This was evident for observations of the North 1 Unit environmental tours during the recertification survey. The findings include: On 05/19/26 at 10:20 AM, the surveyor activated a call bell and observed that there were no audible or visual notifications of the request viewable from the nurses' station. On 05/19/26 at 10:21 AM, LPN #16 was interviewed. She verified that the call bell system monitor by the nurses' station was not on. LPN #16 attempted to power on the call bell system monitor, however the monitor displayed an error message reading no signal. She revealed that the night shift staff regularly turned off the call bell system due to the high volume. On the morning of 05/20/26, the surveyor observed that the call bell system was still turned off. On 05/20/26 at 10:52 AM, the surveyor interviewed the Director of Facilities and Maintenance Aid #19. The Director of Facilities confirmed surveyor observations that the call bell system monitor was turned off and confirmed that the call bell system should be on at all times. The surveyor observed the Director of Facilities restart the call bell system monitor. Maintenance Aid #19 stated that the night shift staff have been turning the system off.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interviews, it was determined that the facility failed to maintain resident's right to a dignified existence as evidenced by clothing labeled with the resident's name visible from the outside. This was evident for 1 (Resident #84) of 2 residents investigated for dignity. The findings include: On 05/19/26 at 9:53 AM, the surveyor observed Resident #84 sitting in the hallway with their name labeled on the top surface of both socks. Geriatric Nursing Assistant (GNA) #26 was interviewed on 05/21/26 at 8:46 AM. During the interview, GNA #26 revealed that resident clothing is tagged for laundry. Interview with the DON on 05/21/26 at 9:05 AM confirmed that laundry services label residents' clothing with their names.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, sanitary, and safe environment. This was evident for 1 of 4 units (North 1) observed during environmental tours in the facility. The findings include: Emergency pull cord is a safety device that is triggered by pulling a cord to alert staff that a resident has fallen or needs immediate help. The cord should end near the floor ensuring a resident can reach it if they fall. A medicine cup with pink colored fluid was observed on the windowsill in the women's shower in North 1 on 05/18/26, 05/19/26, and 5/20/26. The Director of Facilities was made aware and the medicine cup was removed by Environmental Supervisor #18 on 05/20/26 approximately at 11:00 AM. On 05/18/26 surveyors also observed on unit North 1: There was no emergency pull cord by 1 of the women's toilets. The emergency pull cord in the women's shower and men's toilet did not reach the floor. A wall-mounted hand sanitizer dispenser in the hallway was not covered. The hallway walls were damaged with missing paint, cuts, dents, and scuff marks. The surveyor interviewed the Director of Facilities on 05/20/26 at 10:52 AM. During the interview the Director of Facilities acknowledged that the emergency pull cord in the women's shower and men's toilet could not be reached by a resident from the floor. He confirmed that the women's toilet did not have an emergency pull cord. On 05/20/26, the surveyor interviewed Environmental Supervisor #18 with the Director of Facilities present. Environmental Supervisor #18 stated that shared areas including the bathroom and showers were cleaned daily. Her statement was confirmed by the Director of Facilities. On 05/21/26 at 8:46 AM, the surveyor observed a brown stain on the privacy curtain in Resident #47's room. The DON was notified on 05/21/26 about the observed stain on the curtain. On 05/22/26, the DON confirmed that the stained curtain was replaced with a clean curtain.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure a baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP). This was evident for 1 (Resident #14) out of 50 residents reviewed during the facility's recertification survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to the resident and/or RP and there must be evidence in the medical record that it was provided. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 5/21/26 at 8:56 AM in an interview with the Director of Nursing (DON) when asked about the facility's process for BLCP's she stated there was a BLCP assessment that was completed. During the interview, she stated, We print a copy of it and their med (medication) list and give to the resident and/or family. When asked where it was located, she stated, Evaluations tab and a progress note saying a copy was provided. On 5/19/26 at 9:11 AM review of Resident #14's medical record revealed he/she was admitted to the facility on [DATE]. Further review of the medical record revealed a BLCP; however, failed to reveal evidence from the medical record that a copy was given to the resident and/or RP. Continued review revealed the AUTM Baseline Care Plan - V 4 and on the final page was SECTION 7. BLCP Summary and Signatures. Review of this section failed to reveal a signature in the field titled Signature of Resident and Representative. Additionally, there was no progress note that mentioned providing a BLCP to the resident and/or RP. On 5/21/26 at 12:50 PM in an interview with the DON interview, the surveyor shared the concern that for Resident #14 there was no signature on the BLCP assessment or any other evidence from the medical record that the resident/RP received it. The DON stated she would check if there was a progress note documenting that the resident/RP received the BLCP. On 5/21/26 at 1:56 PM in an interview with the DON when asked about evidence from the medical record that Resident #14 and/or his/her RP received the BLCP, she stated, I cannot find that. The surveyor shared this was a concern. The DON acknowledged understanding of the concern.		

