STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215193	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts of Augsburg	6811 Campfield Road Baltimore, MD 21207

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **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 maintain an effective infection control program. Specifically, the facility failed to: 1) follow infection control practices consistent with accepted standards of practice, 2) prevent oxygen tubing from resting on the floor, 3) review and revise infection control policies and procedures annually, and 4) provide required follow-up care for a resident with a major infection. This was evident for 1 out of 4 nursing units reviewed, one of three residents reviewed for oxygen therapy (Resident #6), five of five facility policies reviewed, and one of one resident (Resident #89) reviewed for Transmission-Based Precautions during the facility's recertification survey. The findings include:According to the Centers for Disease Control (CDC), dirt and germs can live under fingernails and contribute to the spread of some infections, such as pinworms. 1) On 12/2/25 at 11:43AM Geriatric Nursing Assistant (GNA #6) was observed in the dining room on the Sudbrook unit cutting his fingernails. At that time, residents were sitting in the dining area, engaged in activities. The observation lasted approximately 5 minutes upon which GNA #6 noticed the surveyor, stopped, stood up, and walked out of the dining room. The surveyor then approached GNA #6 and in an interview, when asked if he was on a break, he stated, Yes, I took my 15 minutes. The surveyor shared the concern that he was clipping his fingernails which were falling all over the floor in a dining room where residents eat and were occupying at that moment. GNA #6 acknowledged understanding. On 12/2/25 at 12:28 PM in an interview with the Regional Nursing Home Administrator (RNHA #5) and the facility's Nursing Home Administrator (NHA), when asked the expectation regarding staff grooming and personal hygiene tasks, RNHA #5 stated, If they have to attend to a personal item. I would expect them to get off the floor and address it. During the interview when asked if they should be taking care of personal hygiene tasks in a public space such as the facility's dining room, he stated, It is not the expectation for staff to be taking care of personal hygiene in a public space. The surveyor shared the concern with RNHA #5 and the Nursing Home Administrator, that GNA #6 was clipping his fingernails in the dining room on the 2nd floor Sudbrook unit while residents were in the area participating in activities, who both acknowledged and confirmed understanding of the concern. 2) On 12/01/25 at 2:26 PM, the surveyor observed Resident #6 receiving 1.5L of oxygen via nasal cannula; however, a portion of the tubing was touching the floor. A second observation on 12/05/25 at 9:56 AM revealed the oxygen tubing was again lying on the floor while connected to the oxygen tank. During an interview on 12/05/25 at 10:00 AM, Staff #45 (LPN) verified that oxygen tubing must not touch the floor to maintain proper infection control. The Director of Nursing (DON) validated these findings during an interview later that afternoon. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On 12/07/25, the surveyor requested infection control policies and procedures. On 12/08/25 at 9:42 AM, the surveyor reviewed policies titled: Infection Control, Isolation Precautions, Antibiotic Stewardship, Pneumococcal Vaccine, and Influenza Vaccine. None of these policies contained a review or revision date. During an interview on 12/08/25 at 10:08 AM, the DON (who also serves as the Infection Preventionist) stated he had not reviewed or revised the policies since starting his role in December 2024. He validated the surveyor's concern. 4) The surveyor received the completed facility matrix on 12/01/25, which identified Resident #89 as the only resident under Transmission-Based Precautions. A medical record review on 12/05/25 revealed that Resident #89 was diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA) via bone biopsy upon re-admission on [DATE]. While the facility-initiated contact isolation on 11/12/25, there was no documentation of follow-up assessments or care regarding the MRSA. On 12/09/25, the DON stated that the resident's precautions were related to a sacral wound and claimed the facility did not conduct follow-up because there were no hospital recommendations. However, a review of the 11/11/25 hospital discharge summary explicitly stated: Bone biopsy grew MRSA . follow up with infectious disease doctor within 1 week. On 12/10/25, the attending Nurse Practitioner (Staff #50) reviewed the discharge summary with the surveyor and stated that a bone biopsy positive for MRSA should have been followed up with a CT scan. A review of Resident #89's progress notes, imaging results, and consultation logs showed no record of an Infectious Disease consultation, CT scan, or follow-up evaluation by the attending physician. The DON and Nursing Home Administrator (NHA) validated these findings on 12/10/25.

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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 staff failed to conduct required performance reviews of Geriatric Nursing Assistants (GNAs) at least once every 12 months. This was found to be evident for 8 (GNA #36, GNA #40, GNA #41, GNA #33, GNA #42, GNA #34, GNA #37, GNA #38) out of 10 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 12/5/25 at 9:57 AM the surveyor requested the complete employee files (including, but not limited to, health records, training, evaluations, et cetera) for GNA #18 and GNA #20. On 12/5/25 at 11:47 AM the Nursing Home Administrator (NHA) provided the employee files to the survey team. At that time, the surveyor asked if these were the complete employee files (including, but not limited to, health records, training, reviews/evaluations, et cetera) for GNA #18 and GNA #20. The NHA stated, This is everything.On 12/8/25 at 12:56 PM review of GNA #18's employee file revealed he/she was hired on 12/3/24; however, further review failed to reveal a performance review for 2025. On 12/8/25 at 1:11 PM review of GNA #20's employee file revealed he/she was hired on 1/1/24; however, further review failed to reveal a performance review for 2025. On 12/8/25 at 1:41 PM in an interview with the Director of Nursing (DON) when asked if performance reviews were conducted for the GNAs he stated, I have not personally done one, but I saw one. When asked where the performance review was observed, he clarified, That was at other facilities. When asked how often they are to be conducted, he stated annually. When asked if he knew of any staff who had completed a performance review for a GNA in this building, he stated, I'm not sure I have to check on that. On 12/9/25 at 11:43 AM in an interview with the Director of Nursing (DON), the surveyor shared that the complete employee files were requested for GNA #18 and GNA #20 and provided by the facility. Additionally, when the NHA provided the employee files, he verified and confirmed that they were the complete employee files including, but not limited to, health records, reviews/evaluations, trainings, et cetera; however, after looking through the files in their entirety there were no annual performance reviews for 2025 for GNA #18 and GNA #20. When asked if he could provide a copy of their performance reviews he stated, I don't have those today. When asked the required amount of in service education GNAs needed per year he stated, Around 15 hours. At that time, the surveyor requested a copy of the 2025 performance reviews for GNA #18 and GNA #20. On 12/9/25 at 2:41 PM the surveyor made a second request for a copy of the 2025 performance reviews for GNA #18 and GNA #20. On 12/10/25 at 8:33 AM the surveyor made a third request to the DON for a copy of the 2025 performance reviews for GNA #18 and GNA #20 and any and all policies and procedures related to GNA Performance Reviews. On 12/10/25 at 9:13 AM the DON provided the surveyor with a copy of a performance review for GNA #18 and GNA #20. In an interview with the DON, the surveyor shared the concern that they were not in the employees' files and when asked where they were found, the DON stated in the Human Resource Director's office. On 12/10/2025 at 9:25 AM in an interview with the Human Resource Director (HRD #8) when asked where she found the performance reviews for GNA # 18 and GNA #20 she stated, Typically they would be in the employee file, but we have a new DON, so he's trying to sort through the stuff on the previous Director of Nursing's desk. They were in the previous DON's office, so that's why they weren't in their personnel file. During the interview when asked the facility's expectation of where performance reviews for GNAs were stored, the HRD stated, The expectation of the facility is that performance reviews are stored in the employee's file. When asked if there was any other place they might be stored, she stated, There may be some in the previous DON's office, but there is no other place they would be stored. When asked if as the Human Resources Director, she kept any GNA performance reviews in her office or any other location in a file cabinet, binder, manilla file, et cetera, she stated, No, I do not have a binder, file cabinet, or file of performance reviews. I do have a small (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pile of papers in my office I have not organized and put away, but no, there are no GNA performance evaluations in that pile. On 12/10/2025 at 9:36 AM in an interview with the DON and HRD #8, the surveyor shared the concern that the DON stated the performance reviews for GNA #18 and GNA #20 were found in the Human Resource Director's office, but HRD #8 stated they were found in the previous DON's office. The DON then turned to face HRD #8 and stated, Didn't you bring these.weren't these in your office? HRD #8 stated, Not that I am aware of. Then, the DON stated, I found them in the HR office.in the inner room. There are files in there. I was looking through the pile of paper there. I searched through there. When asked the facility's expectation of where GNA reviews were stored, the DON stated, Performance reviews should be in the file for that staff but when we looked through the file it was not there. The surveyor asked aside from the employee file was there another location GNA performance reviews would be stored and he stated, No. When asked if there would be any performance reviews in the previous DON's office, he stated, No. On 12/10/2025 at 9:45 AM surveyor, HR, DON walked up to HR office to obtain copies of 8 GNAs' performance reviews. On 12/10/2025 at 9:47 AM HRD #8 reviewed GNA #36's entire employee file and stated there were performance reviews from the years 2008-2018; however, when asked if there was a performance review from 2025, she stated no. On 12/10/2025 at 9:48 AM review of GNA #40's entire employee file revealed performance reviews from 1999-2019; however, failed to reveal a performance review from 2025.On 12/10/2025 at 9:53 AM HRD #8 reviewed GNA #41's entire employee file and stated there were performance reviews from the years 2003-2020; however, when asked if there was a performance review from 2025, she stated no. On 12/10/2025 at 9:55 AM the DON reviewed GNA #33's entire employee file and stated there were performance reviews from the years 2014-2019; however, when asked if there was a performance review from 2025, he stated no. On 12/10/2025 at 9:56 AM HRD #8 reviewed GNA #42's entire employee file and stated there were performance reviews from the years 2005-2018; however, when asked if there was a performance review from 2025, she stated no. On 12/10/2025 at 9:59 AM the DON reviewed GNA #34's entire employee file and when asked if there was a performance review from 2025, the DON stated, I do not see any in there.On 12/10/2025 at 10:00 AM HRD #8 reviewed GNA #37's entire employee file and stated there were performance reviews from the years 2002-2020; however, when asked if there was a performance review from 2025, she stated no. On 12/10/2025 at 10:00 AM the DON reviewed GNA #38's entire employee file and when asked if there was a performance review from 2025, the DON stated, I don't see any.On 12/10/2025 at 10:12 AM in an interview with Staff #43 when asked if he/she had a performance evaluation since the facility changed ownership on 1/1/24 he/she stated, No.On 12/10/2025 at 10:16 AM in an interview with Staff #44 when asked if he/she had a performance evaluation since the facility changed ownership on 1/1/24 he/she stated, No.On 12/10/25 at 1:52 PM in an interview with the DON, when asked who conducted performance reviews for the GNAs, he stated, Clinical Leadership. During the interview when asked to clarify Clinical Leadership he stated, the UMs, the ADON, DON, and the nurses can also do it because they directly supervise the GNAs. At that moment, the Regional Administrator (RA #5) who was in the room approached the DON and surveyor and asked what was going on. The surveyor shared that the DON had just stated that the UMs, ADON, DON and nurses can conduct annual performance reviews for the GNAs, and the RA #5 shook his head and stated, No, it is just nursing administration. When asked what the requirements for the annual in service training/competencies for GNAs were, the DON stated, What it needs to include is to make sure they can do what's included in the packet successfully. The RA #5 stated, 12 hours. At this time, the surveyor shared the concern with RA #5 and the DON that there were no performance reviews for any of the 8 GNAs reviewed in HRD #8's office. When asked how the facility can provide regular in-service education/competencies/training to GNAs that was based on the outcome of their performance review if performance reviews were not being conducted, RA #5 stated, They were conducted, we cannot find them. I have housekeeping and dietary; we cannot find the clinical staff. The surveyor shared this was a concern and he acknowledged understanding.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **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 1) develop policies and procedures that address the time frames for the steps in the MRR process and the steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident 2) ensure a pharmacist conducted a complete MRR, at least monthly 3) ensure monthly Medication Regimen Reviews were completed by the facility's providers, 4) respond to recommendations made by consulting pharmacists in a timely manner, and 5) identify instances where the medication indication was inaccurately documented. This was evident for 2 (Resident #7and #8) out of 5 residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each 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 residents' medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. 1)In an interview with the Director of Nursing (DON) on 12/4/25 at 12:11 PM when asked what happens during the monthly pharmacy MRR, he stated the pharmacist sends the recommendations via email to the attending physician, Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The physician reviews them and they are filed in a binder by the DON. At the end of the interview, the surveyor requested the MRR's from January 2025 to present for Resident #7 for the months that there was a recommendation from the pharmacist. On 12/4/25 at 1:58 PM the Nursing Home Administrator (NHA) brought the MRR documentation for Resident #7 which only included a Note to Nursing from 11/5/25 Atorvastatin Calcium Oral Tablet 10 MG Give 1 tablet by mouth at bedtime for Hyperlipemia. Could not locate lipid panel within the last 12 months. Recommend lipid panel to assess statin dose. Handwritten was agreed with an illegible signature and date of 11/20/25. In an interview with the NHA, when asked if this was the only pharmacist recommendation for Resident #7, he stated he would have to check. On 12/5/25 at 8:58 AM in an interview with the DON and Regional DON, the Regional DON stated that she had seen progress notes written documenting if the resident did or did not have a recommendation and that as soon as we get it the time expectation is that it would be completed before the next monthly review. The surveyor made a second request for all monthly pharmacy recommendations for Resident #7 expanding the request to: from July 2024 to present. On 12/5/25 at 11:45 AM the DON and Regional DON provided documentation for Resident #7, Note to Attending Physician/Prescriber, dated 8/10/25 and another document titled, Order Summary Report. The recommendation form was completed by the provider and addressed by the facility. On 12/5/25 at 12:18 PM in an interview with the NHA, the surveyor requested the policies and procedures for MRR's. On 12/5/25 at 12:36 PM the DON provided the Pharmacy Consultant Report and verified it was the facility's policies and procedures for the monthly MRR. Review of the document failed to reveal that the time frames for the steps in the MRR process were addressed or the steps a pharmacist must (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow when he or she identified an irregularity that required immediate action to protect the resident and prevent an adverse drug event. On 12/5/25 at 1:00 PM in an interview with the DON, when asked to share the facility's process during the monthly MRR, he stated the DON or ADON prints the recommendations from the pharmacist, physically hands them to the UMs, and then the UMs physically hand the recommendations to the doctors. When asked about the process for the physician to respond to the recommendations, the DON stated the physician must respond to the recommendations before the next monthly MRR. Furthermore, he stated that the facility's expectation was for the physician to check one of the three boxes (agree, disagree, or other, write a rationale if he/she disagreed, and to sign and date the form. When asked who was responsible for putting in new orders and/or discontinuing orders, he stated, Doctors put in the new orders and the nurses confirm the orders. When asked who was responsible for following through to ensure that it had been completed, he stated, The DON and ADON. During the interview, a dual observation was conducted of the facility's policies and procedures for the monthly MRR. When asked what whether the MRR's policies and procedures addressed the time frames for the steps in the MRR process, the DON stated, Not technically. There are 6 steps. No, there is no time frame for each step. Additionally, when asked whether the policies and procedures addressed the steps a pharmacist must follow when he or she identified an irregularity that required immediate action to protect a resident and prevent the occurrence of an adverse drug event, he stated, Yes. It may not be specified here but if they notice someone is, for example, on multiple blood pressure medications and they review the resident's vital signs, they might say do this and this and this. The surveyor shared the concern that the facility's policies and procedures did not include the time frames for the steps in the MRR process or the steps a pharmacist must follow when an irregularity was identified that required immediate action. The DON confirmed that the facility's policies and procedures did not include either and acknowledged and validated the surveyor's concern. On 12/7/25 at 10:26 AM the surveyor reviewed the medical record for Resident #7 which revealed progress notes titled, Consultant Pharmacist Note/Medication Regimen Review and documented the following: 11/4/2025 11:50 Note Text: Medication regimen review completed. Recommendation to Nursing. 8/10/2025 13:11 Note Text: Pharmacist MRR completed. See pharmacy report for recommendations. 6/4/2025 14:48 Note Text: Pharmacist medication review completed. See pharmacy report for recommendations noted. 12/2/2024 09:16 Note Text: Pharmacist medication review completed. See pharmacy report for recommendations noted. 8/5/2024 13:53 Note Text: Pharmacist medication review completed. See pharmacy report for recommendations noted. Further review of the medical record revealed that the 11/4/25 and 8/10/25 MRRs had been completed by the provider and addressed by the facility (copies of these two MRRs were provided to the survey team; however, the MRRs from 6/4/25, 12/2/24, and 8/5/24 were not provided by the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/7/25 at 2:07 PM in an interview with the DON, he stated, The additional MRR (8/10/25) I gave you is all that I found. I'm still looking, but that's all I found. The surveyor shared it was a concern that out of the abovementioned 5 MRR's, only 11/4/25 and 8/10/25 had been provided. The DON acknowledged and confirmed understanding of the concern. The surveyor requested a third time for a copy of the completed MRRs from 6/4/25, 12/2/24, and 8/5/24. On 12/8/25 at 8:12 AM in an interview with the 2nd floor, Unit Manager (UM #12), she stated the MRR documentation was not in the residents' paper chart. When asked where it would be found she stated in PCC or with the DON. When asked if she as the UM played a role in the MRR process she stated no, the UM was not involved in the MRR process. When asked to share the process she stated, The DON prints them, gives to the providers who complete them, and give back to the DON. On 12/8/25 at 8:20 AM in an interview with the 1st floor Unit Manager (UM #31), when asked where the MRRs are stored she stated in PCC and they are also emailed. When asked to share the MRR process, she stated, The DON prints them and give them to the providers, they complete them, and the provider either gives it back to the DON, the UM or the nurse, but it's usually the DON who gets them back and he faxes them to the pharmacist. If the provider gives it to me, I fax it to the pharmacist. If the provider gives it to the resident's nurse, they will give it to the DON or UM, whoever they see first, and that person faxes it to the pharmacist. Additionally, she stated the exception to this process was NP #17 who completed and addressed her own recommendations. When asked where the paper copy is stored, she stated in the DON's office. When asked if they were ever stored in the paper chart, she stated no. On 12/8/25 at 8:29AM the surveyor requested any MRR binders or other forms of storage for the MRRs from the DON. On 12/8/25 at 8:55 AM review of the MRR documentation revealed a 3-ring binder labeled Jan-[DATE] and included the following: - September 2025 MRRs, but none of the recommendations were completed by a provider. The boxes were not checked and had no signature or date. - August 2025 MRRs: 29 recommendations that were not completed. - July 2025 documentation: 42 recommendations that were not completed. - June 2025 documentation: 5 recommendations that were not completed. - May 2025 documentation: 12 recommendations completed by NP #17 and 4 MRRs that were not completed. - April 2025 documentation: 6 recommendations completed by NP #17 and 6 MRRs that were not completed. - March 2025 documentation: 6 recommendations completed by NP #17 and 2 MRRs that were not completed. - [DATE] documentation: 10 recommendations completed by NP #17 and 2 MRRs that were not completed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- January 2025 documentation: 23 recommendations completed by NP #17. - December 2024 documentation: 2 MRRs that were not completed. There were no MRRs for Resident #7 in the documentation provided. On 12/8/25 at 9:18 AM in an interview with the DON when asked if Note to Attending Physician/Prescriber and Note to Nursing were different recommendations from the pharmacist, he stated, I believe so, but ultimately it's going to be under the physician's guidance. When asked what staff addressed the monthly recommendations, the DON stated, The physician has to look at the recommendation and address it, but if, for example, someone is on a routine stool softener and the recommendation is to hold the medication for loose stools, the provider does not need to see that recommendation because the nurse can just hold it. When asked for clarification that the provider does not need to be aware of that recommendation to hold the stool softener, the DON stated, It's just a given that if the resident has loose stools to hold it; that doesn't need a doctor's approval for that. When asked where the completed MRRs, that the provider has documented their written response on of agree, disagree, or other and signed and dated, the DON stated, They're stored in the binders in my office. The surveyor shared the concern that the documentation he provided of the binders from his office, it only included 1 month of 2024 (December). The DON acknowledged understanding of the concern. During the interview when asked how often the MRR needed to be conducted by a licensed pharmacist, he stated, Monthly. When asked if for example, a MRR was conducted on 6/4/25, when would the next one need to be completed by, he stated, July 4, 2025. When asked if a MRR was conducted on 8/10/25, when would the next one need to be completed by, he stated, September 25, 2025. In a dual observation of Resident #7's progress notes, it was observed that a MRR was conducted on 6/4/25; however, the next MRR was conducted on 7/17/25. When asked if that was conducted monthly, the DON stated, It looks like it's not. Additionally, it was dually observed that a MRR was conducted on 8/10/25; however, the next MRR was conducted on 9/28/25. When asked if that was conducted monthly, the DON stated, It was not within a month. The surveyor shared that it was a concern and the DON verbalized understanding. On 12/8/25 at 9:59 AM in an interview with the DON the surveyor shared the discrepancies in the facility's MRR process as described by the two UM's and himself as, for example, the 2nd floor UM stated UM's did not even have a role in the monthly MRR process. The DON stated, [NP #17's name] was the NP covering for Attending Physician (AP #24) and AP #25. In other words, NP #17 covered the residents for all the physicians. She came every day, Monday-Friday. When the pharmacist sent the MRR, NP #17 looked at them, signed them, and sent them back. Now NP #17 doesn't come here every day anymore, she only comes on Fridays. So now she doesn't look at them all anymore. So now the UMs give them to the 2 physicians and around September 2025, we got a new NP, [NP #47's name]. On 12/8/2025 at 1:26PM in an interview with the DON, when asked about the requested MRRs from 6/4/25, 12/2/24, and 8/5/24, he stated, I am still looking. The surveyor made a fourth request for the completed MRRs. On 12/9/25 at 9:01 AM the DON provided a manilla folder with some 2024 MRR's; however, none were the requested ones for Resident #7. On 12/9/25 at 10:41 AM the surveyor made a fifth request for the completed MRRs from 6/4/25, (continued on next page)