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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 medical record review and resident and staff interviews it was determined the facility staff failed to ensure that dependent resident's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 1 of 32 (#25) residents reviewed during the survey process. The findings include: The Minimum Data Set (MDS) is a federally-mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. In an interview with Resident #25 on 05/19/2026 9:40 AM, when Resident #25 was asked about their care, they stated that the only concern they had was that they didn't get a shower on most Tuesdays. The resident stated they were scheduled for a shower on Tuesdays during day shift and Fridays during evening shift. The resident stated that they consistently got their shower on Friday but rarely got it on Tuesday. Review of Resident #25's most recent MDS completed on 5/19/26 revealed that s/he is totally dependent for bathing requiring extensive assistance for all Activities of Daily Living (ADL). The Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating adequate cognitive ability. Further review of Resident #25's shower schedule which is every Tuesday and Friday, as well as the Geriatric Nursing Assistant (GNA) task documentation of Activity of Daily Living (ADL) revealed that for Resident #25 from 4/1/2026 until 5/20/2026, only received shower on 8 out of the 14 days they were to receive a shower. On 5/21/2026 at 9:40 AM, the Director of Nursing (DON) was made aware of this concern and was unable to explain why this had occurred.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observations, record review, and staff interview, it was determined that the facility failed to follow a doctor's wound care order. This was evident for 1 (Resident #47) of 50 residents reviewed in the investigation phase of the survey. The findings include: ACE bandage: a stretchable cloth used to provide adjustable pressure and support for muscle sprains, strains, and swelling. On 05/18/26 at 8:32 AM, the surveyor observed Resident #47's left lower leg wrapped in an ACE bandage. Resident #47's medical record was reviewed on 05/20/26 at 9:38 AM. The review revealed a doctor's order to discontinue ACE bandage wrap to left leg for gentle compression effective 05/15/26. On 05/20/26 at 10:40 AM, the surveyor observed Resident #47's left lower leg wrapped in an ACE bandage. On 05/21/26 at 9:00AM, the Director of Nursing (DON) was interviewed. During the interview, the DON confirmed that there were no active ACE bandage wrap orders for Resident #47's left leg after 5/16/26.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to monitor and follow physician orders to obtain a resident's weight. This was evident for 1 (Resident #14) of 4 residents reviewed for nutrition during the facility's recertification survey. The findings include: On 5/19/26 at 9:11 AM review of Resident #14's medical record revealed he/she was originally admitted to the facility on [DATE]. Further review revealed that on 4/27/26 he/she was identified as Malnourished on his/her admission nutritional assessment. Continued review revealed the following physician order, Weigh resident weekly x4 weeks, then monthly if stable which was ordered on his/her admission date, 4/27/26. Review of Resident #14's weights revealed he/she was weighed three times since admission. On 4/27/26, the resident weighed 166 pounds, 4/28/26 weighed 161 pounds, and on 5/1/26, the resident weighed 161.2 pounds, which is a 2.89% loss in less than a week. According to the State Operations Manual (2025), 5% weight loss in 1 months' time is considered Significant Loss with regards to a resident's weight. On 5/19/26 at 10:16 AM review of Resident #14's medical record revealed an assessment, AUTM Nutrition Evaluation - V 2 dated 5/4/26. Continued review revealed the following questions and responses documented by the Registered Dietician (RD #33): Is there an actual or potential Nutritional Problem? Yes= varied intakes, impaired skin integrity Is there an active Nutrition Problem identified? Yes Nutrition Interventions: Monitor wts (weights), intakes & labs as available On 5/22/26 at 8:51 AM in an interview with RD #33 when asked about her role in the facility regarding residents' weight loss, she stated she reviewed their weights to see who triggered for weight loss. During the interview she stated that nursing staff should reweigh a resident if there was a 5 pound weight change. Additionally, she stated, Sometimes I have to remind nursing to reweigh. When asked if she monitored residents' weights, she stated, Yes, I can't say daily, but weekly. It's an ongoing process. When asked how she monitored the residents' weights, she stated by going into PCC (Point Click Care, the electronic medical record) and reviewing their weights. When asked how she knew if a resident had lost weight, she stated by reviewing their weights and I have a weight log that I use because I know PCC looks for any in between weights (and clarified in between to mean not just monthly weight loss but in between each month). When asked to explain the weight log she stated it