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Resorts of Augsburg	6811 Campfield Road Baltimore, MD 21207

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/24, and 8/5/24 along with evidence they were addressed by the facility. On 12/10/25 at 8:26 AM in an interview with the DON, he stated, I sent an email to pharmacy to clarify their progress notes. I looked at these dates you shared, and I don't see we have a recommendation for those dates. The surveyor shared this was a concern. The DON stated, It's concerning to me too. On 12/10/25 at 2:10 PM the DON provided a copy of Resident #7's 8/5/24 MRR. Review of the document titled, Consultant Pharmacist Recommendation to the Physician, revealed Resident has been receiving levothyroxine 112mcg (micrograms) daily. The last TSH noted is from 6/2023. Consider checking a TSH with the next labs. Further review revealed the provider checked the box, Agree and signed and dated it on 8/14/24. In an interview with the DON, the surveyor requested evidence that the TSH lab was obtained after the facility's provider signed and dated the recommendation on 8/14/24 and before the next monthly MRR on 9/5/24. At this time the surveyor provided an additional opportunity for any and all further documentation to be provided by the facility for surveyor review. No additional information was provided by the facility at the time of survey exit. 2)In a review of Resident #8's medical records on 12/04/25 at 10:20 AM, it was revealed that the facility's contracted pharmacist sent a monthly Medication Regimen Review (MRR). The MRR report dated 5/23/25 contained the note: Review resident's medical history to ensure this is an appropriate dx (diagnosis) for Seroquel. It has previously been listed for Bipolar. The attending physician accepted the recommendation and provided a signature on the same day. Consequently, the order indication was revised on 5/23/25 from Schizophrenia to Bipolar. However, further review of Resident #8's medical records on 12/05/25 around 1:00 PM noted that the Seroquel was again incorrectly indicated for Schizophrenia from 7/08/25 to 9/23/25. The MRR reports documented on 7/18/25 and 8/08/25 failed to identify this inaccurate indication of Seroquel. In an interview with the Director of Nursing (DON) on 12/05/25 at 1:43 PM, he confirmed that Resident #8's Seroquel has been used for Bipolar Disorder. The surveyor reviewed the resident's medical records with the DON and shared the concern regarding the pharmacist's failure to identify the inaccurate Seroquel indication. The DON validated the concern.

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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. **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 medications were secured as evidenced by observations of medications left at the bedside and on the floor, and 2) store and label medication in accordance with currently accepted professional principles. This was evident for 2 (Resident #35 and #9) out of 36 residents reviewed, 2 of 3 medication cart observed, and 2 of 2 nursing supply rooms observed during the recertification/complaint survey.The findings include 1) On [DATE] at 2:49 PM the surveyor observed from the hallway one white tablet on Resident #9's floor. At that time, Registered Nurse (RN #9) walked by and the surveyor requested an interview. During the interview when asked if she stayed with residents until they finished taking all medications she stated yes. She stated Resident #35, takes all day to take his/her medication, so she said to herself that she would come back and check on him/her. Additionally, she stated that she had administered 4 capsules around 9:00 AM and then the cardiologist called and the facility's provider, Attending Physician (AP #25), was calling for her to talk to the cardiologist. She stated, It's not the policy that you leave medications at the bedside. The policy is when you give a medication, you wait until they take it. My goal was to come back. I said, let me go and see what the doctor needs from me, but when I came back, rehab had taken him/her. RN #9 went into Resident #35's room, retrieved a small, white medicine cup from the bedside table, and came back into the hallway. The surveyor observed 1 capsule inside the medicine cup. Resident #35 was not observed in the room. The surveyor was inquiring about a medication observed on Resident #9's floor; however, RN #9's interview and observation referenced another unsecured medication from the room across the hall, belonging to Resident #35. The surveyor shared this was a concern and RN #9 verbalized understanding of the concern. The surveyor and RN #9 entered Resident #9's room on [DATE] at 3:04 PM and the surveyor pointed out the white tablet on the floor. In an interview with Resident #9 and RN #9, Resident #9 stated that when he/she was given the medication, as he/she was taking the medication, he/she dropped one and had tried to call for RN #9 but did not get a response. The surveyor shared the two medications left unsecured were a concern. RN #9 acknowledged and confirmed understanding of the concern. A few moments later in the hallway, RN #9 approached the surveyor and stated, I'm just being honest. I've been a nurse for a long time, and I know it's not the right thing to do, but the doctor called me. I do apologize. I messed up. It's not something that's supposed to happen, but it did. 2) On [DATE] at 2:25 PM, the surveyor began conducting a check of the facility's medication storage and labeling of; the medication carts, treatment carts and nursing supply rooms (which stores commonly used items for resident care). On the Sudbrook Unit Medication Cart 1-590, the surveyor, in the presence of Staff #49 (LPN), observed a large open bottle of Sennoside 8.6 mg tablets and a large open bottle of Acetaminophen 500 mg tablets. Both bottles of this floor stock medication, or non-resident specific medication, lacked an open date. On [DATE] at approximately 2:42 PM, in the Sudbrook Unit Nursing Supply Room the surveyor observed: (2) one-liter bags of 5% Dextrose Intravenous Fluid that expired in [DATE]; A one-liter bag of Lactated Ringer's Intravenous Fluid that expired in [DATE]; and a single 24-gauge needle with a yellow-colored cap, stored among other needles, was no longer in its original packaging. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:51 PM, in the Meadowood Unit Nursing Supply Room, the surveyor observed a box of various needles that included an orange-capped needle stored without its original packaging. On [DATE] at 2:51 PM on Meadowood Unit Medication Cart 1-590, the surveyor found a container of Vitamin D 10 mcg pills that was unlabeled and a bottle of liquid Multivitamin Iron Supplement (220 mg/5 ml) was marked with the date 6/12, but the year the medication was opened was unknown, and the expiration date was illegible. On [DATE] at 3:16 PM, the Director of Nursing (DON) was present throughout the medication storage and labeling facility task. At the conclusion of this task, the surveyor made the DON aware of the concerns, which the DON acknowledged.

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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 ensure the labeling, dating, and expiration of nourishment items and that expired food items were discarded. This was observed in the facility's kitchen during the recertification/complaint survey.The findings include:On 12/1/25 at 7:35 AM, the surveyor conducted an initial tour of the facility's kitchen.On 12/1/25 at 7:39 AM the surveyor observed the following:- Turkey with a use by date of 11/20/25- Jelly with a use by date of 11/24- Woeber's Salad Style Mustard labeled 4/18- Orange cheese with no use by date- Chef's Wonder Instant Soup labeled 11/20/25- Cross Valley Farms [NAME] Caseras with a use by date of 11/12/25- Loose potatoes in a white plastic container with a use by date of 11/30/25- Loose lettuce in a white plastic container which had no labeling or dates present to indicate preparation or expiration dates- Loose green bell peppers in a white plastic container which had no labeling or dates present to indicate preparation or expiration dates- Loose cabbage in a white plastic container which had no labeling or dates present to indicate preparation or expiration dates- A plastic container with a clear flip lid labeled Breadcrumbs Nov.1, 2025 to Nov. 30, 2025- A plastic container with a clear flip lid labeled Flour Nov.1, 2025 to Nov. 30, 2025On 12/1/25 at 8:01 AM in an interview with Dietary Manager (DM #2) the surveyor shared the abovementioned concerns and DM #2 acknowledged and confirmed understanding of the concerns. When asked whose responsibility it was to properly label the nourishment items, he stated, It's everybody's responsibility to date items when they open them. I expect them to have the right thing labeled on each product. The expectation is to have an open date and an expiration date. When asked if all kitchen staff had been trained on how to properly label items, he stated, No I can't say everybody. When asked if the lack of training could have contributed to items not having any date, only having the month and date and no year, having a date without labeling on if it is the open date or the expiration date, he stated, I see what you're saying.

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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 - Some	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 ensure key essential personnel were present during monthly Quality Assurance (QA) meetings. This was evident in 6 out of 11 monthly QA meeting attendance sheets reviewed during this recertification/complaint survey.The findings include:On 12/10/25 at 10:00 AM, surveyors requested the January through November 2025 QA monthly meeting sign-in sheets. The review revealed the following:The Medical Director's signature was missing for January, April, June, July, and August 2025.The Infection Preventionist's signature was missing for May 2025.During an interview with the Director of Nursing (DON) on 12/10/25 at 11:22 AM, he stated that the facility administrator and himself are the individuals responsible for Quality Assurance and Performance Improvement (QAPI). The DON also explained that monthly QAPI meetings should be held with the Medical Director, Administrator, DON, Infection Preventionist, Social Worker, Therapy team, Activity Director, Dietitian, and Nursing Aides.In a follow-up interview with the Nursing Home Administrator (NHA), DON, and Staff #5 (Regional Administrator) on 12/10/25 at 2:23 PM, the surveyor reviewed the facility's QAPI attendance sheets with the DON and NHA. They verified that the Medical Director's signature was missing for January, April, June, July, and August 2025. Additionally, they confirmed the Infection Preventionist's signature was missing for May 2025. The surveyor shared the above concerns, and the NHA validated 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 interviews with residents and outside agency staff, surveyor observation, review of pertinent documentation, and interview with facility staff, 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:On the initial tour of the facility on 12/1/25 at 9:50 AM, in an interview with Resident #83, he/she stated that mice were a big problem in the facility. During the interview, he/she started to look under the radiator. The surveyor observed sticky mice traps. He/she said even the man who laid the traps said there was a hole in that wall. Additionally, he stated, I've seen up to 5 mice at a time running across the floor where you're standing. Some come out at and have the insulation from the walls on them. I can hear them in the walls. On 12/1/25 at 11:43 AM in an interview with Outside Agency Staff ([NAME] #48), he/she shared concerns about a mice infestation in the facility and that there are mice traps all over the facility. During the interview, he/she shared that these concerns were continuous and ongoing for over 2-3 years. An interview was conducted with Maintenance Technician (MT #29) and the Regional Nursing Home Administrator (RNHA #5) on 12/8/25 at 1:30 PM. During the interview, when asked if the facility had an insect/pest control program, MT #29 stated, Yes. When asked who the servicer was and how often they came, he stated, Allstate. Twice a week. an issue with insects or rodents, MT #29 stated, Yes, we may have, but they get addressed immediately. Staff are instructed to put it in the log binder, and it's addressed the next visit. There's a binder at each nurse's station and at the reception area and kitchen. On 12/8/25 at 2:50 PM RNHA #5 provided Pest Management Logs from the facility and Allstate Service Inspection Reports dated: 9/2/25, 9/9/25, 9/16/25, 9/21/25, 9/30/25, 10/5/25, 10/12/25, 10/21/25, 10/28/25, 11/4/25, 11/11/25, 11/18/25, and 11/25/25.On 12/8/25 at 2:51 PM review of the Allstate Service Inspection Reports conducted by Allstate technicians revealed the following:- 9/2/25: All logbooks are missing from each nurse's station and logbook is missing at the front desk.Inspected and treated basement dry storage for prior mice activity.- 9/9/25 (1 week later): Checked logbooks. Inspected and treated room [ROOM NUMBER] for reported mice activity. Inspected and treated wood dining room for reported mice activity. - 9/21/25 (12 days later): Inspected and treated dry storage room for prior mice activity.- 9/30/25 (9 days later)- 10/5/25 (5 days later, 2 times this week): One time move from 10/7. - 10/12/25 (1 week later): One time move from 10/14. Inspected and treated room [ROOM NUMBER] for reported mice activity. - 10/21/25 (9 days later): Inspected and treated movie theater room for prior roach activity. - 10/28/25 (1 week later): Inspected and treated men's and women's locker room for prior roach activity. - 11/4/25 (1 week later)- 11/11/25 (1 week later)- 11/18/25 (1 week later)- 11/25/25 (1 week later): Inspected and treated dry storage room for prior mice activity.On 12/8/25 at 4:21 PM review of the Allstate Pest Management logs revealed the following staff observations:- 5/3/25, Staff Observations: Mice, Location: 138, Location of Application: Running around in room- 5/5/25, Staff Observations: Mice, Location: Storage Room, Location of Application: Storage- 5/8/25, Staff Observations: Mouse nest beside and under heater, Location of Application: 244- 7/2/25, Staff Observations: Mice using insulation under heater, Location: Watersedge, Location of Application: Under heater- 7/11/25, Staff Observations: Mice dining/Rm 242, Location: Watersedge, Location of Application: 242- 7/16/25, Staff Observations: Mouse nesting under every heater, Location of Application: under each heater- 8/2/25, Staff Observations: Mice, Location: room [ROOM NUMBER]-A, Location of Application: 124- 8/6/25, Staff Observations: Mice, Location: room [ROOM NUMBER]-B, Location of Application: 128-B- 9/2/25, Staff Observations: Mice, Location: Meadowood, Location of Application: Nurse's Station- 9/3/25, Staff Observations: Mice, Location: Meadowood, Location of Application: room [ROOM NUMBER]- 9/4/25, Staff Observations: Mice, Location: Meadowood, Location of Application: Common Area- 9/5/25, Staff Observations: Mice, Location: Meadowood, Location of Application: Nurse's Station- 10/7/25, Staff Observations: Mice in (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	both room, Location: Powdermill, Location of Application: 137 and 138- 11/15/25, Staff Observations: Mouse, Location: 218, Location of Application: RM [ROOM NUMBER]On 12/9/25 at 12:43 PM in an interview with the Nursing Home Administrator (NHA) when asked if he was aware that mice were an issue in the building, he stated, I am not aware. When asked what interventions had been put in place to address the issue, he stated, Allstate comes twice a week. When asked what additional interventions had been put in place to address the issue since, based on the Allstate Pest Management logs and Allstate Service Inspection Reports (which were shared and shown with the NHA), it was still an issue. The NHA stated, It's not my documents, it's for Allstate and they handle it. The surveyor shared this was a concern and the NHA acknowledged understanding.