was an excel program she used to plug in and monitor residents' weights. During the interview when asked if when she logged into PCC there was a dashboard that notified her of residents who had lost weight she stated yes. When asked once PCC had triggered a resident with weight loss, what were her next steps, she stated, I will go in and do a review to assess their intakes, weights, diet, skin, and labs. Then I go visit the resident to see what was going on during the time frame they would have triggered. When asked if the facility held any meetings where weight loss was discussed, she stated, We have our weekly Risk meetings where weight loss is discussed and our morning clinical meeting where weight loss is also discussed. When asked if Resident #14 was at risk for impaired nutritional status, RD #33 stated, Well, we consider everyone at risk. When asked if Resident #14 was discussed in any of the risk or morning clinical meetings for weight loss, she stated, No, not specifically as a weight loss. When asked if she was monitoring Resident #14's weights weekly, she stated, I cannot say I looked specifically at them. The surveyor shared the concern that there were no weights obtained for Resident #14 past his/her first week of admission to the facility. The resident was not weighed on 5/4/26, 5/11/26, or 5/18/26 as per the physician order. RD #33 acknowledged understanding of the concern. The surveyor then shared the concern that on Resident #14's admission nutritional assessment he/she was identified as (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Malnourished, in less than one week he/she lost 2.9% of his/her body weight, that in her 5/4/26 nutrition evaluation she documented Resident #14 as malnourished, noting weight loss from his/her admission [DATE] to 5/1/26 of 166 pounds to 161.2 pounds, documented there was an actual or potential nutritional problem, and in the nutrition interventions section documented that she would be monitoring the resident's weights; however, she failed to monitor the weights as confirmed and verified by her interview. RD #33 acknowledged understanding of the concern. The facility policy, Weight Monitoring, was reviewed on 5/22/26 at 11:37 AM. The review revealed, Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a) Identifying and assessing each resident's nutritional status and risk factors, b) Evaluating/analyzing the assessment information, c) Developing and consistently implementing pertinent approaches, d) Monitoring the effectiveness of interventions and revising them as necessary. Further review revealed, Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. On 5/22/26 at 9:24 AM in an interview with the Director of Nursing (DON) when asked about the process for new admissions regarding weight, she stated, that residents were weighed within the first 24 hours of admission and then they should be weighed weekly x 4 [weeks] as long as their weight was stable. When asked who was responsible for entering the weights into PCC, she stated typically the nurses. When asked if the nurses or whomever entered the weights into the system were immediately able to see if the resident had lost weight, she stated yes, it would be flagged. When asked what happened when weight loss was noted, she stated the resident would be reweighed, typically the same shift or sometimes the next day. When asked whose responsibility it was to monitor residents' weights, she stated, Historically it's always been the dietician who keeps an eye on weights and weight losses/gains, but everyone should be involved. The surveyor shared the concern that RD #33 was not monitoring Resident #14's weights as verified and confirmed in her interview nor was the resident being weighed as per the physician order. The DON acknowledged understanding of the concern.		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Calvert Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1881 Telegraph Road Rising Sun, MD 21911	
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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 observations, medical record review, policy review, and staff interviews, it was determined that the facility failed to provide respiratory care consistent with professional standards and facility policy related to oxygen administration and nebulizer care. This is evident for 2 (Residents #3 and #47) of 6 residents reviewed for respiratory care during the recertification survey. The findings include: Supplemental oxygen: a medical treatment that delivers concentrated oxygen to individuals who cannot get enough through normal breathing. Flow rate: the amount of supplemental oxygen delivered per minute, typically measured in Liters Per Minute (LPM). Humidifier bottle: a bottle of sterile, distilled water that adds moisture to continuous-flow oxygen therapy to prevent dry, irritated, and bleeding nasal passages. Nasal cannula: a thin, flexible plastic tube that delivers supplemental oxygen directly into the nose. A nebulizer is a medical device that transforms liquid medication into a fine, breathable mist. Patients inhale this mist through a mouthpiece or face mask to deliver treatment directly into their lungs and airways. 