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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 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 review and staff interview, it was determined that the facility failed to ensure that advance directives were discussed with residents and/or responsible representatives and failed to ensure that residents were evaluated by two physicians for a decision-making capacity. This was found to be evident for 1 (Resident #6) out of 5 residents reviewed for advance directives during this recertification/complaint survey.The findings include:A physician's certification for decision-making capacity confirms if a patient can understand their medical situation, appreciate the consequences, use reasoning, and communicate a choice for treatment, often requiring formal documentation by one or two doctors based on specific legal standards, like Maryland's law requiring two physicians (one being the attending) for incapacity certification, ensuring the process is documented, consistent, and follows patient rights. During the screening process on 12/02/25 at 11:18 AM, the surveyor attempted to interview Resident #6. Since the resident was mumbling, the surveyor could not determine the resident's current cognitive status.On 12/03/25 at 1:49 PM, the surveyor reviewed Resident #6's medical records including Medical Orders for Life-Sustaining Treatment (MOLST) form. The review revealed that MOLST was completed by him/herself as full code upon his/her admission. However, there was no Advance Directive or Physician's Certificate of Incapacity documented in Resident #6's medical records.In an interview with the Social Worker (Staff #10) on 12/03/25 at 1:30 PM, he explained that facility staff assess all residents' advance directive status upon admission: they ask residents to bring any existing documents or assist residents in completing one. He also confirmed that regardless of a resident's cognitive level, the facility should evaluate their capacity using two physicians.During a subsequent interview with Staff #10 on 12/04/25 at 2:56 PM, the surveyor shared the concerns that Resident #6 lacked an Advance Directive and an incapacity evaluation in his/her medical records. Staff #10 verified that the facility did not have Resident #6's Advance Directive or incapacity evaluations.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of pertinent documentation and interview with facility staff, it was determined that the facility failed to follow the grievance process and communicate the resolution to the resident. This was evident for 1 (Resident #9) out of 2 residents reviewed for grievances during the recertification/complaint survey.The findings include:On 12/4/25 at 8:47 AM in an interview with the Nursing Home Administrator (NHA) and the Regional Nursing Home Administrator (RNHA) when asked who the grievance official for the facility was, they stated the Social Services Director (SSD). On 12/4/25 at 12:01 PM in an interview with the SSD when asked about the grievance process, he stated, We have a grievance form posted all around the building that anyone can complete and then it is forwarded to me. I address the issue with whatever department is involved and then share the findings. On 12/4/25 at 9:00 AM the facility provided the survey team with copies of grievance forms including a grievance form for Resident #9 dated11/15/24. Review of the Resorts at Augsburg Resident/Guest Grievance Form for Resident #9 revealed the bottom of the form was not completed. There were three lines that were blank: Resolution communicated to, Copy Offered, and Response to Investigation. On 12/4/25 at 1:40 PM review of the facility's grievance policies and procedures revealed, Once the resolution is completed the responsible party/resident will be notified. On 12/8/25 at 10:36 AM in an interview with the SSD, a dual observation of the Resorts at Augsburg Resident/Guest Grievance Form for Resident #9 was conducted. When asked if the SSD saw evidence that the resolution was communicated to the resident he stated, It was communicated to her because I communicated it to her. When asked where in the form it included that the resolution was communicated to the resident he stated, It was communicated to him/her, but I see what you are saying. The surveyor shared this was a concern and the SSD acknowledged understanding.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview with facility staff, it was determined the facility failed to 1) ensure the monitoring of a psychotropic medication for a resident and 2) ensure a resident's medication regimen was free from unnecessary medications. Specifically, the facility prescribed as needed (PRN) psychotropic medication without documentation of a supporting evaluation This was evident for 2 (Resident #7 and #13) out of 5 residents reviewed for unnecessary medications during the facility's recertification/complaint survey.The findings include: The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at 483.45(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. 1) On 12/2/2025 1:10 PM review of Resident #7's medical record revealed an order for Duloxetine HCl (hydrochloride) Oral Capsule Delayed Release Particles 20 mg (milligrams). Give 20 mg by mouth two times a day for depression. Further review failed to reveal a behavior monitoring order. On 12/4/25 at 12:22 PM in an interview with the Director of Nursing (DON) when asked if there were certain medications that required behavior monitoring, he stated Yes, the psych medications. During the interview when asked if there would be an order and where it would be documented, he stated, There's an order called behavior monitoring and so you will see it in the TAR (treatment administration record). On 12/8/25 at 9:38 AM in an interview with the DON when asked why residents ordered psychotropic medications have their behaviors monitored, he stated, To see if the medication is working or not or if or it is having any adverse effects. If someone is on anti-anxiety med, you want to check their behavior to see if they are showing signs of anxiety. During the interview, a dual observation of Resident #7's orders was conducted. The surveyor pointed out that Resident #7 was ordered Duloxetine for depression and when asked if the resident had a behavior monitoring order, the DON stated, I do not see a behavior monitoring order. When asked why he/she was ordered a psychotropic medication and did not have a behavior monitoring order, he stated, Well, he/she has this order, Monitor and report tremors, dizziness and other side effects every 12 hours for drug side effects monitoring. The surveyor pointed out that the order was written for drug side effects monitoring and that Resident #7 was ordered a psychotropic medication and did not have a behavior monitoring order was stated was the expectation in the previous interview. The DON acknowledged and confirmed understanding of the concern. 2) A review of Resident #13's medical records on 12/04/25 at 11:05 AM revealed that the resident was diagnosed with anxiety upon admission. Since admission, the resident was administered scheduled Lorazepam (a benzodiazepine used to treat anxiety and related sleep disturbances) twice daily. In addition to the scheduled dose, Resident #13 had the following PRN Lorazepam orders: 10/06/25 to 10/17/25: One tablet PRN every 24 hours.10/17/25 to 10/31/25: One tablet PRN every 24 hours.11/03/25 to 11/05/25: One tablet PRN every 12 hours.11/05/25 to 11/19/25: One tablet (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN every 12 hours. A further review of Resident #13's medical records on 12/08/25 at 2:22 PM revealed no documentation of an evaluation by the attending physician or psychiatry services prior to the PRN orders placed on 10/17/25 and 11/05/25. While the attending physician wrote a progress note on 11/03/25 detailing an increase in the routine Lorazepam dose (from 1 mg twice daily to three times daily per family request), there was no documented assessment or evaluation regarding the PRN dosage. During an interview with the Director of Nursing (DON) on 12/09/25 at 11:23 AM, the DON stated that the facility has a Psychiatric Nurse Practitioner (NP) who visits at least once a week to assess residents. The DON explained that PRN psychotropic medication orders are limited to a maximum of 14 days and stated that a re-evaluation is required to renew the order. The surveyor reviewed Resident #13's Lorazepam order history with DON. The DON claimed that because the PRN order on 10/17/25 was written by an attending NP, it was assumed the NP had evaluated the resident. However, the PRN order starting 11/05/25 was entered by a nurse and was not verified by a provider until 11/10/25. In an interview on 12/10/25 at 2:08 PM, Staff #50 (Nurse Practitioner) stated that while nurses are permitted to enter verbal or telephone orders into the electronic medical record, these must be verified by a physician within 48 hours. Staff #50 further emphasized that any resident taking PRN psychotropic medication must be evaluated by a provider. During a follow-up interview with the DON on 12/10/25 at approximately 3:00 PM, the surveyor presented the concerns. The DON validated the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a facility reported incident #2623258, record review and interviews, it was determined that the facility failed to report the investigative results of an alleged resident-to resident interaction which resulted in serious bodily injury, to the Office of Health Care Quality (OHCQ) within 5 working days as required. This was true for 1 of 10 (#2623258) facility reported incident reviewed during the survey process.Findings Included:On 12/3/25 at 11:15 AM, a review of Intake #: 2623258 revealed that Resident #128 reported that Resident #136 punched him/her in the face and turned over his/her wheelchair.On 12/3/25 at 12:48 PM, a review of the facility's documentation related to the above-mentioned incident report revealed that approximately 11:45 PM on 9/19/2025 Resident #128 alleged that he/she was punched in the face by Resident #136. According to the report, Resident #128 requested to be sent to the hospital after the alleged incident and Resident # 136 was incoherent and denied the assault.A review of the Emergency Department (ED) notes on 9/20/2025 revealed that the resident presented to the ED with foot pain, able to bear weight following an alleged assault. A review of Resident #128's Discharge summary dated [DATE] showed that the resident had an acute fracture of the 5th metatarsal, based on Left Foot X-ray results.A review of the facility's incident folder revealed documented evidence that the Initial Report Form (39-555F) was submitted to OHCQ on 9/20/2025 at 2 PM; However, the Follow-up Investigation Report Form (39-556F) was submitted more than 5 working days later, on 9/29/2025 at 3 PM by the previous Director of Nursing (DON).On 12/4/2025 at 1:20 PM, in an interview with the Nursing Home Administrator (NHA), the surveyor notified the NHA that the follow-up report form was submitted late (more than 5 working days after the incident was identified). The surveyor also requested a confirmation email from OHCQ's Smartsheet submission portal for the above-mentioned incident that will show the date and time of submission. Documentation was later provided by the facility; however, they were unable to provide an email confirmation, as requested. The NHA stated that he did not receive an email confirmation after submitting the follow-up investigation report form to OHCQ.On 12/4/2025 at 1:55 PM, the NHA provided a second Follow-up Investigation Report Form for incident #2623258; however, the newly provided form showed that the report was submitted on 9/24/2025 at 2 PM by the previous DON. The NHA was asked to explain why there were two copies of the same document with different submission dates and time. The DON stated he was not sure why the date and time did not match.On 12/4/2025 at approximately 2:50 PM, the office was contacted to verify the date and time the facility submitted incident #2623258 to OHCQ and the office confirmed that the date of submission was 9/29/2025 at 3:18 PM.12/4/2025 at approximately 3:00 PM. The Administrator was notified that the Follow-up Investigation Report submission date and time was clarified with OHCQ and report was received by OHCQ on 9/29/2025 at 3:18 PM, which was later than the 5 working days required.

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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 clinical record review and staff interview, it was determined that the facility staff failed to 1) ensure that a written notice which specifies the duration of the bed-hold policy and return to the facility was provided to the resident and/or to resident representative(s) at the time when the resident was transferred to the hospital, and 2) ensure written notice of a hospitalization and the reason for the hospitalization were provided to the resident and to family. This was evident for 2 (Resident #89 and #128) out of 2 residents sent to the hospital that were reviewed during the recertification/complaint survey.Findings Included:Situation, Background, Assessment, and Recommendation (SBAR) is a communication tool that aides healthcare professionals to share information about a patient's condition in a concise manner. 1) On 12/3/25 at 11:15 AM, a review of the facility's incident report revealed that Resident #128 was sent to the hospital on 9/20/2025 after an alleged assault with injury. Further review of the resident's medical record revealed no documented evidence to support that the facility provided written notice to the resident at the time of transfer to the hospital. On 12/09/2025 at 1:38 PM, during an interview with Staff #46, she was asked about the facility's process for transfers to the hospital. She explained that the nurse would obtain and send a copy of the resident's: vital signs; a written summary of the resident status; face-sheet, Maryland Order of Life Support Treatment (MOLST), medication reconciliation, recent labs, history and physical, and SBAR. Staff #46 was asked if a bed-hold policy was included in the documentation provided to the resident at the time of hospital transfer and she stated that unaware if the facility's bed hold policy was provided during transfer and believed the admission office was responsible for contacting the family. On 12/9/2025 at 11:38 AM, in an interview with the Director of Nursing (DON), he was asked about the bed hold policy, and he stated we don't have any policy. We follow the state regulations and none of our residents have any issues coming back to the facility. 2) This surveyor reviewed Resident #89's clinical record on 12/8/25 at 2:00 PM. The review revealed that the resident was sent to the hospital on [DATE]. Further review revealed that there was no evidence that the resident and/or family received written notice of the hospitalization. Interviewed the DON on 12/9/25 at 1:32 PM. This surveyor asked how do they inform the resident and family of a resident going to the hospital. He said they verbally tell the resident and family. This surveyor said the regulation states that it has to be both verbally and in writing. He replied that if he tells them verbally then why in writing. This surveyor said it is in the regulation. He said he would have to take a look at the regulations and he said he would have to look to see if they have copies in writing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility staff failed to accurately code Minimum Data Set (MDS) assessments. This was evident for two (Resident #4 and #8) of five residents reviewed during this recertification/complaint survey.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each resident receives the care they need. Active diagnoses documented on the MDS assessment are those attending provider-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. 1) On 12/04/25 at 8:52 AM, a review of Resident #8's medical record revealed that the resident was admitted in May 2025 with a diagnosis of bipolar disorder. While Resident #8's initial MDS assessment in May 2025 documented Bipolar Disorder as an active diagnosis, the subsequent MDS assessment dated [DATE] did not code Bipolar Disorder under active diagnoses. In an interview with the Director of Nursing (DON) on 12/05/25 at 1:43 PM, the surveyor reviewed Resident #8's MDS assessment records with him. The DON confirmed that Resident #8 had been diagnosed with Bipolar Disorder since his/her admission and agreed that it should be documented in the MDS active diagnoses. The DON validated the surveyor's concern. 2) A review of Resident #4's clinical record on 12/8/25 revealed that the resident was admitted with a diagnosis of schizoaffective disorder. A review of the resident's medications revealed the resident was not ordered a medication to treat the schizoaffective disorder. The Psychiatric Nurse Practitioner (Staff #28) was interviewed on 12/8/25 at 12:28 PM. This surveyor asked if she was aware of the diagnosis of schizoaffective disorder. She replied that she was aware of the diagnosis. She was asked why she did not order a medication to treat the schizoaffective disorder. She replied that the medication Olanzipine was ordered to treat the schizoaffective disorder as well as the listed reason of bipolar disorder. She was asked why schizoaffective disorder was not included with the list of diagnoses under Section I of the MDS. She said she was not sure why it was not listed under the list of diagnoses other than because of oversight. The Director of Nursing was interviewed on 12/8/25 at 3:48 PM. This surveyor shared the concern that the resident's schizoaffective disorder was not listed under Section I. He acknowledged that the diagnosis was not listed. He was asked if it should have been and he replied that it should have been. 3) This surveyor interviewed Resident #4 on 12/3/25 at 8:47 AM. This surveyor asked when they had a vision examination and they replied more than a year ago. A review of the resident's clinical record on 12/8/25 revealed that a vision consult had been completed on 5/29/25 with a newly diagnosed visually significant cataract and a plan to refer for cataract [removal] to improve vision. There was no further mention of the referral in the clinical (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record. A review of the annual MDS revealed that there was no mention under Section I that the resident had been diagnosed with cataracts. This surveyor interviewed the Director of Nursing (DON) on 12/8/25 at 3:48 PM. This surveyor showed the result of the vision consult to the DON. He replied that he understood the diagnosis. This surveyor then showed the most recent annual MDS and that the diagnosis of cataracts was not listed. He acknowledged the findings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff, it was determined that the facility failed to incorporate the recommendations from the Pre-admission Screening and Resident Review Level II determination and evaluation report into the resident's care and refer residents to the appropriate state-designated authority for review when a resident was identified with newly evident or possible serious mental disorders, intellectual disabilities, or a related condition. This was evident for 1 resident (Resident #83) of 4 residents reviewed for PASARR during the recertification survey. The findings include: According to the State Operations Manual, The Pre-admission Screening and Resident Review (PASARR) process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders (MD) or intellectual disabilities (ID) and related conditions. This initial pre-screening is referred to as PASARR Level I and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. PASARR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD, ID or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs. On 12/2/2025 at 9:24 PM review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, paranoid personality disorder and delusional disorders. On 12/3/25 at 1:20 PM the surveyor requested Resident #83's PASARR documentation and any and all policies and procedures related to PASARR. On 12/3/25 at 2:19 PM Resident #83's PASARR II Level II determination and evaluation report were provided. Review of the documentation revealed that the resident was approved for admission to a Maryland nursing facility and the following specialized behavior health services are recommended: Psychiatric Care (outpatient) with an individualized treatment plan. On 12/3/25 at 2:23 PM review of Resident #83's medical record revealed the following:- 11/25/24 progress note Nurse Practitioner (NP#17): Patient is alert and oriented x 3; however, has tangential speech and grandiose delusions requesting psych (psychiatry) consult for capacity evaluation.- 12/2/24 and 12/6/24 progress notes NP#17: Delusional disorder: Chronic delusions and paranoia. Psych consult requested. - 12/9/24 progress note NP#17: Patient continues to have paranoia and delusions. Delusional disorder: Chronic delusions and paranoia. Psych consult requested.- 12/13/24 nursing progress note Patient delusional at times but no aggression. - 12/31/24 nursing progress note Consent obtained from Niece and referral paper faxed to [facility's psychiatry provider]. - 4/12/25 Adjustment disorder with mixed anxiety and depressed mood listed under his/her medical diagnoses with an onset date of 4/12/25 and classification of During Stay (as opposed to a diagnosis from Admission) Resident #83's PASARR II Level II determination and evaluation report included Psychiatric Care (outpatient) with an individualized treatment plan and NP #17 requested the resident to be seen by psych starting 11/25/24; however, the resident was not seen by a psychiatric provider until 42 days after his/her admission and 39 days from NP #17's request. On 12/4/25 at 8:51 AM in an interview with the Regional Nursing Home Administrator (RNHA #5) regarding PASARR policies and procedures for the facility, he stated there was no policy, we just follow the regs (regulations). On 12/5/25 at 11:47 AM in an interview with the Social Services Director (SSD #10), a dual observation of Resident #83's PASARR Level II was conducted and when asked how the facility incorporated the resident's recommendations from his/her PASARR II Level II determination and evaluation report, he stated, When they come from the hospital, they come with a completed Level I. We reach out to Adult (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluation & Review Services (AERS) that they have been admitted and if they are going to be long term care, to do an evaluation for those that are Level II. We do have psych in the facility that will follow up. The expectation is that they follow up upon admission. When asked when the resident was first seen by a psychiatric provider, SSD #10 took a few minutes to look in the medical record on his laptop and stated, The first note I am seeing is 1/3/25. When asked when the resident was admitted he stated, He/she was admitted [DATE]. The surveyor shared the concern that Resident #83 was not seen by a psychiatric provider until 42 days after his/her admission. SSD #10 stated, Yes, I am seeing he/she was first seen by psych almost 2 months after his/her admission and acknowledged and confirmed understanding of the concern. During the interview when asked when PASARR's need to be completed, SSD #10 stated admission or readmission for a Level I and with a positive Level I or newly diagnosed mental disorders for a Level II. When asked if adjustment disorder with mixed anxiety and depressed mood would be considered a mental disorder, he stated, I'm not too sure, I send the records to AERS so they could come and do an evaluation. A dual observation of Resident #83's diagnoses was conducted and Resident #83's newly diagnosed, during stay diagnosis of adjustment disorder with mixed anxiety and depressed mood with a date of 4/12/25, approximately 5 months after his/her admission was observed. When asked if he sent Resident #83's records to AERS after Resident #83 was diagnosed with adjustment disorder with mixed anxiety and depressed mood, he took a few minutes to look in the medical record on his laptop and stated, I'm not seeing anything. The surveyor shared this was a concern and SSD #10 acknowledged and confirmed understanding of the concern.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on a medical record review and an interview with facility staff, it was determined that the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) form was completed prior to or upon admission to the facility. This was evident during the review of two residents (Resident #5 and #13) of the 3 residents reviewed for PASARR screening during this recertification/complaint survey.The findings include:Preadmission Screening and Resident Review is a federal requirement designed to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. Every individual who applies for admission to a nursing facility must be screened for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions. 1) During the review of facility residents on 12/02/25 at 11:50 AM, it was revealed that Resident #13 did not have a completed PASARR upon his/her admission. In an interview with the Social Worker on 12/03/25 at 1:52 PM, he confirmed that the facility should review a resident's PASARR status upon their admission. The surveyor requested Resident #13's PASARR documentation. On 12/08/25 at 10:43 AM, the Social Worker confirmed that the facility did not have Resident #13's completed PASARR on file. The surveyor shared concerns about this deficiency, and the Social Worker validated them. 2) A review of Resident #5's clinical record on 12/3/25 at 2:44 PM revealed that a PASARR was not in the chart. This surveyor interviewed the first-floor unit manager (Staff #31) on 12/5/25 at 12:25 PM. This surveyor asked if there was a PASARR on the chart. She replied, Did you ask the social worker? This surveyor said, it should be in the chart. She replied, It should. She then looked at the electronic clinical record, but she could not find it. She then looked through the hard chart and could not find it. She said she would have to call the social worker to see if he has it. This surveyor agreed to come back an hour later. This surveyor interviewed the Unit Manager on 12/5/25 at 1:44 PM. The Unit Manager said that she could not find a PASARR anywhere, so she called the social worker, and he was not sure if one was done. She also called the Medical Records coordinator and asked her to search. The PASARR was Resident #5 was not presented to the team prior to exit.

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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 written summary of the baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP) and evidence in the resident's medical record that it was provided. This was evident for 1 (Resident #98) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to each resident and/or his/her representative and documented in the medical record. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 12/2/25 at 10:06 AM review of Resident #98's medical record revealed the resident was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP for Resident #98.On 12/3/25 at 1:35 PM in an interview with the Social Services Director (SSD) when asked to describe the facility's BLCP process, he stated the team (SSD, activities staff, and nursing) meet with the resident and then we try to get it completed in 48-72 hours. We review it with the resident, and a copy is provided as well. The resident and/or RP signs it and then it is uploaded into PCC (Point Click Care, the facility's electronic health record) under Miscellaneous. During the interview, when asked who was responsible for providing the residents and/or RP's with the BLCP copies he stated, I am the one responsible for getting them to sign it and providing them a copy. If the family is not available in person, we review it with them over the phone and also send them a copy and the email serves as verification. When asked who was ultimately responsible for ensuring the completion of the BLCP process, the SSD stated, That's me. On 12/5/25 at 2:11 PM in an interview with the SSD, the surveyor requested a copy of the BLCP for Resident #98 and evidence from the medical record that it was provided to the resident and/or RP.On 12/5/25 at 2:47 PM in an interview with the SSD, the surveyor made a second request for a copy of Resident #98's BLCP and evidence from the medical record that it was provided to the resident and/or RP. During the interview the SSD stated, I did not see one for him/her. The surveyor shared this was a concern and the SSD acknowledged understanding.

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Resorts of Augsburg	6811 Campfield Road Baltimore, MD 21207

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to 1)develop and implement person-centered comprehensive care plans as required and 2) to ensure interventions agreed to as part of a resident's care plan are initiated. This was evident for three (Resident #5, # 9 and #29) of 76 residents care plans reviewed during the survey process.Findings Included:The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents. 1) On 12/01/2025 at 11:09 AM, in an interview with Resident #9, the resident reported that he/she had multiple urinary tract infections since admission. On 12/08/2025 9:44 AM, a review of Resident #9 medical records revealed that the resident had a positive urine culture for urinary tract infection (UTI) on 6/22/2025 at 09:00 AM. A review of the resident's orders revealed that on 6/23/2025 the resident was started on Ciprofloxacin HCl Tablet 500 MG Give 1 tablet by mouth every 24 hours for UTI for 5 Days. A review of a nursing progress note written on10/20/2025 revealed that the resident reported feeling clammy and experiencing slight pain with urination. The resident advised he/she would like to be tested for UTI. No acute distress was noted. Skin warm and dry to touch. Vitals obtained and within normal limits. The resident was encouraged to increase fluid intake as tolerated. A review of a physician's note written on 10/27/2025 revealed that the urine culture report was probably contaminated. Resident symptoms have been stable. The resident has not complained of any further dysuria or urinary symptoms. He/She also has not had any suprapubic pain or back pain and has been afebrile. On 12/08/2025 at approximately 10:02 AM, a review of Resident #9's care plan revealed no documented evidence to support that the facility developed a care plan to address the prevention and treatment related to UTIs. On 12/08/2025 1:32 PM in an interview with the Director of Nursing (DON), the surveyor asked the DON who was responsible for the development and update of the care plan and he stated that it depends of the type of care the resident was receiving, he continued to explain that the clinical team does the clinical services updates, dietary does their own update, rehab services and etc. The DON was then asked for clinical updates who was responsible for ensuring the care plan was developed and updated, he explained that the DON, Assistant Director Of Nursing, unit managers, supervisors and the floor nurses are also capable of doing the update, but the clinical leaders were ultimately responsible. The DON was asked, if a resident was started on antibiotics for UTI for 5 days, what was the expectation regarding the care plan, and he revealed that the care plan should be updated to reflect the UTI diagnosis. The DON was informed that there was no evidence to support that the care plan was developed for a resident with UTI concerns and he acknowledged the concern. 2) On 12/03/2025 at 9:15 AM, during the initial screening process Resident #29 was asked about antibiotics treatment and the resident revealed that he/she just finished their antibiotics about a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	week ago for Pneumonia. On12/08/2025 at 12:27 PM, a review of Resident #29's MDS completed on [DATE] revealed that the resident was diagnosed with Pneumonia. A review of Resident #29's orders revealed that on 11/19/2025 the resident had an order for Amoxicillin Oral Capsule 500 MG (Amoxicillin) Give 1 capsule by mouth three times a day for PNA and sinus infection for 7 days. On 12/08/2025 at approximately12:49 PM, a review of Resident #29's care plan revealed that there was no documented evidence to support that the facility developed a care plan to address the prevention and or treatment interventions of Pneumonia. On 12/08/2025 at 1:32 PM, the DON was informed that there was no evidence to support that the care plan was developed for a resident with the above-mentioned concerns and he acknowledged the concern. 3)This surveyor reviewed Resident #5's clinical record on 12/4/25 at 9:06 AM. The resident had a care plan to address depression related to disease process. One intervention was to monitor for lethargy, grogginess, or slurred speech. The resident also had a care plan to address anxiety related to anxiety and a schizoaffective disorder. One of the interventions was to monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. A review of the resident's Treatment Administration Record (TAR) on 12/5/25 revealed the facility staff were monitoring for the following: worrying, delusions that are crippling to the patient, worry, tearfulness, emotional distress, hallucinations, crying, sadness. The resident's care plan identified eight behaviors that were to be monitored but not one of those was on the TAR to record so that staff are aware of the resident having signs of worsening mental health. This surveyor interviewed the Director of Nursing (DON) on 12/5/25 at 1:25 PM. This surveyor showed the DON the care plans and the TARs. The concerns were explained to the DON. He said he understood that when a care plan specifies monitoring/recording a behavior then it should be on the TAR. He said he would review and get back to the team. No further information was provided to the team prior to the exit conference.