1. On 05/18/26 at 8:35 AM and 05/19/26 at 9:58 AM, the surveyor observed Resident #47 receiving supplemental oxygen through a nasal cannula at a flow rate of 3 liters per minute (LPM). The nasal cannula was not labeled or dated. The humidifier bottle was dated 05/14/26. On 05/20/26 at 8:38 AM, Resident #47's medical record was reviewed. The record revealed a physician order effective 01/28/26 directing staff to change oxygen tubing and humidification bottle every Wednesday during the 11-7 shift and to date and initial the equipment when changed. The medical record also revealed an active physician order for oxygen at 2 LPM via nasal cannula beginning 02/24/26. On 05/20/26, the facility policy titled Oxygen Administration dated 10/27/25 was reviewed. The policy stated, Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated, and Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Licensed Practical Nurse (LPN) #16 was interviewed on 05/20/26 at 10:37 AM. LPN #16 verified that facility policy required oxygen tubing and humidifier bottles to be changed weekly during the 11-7 shift and dated and initialed when changed. LPN #16 stated nursing staff were responsible for reviewing physician orders to determine the scheduled change day. During a joint observation with the surveyor, LPN #16 confirmed the oxygen tubing was not labeled, the humidifier bottle was dated 05/14/26, and the oxygen flow rate was set at 3 LPM. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/26 at 8:40 AM, the surveyor observed Resident #47's nasal cannula dated 05/21/26; however, the humidifier bottle remained unlabeled and the oxygen flow rate was set at 2.5 LPM. 2. On 05/18/26 at 12:34 PM, Resident #3's nebulizer machine was observed on the bedside table with an attached nebulizer face mask. No label with date or time was observed on the nebulizer machine or nebulizer mask to indicate when the equipment was last changed. The nebulizer mask was not stored in a clean bag and was laying directly on the bedside table. On 05/19/26 at 9:25 AM, the nebulizer mask was observed laying on Resident #3's pillow, not stored in a bag, and without a date or time label. On 05/19/26 at 12:08 PM, the nebulizer mask was observed hanging on the side of Resident #3's bed, not stored in a bag, and without a date or time label. On 05/18/26 at 1:42 PM, the facility's nebulizer policy was reviewed. The policy directed staff to change nebulizer tubing every seventy-two hours or per facility policy and to store the nebulizer cup and the mouthpiece in a zip lock bag. On 05/19/26 at 2:05 PM, the Director of Nursing (DON) toured Resident #3's room with the surveyor. The DON observed the nebulizer mask hanging on the side of the resident's bed without a date or label and not stored in a bag. The DON stated it was the facility's expectation that nebulizer tubing be changed weekly or when dirty and stored in a bag when not in use. These concerns were discussed with the DON on 05/21/26 and again on 05/22/26 at 11:50 AM.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure bed rails were used in accordance with facility policy and physician orders. This is evident for 2 (Residents #1 and #16) of 2 residents reviewed for bed rail use. The findings include: On 05/18/2026 at 10:36 AM, Resident #16 was observed in bed with bilateral upper bed rails in the raised position. At 12:45 PM, review of the electronic medical record (EMAR) for Resident #16 revealed no physician order for bed rail use. On 05/19/2026 at 8:30 AM, Resident #1 was observed in bed with bilateral upper bed rails in the raised position. At 8:57 AM, review of the EMAR for Resident #1 revealed no physician order for bed rail use. On 05/20/2026 at 9:38 AM, review of a bed rail assessment completed earlier that day at 6:25 AM for Resident #1 revealed the question, Does the resident request use of enabler bars for assistance with bed mobility? was marked No. The assessment further indicated No benefits noted at this time regarding bed rail use. At 9:48 AM, Resident #1 was again observed in bed with bilateral upper bed rails in the raised position. At 10:44 AM, the Director of Nursing (DON) was notified of Resident #1 being observed with bed rails in use despite the assessment documentation indicating no identified benefit. At 11:30 AM, during interview, the DON stated the nurse had completed the bed rail assessment incorrectly and had been re-educated. The surveyor identified that a previous bed rail assessment dated [DATE] also documented no identified benefit and indicated the bed rails were not recommended for use. The surveyor further informed the DON that Resident #1 had been observed with bed rails in use both prior to and after completion of the assessment. At 12:02 PM, the surveyor requested the facility's bed rail policy from the DON. At 12:22 PM, review of the facility's bed rail policy provided by the DON revealed, Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bedrail. At 12:25 PM, during interview regarding initiation of bed rail use, the DON did not indicate the need for a physician order. The DON was informed that Residents #1 and #16 had been observed using bed rails without physician orders in place, contrary to facility policy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, it was determined that the facility failed to ensure medications were stored in accordance with professional standards and manufacturer guidelines by failing to date an opened multidose medication vial. This is evident for 1 of 2 medication storage rooms reviewed. The findings include: On 05/21/2026 at 11:52 AM, a medication storage observation was conducted. An opened box containing an opened vial of Tuberculin Purified Protein Derivative, Diluted Aplisol 1 mL was observed without a date indicating when the vial had been opened. This vial was intended for multiple uses and was kept in a medication refrigerator among other medications. The directions on the side of the box stated that the vial was to be discarded 30 days after opening and no date was found on the box or the vial indicating when it had been opened. At 12:06 PM, the Director of Nursing (DON) was presented with the vial and box and notified of the findings.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review, it was determined that the facility failed to assist a resident in obtaining routine and necessary dental services. This is evident for 1 (Resident #1) of 1 resident reviewed for dental services. The findings include: On 05/19/2026 at 8:47 AM, Resident #1 stated during interview that they had not seen a dentist. On 05/20/2026 at 8:29 AM, review of the current care plan for Resident #1 in the electronic medical record revealed the following, The resident has dental health problems r/t (related to) cavities and broken, chipped teeth. At 8:33 AM, review of dental/oral evaluation documentation revealed assessments completed on 03/29/2025, 09/21/2025, and 02/09/2026 identified concerns with Resident #1's teeth. On 05/20/2026 at 11:30 AM, the Director of Nursing (DON) stated the resident refused a dental appointment when asked that day. The surveyor shared the concern that the resident had resided in the facility since 2023, was identified as having dental concerns, and did not have documentation to show dental services had been provided or consistently offered. On 05/21/2026 at 12:06 PM, the DON provided documentation showing the resident declined a dental appointment on 04/01/2025. No additional evidence was provided to show the facility had arranged or attempted to obtain routine dental services despite ongoing identified dental concerns.		

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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 staff interviews it was determined that the facility failed to 1.) follow infection control policy and procedure by maintaining and storing the face mask and tubing for a resident's nebulizer in the manner that was consistent with the facility's policy and procedure, and 2.) ensure staff performed appropriate hand hygiene during medication administration and resident care to prevent the potential spread of infection This was evident for 1 out of 32 residents sampled and for 1 (Staff #34) of 3 staff observed during medication administration observations. The findings include: 1.) During initial observation on 05/18/2026 at 10:25 AM, Resident # 71's Nebulizer mask was seen on the bookshelf next to the resident's bed uncovered, and neither the tubing or the mask had a date on them. During an observation on 05/19/2026 at 9:45 AM the Nebulizer mask was observed appropriately covered and sitting on the nebulizer machine in a bag with the date, but the tubing was not connected and on the floor, slightly under the bed and was not dated. The policy and procedure for maintaining was requested and received from the DON. This policy stated that the mask should be rinsed with sterile or distilled water, then placed on a paper towel to dry before being returned to a plastic bag that has the date it was put in use. Employee # 18 regarding the cleaning and storage of the mask and tubing and they stated that the rinsed the mask with tap water and allowed it to dry on a paper towel. When asked if they were aware that distilled or sterile water was supposed to be used they said no and that they would review the policy. They also stated that they had repeatedly reminded their co-workers to date the mask and tubing. During follow-up observations on 05/22/2026 at 10:05 AM The Nebulizer mask was attached to tubing and sitting on the shelf next to the nebulizer uncovered. Again, neither the mask or the tubing were dated. 2.) On 05/21/2026 at 8:32 AM, Staff #34 was observed administering medications to Resident #157. After completing the medication administration, Staff #34 used bare hands to adjust the resident's leg in bed. Staff #34 then exited the resident's room without performing hand hygiene and began preparing equipment to enter the room of Resident #154. Surveyor intervention occurred when Staff #34 put on gloves and attempted to enter Resident #154's room without first performing hand hygiene. On 05/26/2026 at 11:12 AM, the Director of Nursing was informed of the infection control concern involving Staff #34 failing to perform hand hygiene between care provided to Residents #157 and #154 during medication administration.		