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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 resident and staff interviews and review of the medical record, it was determined the facility failed to ensure that dependent resident's personal hygiene needs were adequately met by providing incontinence care in a timely manner. This was evident for 1 (Resident #9) out of 2 residents reviewed for Activities of Daily Living (ADL's) during the facility's recertification survey. The findings include: Activities of Daily Living (ADLs) are the basic, essential self-care tasks individuals perform to maintain their daily lives such as hygiene, eating, mobility, and toileting.On 12/1/2025 at 11:27 AM in an interview with Resident #9, he/she stated he/she had not been changed since the previous shift (7PM-7AM) at approximately 6:00 AM. During the interview he/she stated that it was the norm and that he/she was not usually changed until after 11:00AM during the 7AM-7PM shift. Resident #9 stated, I get changed at 5/6 AM (by the 7PM-7AM shift) and then when I'm wet and need to be changed on the 7AM-7PM shift, they're serving breakfast and feeding residents. I have to ask them around 11AM to get changed so I can get ready for therapy. On 12/1/2025 at 11:35 AM in an interview with Registered Nurse (RN #9) when asked how often residents who wear incontinence briefs should be changed, she stated, Every 2 hours or before 2 hours if needed. The surveyor and RN #9 walked down the hallway and into Resident #9's room. In an interview with RN #9 and Resident #9, the surveyor shared the concern that Resident #9 had not been changed once since the start of the shift (7AM-7PM). The resident verified and confirmed to RN #9 he/she had not been changed since around 6:00 AM on the previous shift (7P-7A). The nurse stated, I can talk to the aide, [GNA #38's first name], and figure out why Mr./Ms. [Resident #9's last name] has not been changed yet. During the interview when asked if there were potential complications of a resident not being changed frequently enough and/or as needed (when wet), she stated skin issues such as skin breakdown and urinary tract infections. The surveyor shared the concern that the Resident #9 had not been changed since around 6:00 AM, over 5.5 hours ago. RN #9 stated, This is a concern. I agree with you. The GNAs that are here, they know what to do. On 12/1/2025 at 11:40 AM RN #9 stated, I spoke with [GNA #38's first name], and she said she saw the surveyor and that's why she didn't come in and change the resident. On 12/9/25 at 8:38 AM in an interview with GNA #38 when asked how many times she was supposed to change a resident's incontinence brief in a 12 hour shift, she stated, We check and change every 2 hours, unless they say they're not wet. When asked if the expectation and/or frequency which she changed a resident differed if the resident required the use of a Hoyer lift, she stated, No.On 12/9/25 at 9:32 AM in an interview with the Unit Manager (UM #12) when asked the facility's expectation of how many times a resident's incontinence brief should be changed in a 12 hour shift, she stated, They are supposed to check every 2 hours, so in a 12 hour shift 5-6 times. The surveyor shared the concern that Resident #9 was not checked or changed for over 5.5 hours which RN #9 verified and validated with GNA #38. UM #12 acknowledged and confirmed understanding of the concern.

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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 and interviews, it was determined that the facility failed to: 1) ensure that the resident received treatment and care by assisting a resident with transportation to medical appointments and 2) meet the professional standards of practice during medication administration task. This was evident for 1 (Resident #9) of 2 Resident reviewed for missed medical appointments. This was evident for 1 of 29 opportunities for medication error observed during the medication administration task reviewed during the recertification/complaint survey.Findings Included1) On 12/01/2025 10:45 AM, in an interview with Resident #9, the resident alleged they stopped me from getting mobility. I got the form to renew it, and all the facility had to do was give them the size of my wheelchair and have the doctor sign it and they wouldn't. They said I couldn't use both transportation and to use theirs. So I've missed appointments. The resident continued to explain that the most recent appointment he/she missed was with the vascular doctor and another missed appointment was with the Ear-Nose and Throat (ENT) doctor. The resident stated that he/she was supposed to return for a 3rd appointment, and the facility cancelled it and never made another one.On 12/4/25 at 8:55AM, in an interview, Staff #11 explained that she was responsible for scheduling appointments and arranging the transportation. When I make the appointments, I automatically schedule the transportation as well. She explained that the facility used an electronic calendar to communicate the appointments. She was then asked how the cancellation of appointments were handled and she explained they would call the facility to cancel the appt. Whoever took the call would relay the message to the nurse and whatever the person said would be communicated to me. It might be canceled completely, they might say call back in 2 weeks, whatever the instructions are from the provider's office. Staff #11 was then asked if the facility ever had to cancel a resident appointment before and she replied unless the family said we don't want them to go for a reason, no.On 12/09/2025 at 10:58 AM, a review of Resident #9's progress notes revealed that on 9/24/2025 11:56 AM, a Psychiatry Progress Note revealed The resident engages well with the provider during assessment; he/she was seen in bed. He/She was upset about missing vascular appointment today, and the staff verbalized they are helping with rescheduling another appointment. Further review of the resident's chart revealed that the appointment was rescheduled for a later date and the resident attended the appointment on 10/12/2025.Upon further review of Resident #9's chart, a progress note written on 5/22/2025 at 6 PM revealed .Resident returned from scheduled ENT Appointment with findings of mild senior, neural hearing loss both ears and recommendations to follow-up W/ENIgarding (R) Ear itching on Monday June 2nd. at 3:30 p.m.A progress note written on 6/2/2025 at 3:44 PM revealed Resident ENT appointment was cancelled and to be reschedule. Resident notified.A progress note written on 6/6/2025 at 1:00 AM revealed .Patient continues to report right neck/ear pain and ENT appointment scheduled for last week was canceled for unknown reason.On 12/09/2025 at approximately 12:05 PM, in an interview with the Staff #11, she explained that she was the staff responsible for scheduling the appointments and arranging transportation to and from the appointments. She was asked, How are you notified if the resident's appointment was cancelled? She explained that the nurses would let her know if the appointment was cancelled. If the nurses do not notify her then she wouldn't know that the appointment was cancelled. She was asked about Resident #9's appointment on 6/2/2025 that was cancelled for unknown reason and she explained that the cancelation might be from the doctor's office but she was not sure an was not made aware that the resident's appointment was canceled.On 12/09/2025 at 12:12 PM, in an interview Staff #32, he explained that he has been a driver for the facility for about 4 years. He was asked how he gets notified of a resident's appointment and he explained Staff#11 gives him the appointment on a sheet of paper the day before so he will know where he was going for the next day. He was asked if he kept a log of the appointments he does and he stated No I just keep log of the mileage so that they will know how many miles they went. I keep the papers with the appointment information for about 2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks only. When asked he explained that the escort who accompanies the residents will makes notation about any event that might take place during transport, the escorts were Geriatric Nursing Assistants. He was asked if the residents missed any appointment due to a driver not being available and he explained that he has not called off from his shift in about 5 years and the facility now has a back-up driver who works as needed. He denied having any knowledge of residents missing their appointment.On 12/09/2025 2:49 PM, the surveyor reached out to the Resident's otolaryngologist office via telephone and the office staff shared that Resident #9 missed two separate appointments, one that was scheduled on 6/2/2025 and a rescheduled appointment that was made on 6/18/2025 and the resident was a no show for both appointments. The doctor's office confirmed that they did not cancel Resident's appointments.On 12/09/2025 at 3:25 PM, in a telephone interview with Staff #11, the surveyor asked if there were residents that used their own private transportation or hired a company that provide transportation to medical appointments. She stated that she was not aware that any of the residents used their own transportation services or hired transportation services. Everyone used the facility's transportation services to get to and from appointments. Staff#11 was asked to provide a copy of Resident #9's appointment and a review of the documentation provided showed that the resident was scheduled for a ENT appointment on 6/2/2025 at 3:30 PM and 6/16/2025 at 2:30 PM.On 12/09/2025 at 4:56 PM, the Director of Nursing was made aware that Resident #9 missed two ENT doctor's appointments in June 2025 and the facility failed to follow-up with cancelled appointments or reschedule the appointment as recommended to ensure that the resident was receiving adequate treatment and care for the above-mentioned right neck/ear pain.2) On 12/05/2025 at 8:53 AM, during the medication administration facility task the surveyor observed Staff #45 (License Practical Nurse) during medication pass. Staff #45 was observed preparing Resident #32 morning medication which included Enulose Solution 10 GM/15ML, 30 milliliters by mouth one time a day every Monday, Wednesday and Friday for constipation; however, during this time the surveyor observed Staff #45 pour medication for a enulose 10GM/15ml container with another resident's name (Resident #8). The nurse was asked if it was typical for the nurses to share the resident's medication with other residents and she stated not typically. She was asked if the resident had their own bottle of the enulose and she stated that she didn't see a bottle for the resident in the medication cart. She attempted to administer the 30ml of enulose to the resident at 9 AM; however, the resident refused medication stating that he/she did not need it.On 12/05/2025 at 10:05 AM, in an interview with Staff#46 (Registered Nurse), the surveyor asked Staff #46 about a scenario in which a medication(lactulose/enulose) was ordered for a specified resident; however, if the resident specific medication was not available, would she use another resident medication as a substitute, Staff #46 answered that she would not use another resident's medication. Staff #46 was asked if enulose/lactulose was a floor stock (non-patient specific) medication within the facility and she explained that the medication was not usually floor stock and was ordered for specific residents.On 12/05/2025 at 3:16 PM, the Director of Nursing (DON) was notified about the above-mentioned findings and he acknowledged the findings.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, record review and interviews, it was determined that the facility failed to ensure that the resident received assistive devices to maintain vision abilities. This was true for 1 (Resident #9) of 2 Residents reviewed for vision impairment during the recertification/complaint survey.Finding Included:On 12/01/2025 at 10:57 AM, in an interview with Resident #9, the resident explained that he/she got fitted for glasses, but he/she never received the glasses, and it has been a few months. During the interview, the surveyor did not observe the resident in possession of any glasses at bedside.On 12/08/2025 at 2:36 PM, a review of a progress note written on 7/29/2025 at 1:27 PM revealed that Resident #9 went to eye appointment in-house this morning. The resident came back with no glasses stated that the appointment was just for the measurement of the frame and no new appt scheduled at this point. A 8/25/2025 7:18 PM NURSING QUARTERLY CHARTING stated, vision is adequate Wears glasses.On 12/08/2025 at approximately 3:30 PM, in an interview with Staff #12 (unit manager) she was asked about Resident #9's glasses and the current plan of care, Staff #12 stated that she was not aware of the resident's vision concern as she was newly hired. The surveyor asked Staff #12 if the resident had glasses and she stated no. The surveyor requested that Staff #12 follow up with the resident's care.On 12/09/2025 at 8:57 AM, in an interview with the Director of Nursing (DON) was asked how often the ophthalmologist visits were done at the facility and he stated that they come twice a year for evaluations and exams. He was then asked about how the facility obtain documentation from the ophthalmologist visits, and he stated that after an ophthalmologist visit, they would provide documentation of the evaluation results to the social worker or nursing services via email. The DON was informed that the surveyor was unable to locate documentation in Resident #9's medical record to show recommendation from the ophthalmologist after their visits. He was asked to provide any available documentation about the resident's ophthalmologist visit and the current plan of care or recommendations.On 12/09/2025 at10:30 AM, the DON was asked about the ophthalmologist documentation, and he stated that they were still working on it. On 12/10/2025 at 09:03 AM, a review of Resident #9's visual acuity exam completed on June 25, 2025 revealed mild to moderate cataract; plan: pt prefers observation at this time. However, about a month later, a 7/29/2025 progress notes revealed that the resident was fitted for glasses, without a follow-up appointment.On 12/10/2025 at 9:08 AM, in an interview with the DON, the DON stated that there was a note stating that Resident #9 did not request any frames. The surveyor requested documentation from the DON; however, the facility failed to provide additional documentation to support that the resident either refused glasses or that the facility appropriately provided treatment and assistive devices to maintain the resident's vision abilities.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on resident interview and staff interview it was determined that the facility staff failed to ensure a resident's colostomy bag was monitored and changed as needed by staff. This was evident for 1 (Resident #2) out of 1 resident reviewed for colostomy care during the recertification/complaint survey. The findings include:Resident #2 was interviewed on 12/03/2025 at 9:04 AM. The resident stated that they don't check their colostomy bags more than once per shift.The resident came down to the ground level where the survey team was located on 12/4/25 at 1:00 PM. The resident said that yesterday at 10:30 AM the colostomy bag exploded, and they were not changed until 3:00 PM. The resident stated that they had feces all over [their] body, pants, and shoes. The physical therapist (staff # 27) was interviewed on 12/5/25 at 2:44 PM. This surveyor asked if she worked with the resident yesterday. She confirmed that she worked with the resident yesterday,12/4/25. She initially was not sure what time but after thinking for a few seconds she said it was definitely before noon. She was asked if she noticed anything unusual with how the resident looked. She said she was not sure what that meant. This surveyor asked if the resident was dressed. She replied well, I had to put [his/her] pants on. She was asked if his/her colostomy bag had exploded or was opened. She said not yesterday. She was then asked if the resident had had an open or overflowing colostomy bag before. She replied yes, many times and there have been times where [he/she] did not have a bag on at all. The findings were presented to the facility administrative team on 12/9/25 at 4:30 PM.

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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 a review of resident medical records and an interview with facility staff, it was determined that the facility failed to timely address significant weight loss for a resident. This was evident for two (Residents #6 and #13) of the four residents reviewed for nutrition during this recertification/complaint survey.The findings include:1) During the initial screening of Resident #6 on 12/02/25 at 7:26 AM, it was noted that the resident had a triggered weight loss alert on the Minimum Data Set (MDS, which is a federally mandated, standardized assessment tool used by Medicare/Medicaid certified facilities to comprehensively evaluate residents' health, functional, and psychosocial needs for care planning, quality improvement, and funding.)A review of Resident #6's medical records on 12/03/25 at 1:09 PM revealed the following documented body weights:5/01/25: 203 lb. (pound) via Hoyer5/30/25: 184.4 lb. via Hoyer6/02/25: 184.2 lb. via Hoyer6/09/25: 185.4 lb. via Hoyer7/03/25: 185.0 lb. via Hoyer8/05/25: 175.4 lb. via Hoyer9/01/25: 177.1 lb. via Mechanical lift10/03/25: 178.2 lb. via Mechanical lift10/22/25: 176.2 lb. via HoyerThe weight documented on 5/30/25 (184.4 lbs.) represented an 18.6 lb. loss (9.1% change) within a one-month period compared to the 5/01/25 weight (203 lbs.).Further review of Resident #6's medical records revealed that the resident had been transferred to the hospital on 5/21/25 and readmitted on [DATE]. However, there was no assessment and/or interventions documented in the resident's chart regarding this significant weight change: the first dietitian's note after the readmission was documented on 6/27/25.A second weight loss was noted on 8/05/25, showing a 9.6 lb. difference (5.1% loss) from the 7/03/25 weight. Per Resident #6's medical record, this was also right after his/her recent hospitalization (from 8/01/25 to 8/04/25). However, there was no follow-up weight check until a month later.In an interview with the dietitian (Staff #14) on 12/04/25 at 9:26 AM, she stated the facility should follow-up with a weekly re-check of body weight for a month, encouraging oral intake, providing high protein snacks, and so on, after identifying a resident's weight loss. The surveyor reviewed Resident #6's body weight records with Staff #14 and asked whether the readmission weight changes constituted significant weight changes or not. Staff #14 stated that for Resident #6's weight, it needed to be re-checked at least weekly for a month, and assessment and interventions should be documented in the resident's medical records.During an interview with the Director of Nursing (DON) on 12/04/25 at 12:27 PM, he reviewed Resident #6's body weight records with the surveyor. The surveyor shared concerns that the resident's weight changes were not closely monitored by the facility staff and that no appropriate assessment/intervention was provided in a timely manner. He validated these concerns.2) During a review of Resident #13's medical records on 12/02/25 at 11:46 AM, the resident's body weight was documented as follows:9/08/25: 95.5 lbs. (pounds) by Hoyer9/16/25: 90.2 lbs.9/17/25: 89.6 lbs. by mechanical lift9/24/25: 90.4 lbs. by HoyerThe weight measured on 9/16/25 (90.2 lbs.) was 5.5% less than the weight recorded a week prior (9/08/25: 95.5 lbs.).Further review of Resident #13's medical records revealed that a physician's progress note was written on 9/18/25 by the attending doctor without addressing the significant weight loss. A dietitian wrote a progress note a week later (on 9/25/25) than when the initial significant weight loss was noted.In an interview with Staff #14 (Dietitian) on 12/04/25 at 9:26 AM, she explained that the facility staff were made aware of residents' weight loss by nurses' weight documentation and/or weekly meetings. The surveyor reviewed Resident #13's body weight records with Staff #14. The staff verified that the resident's significant weight loss was not addressed in a timely manner.In an interview with the Director of Nursing (DON) on 12/04/25 at 12:27 PM, the surveyor shared the above concerns regarding Resident #13's significant weight loss. The DON validated them.

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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 surveyor observation, review of the medical record, and interview with facility staff, it was determined that the facility staff failed to provide necessary respiratory care services by failing to document the indication for oxygen therapy, failing to properly label the oxygen tubing, and failing to administer oxygen at the prescribed flow rate. This was evident for 1 (Resident #6) of 3 residents reviewed for Respiratory Care during this recertification/complaint survey.The findings include:During the initial tour on the first floor of the facility on 12/01/25 at 2:26 PM, it was observed that Resident #6 was receiving Oxygen at 1.5 L/minute through a nasal cannula. At this time, it was noted that the oxygen tubing was not labeled.On 12/05/25 at 9:56 AM, a second observation was conducted by the surveyor. It was noted that Resident #6's oxygen tubing did not have a label, and the oxygen was infused at 1.5 L/minute.A review of Resident #6's medical record on 12/05/25 at 9:41 AM revealed that the resident had an order: [resident's name] wears O2 at 2 L/min via nasal cannula continuously via (concentrator, portable or both), started on 12/01/25. Crucially, there was no documented indication for the oxygen therapy.In an interview with Staff #45 (Licensed Practical Nurse) on 12/05/25 at 9:57 AM, she confirmed that the facility nurses are responsible for managing residents' oxygen therapy, including setting the accurate amount of oxygen, changing tubing weekly, and dating the label. The surveyor asked Staff #45 about Resident #6's Oxygen therapy. She stated that the resident needed oxygen for COPD but she verified it was not contained in the his/her oxygen order. The surveyor also observed Resident #6's oxygen setting with Staff #45. The staff validated that the oxygen tubing did not have a label and was currently administering 1.5 L/minute. Staff #45 confirmed that the prescribed flow rate was 2 L/minute.During an interview with the Director of Nursing on 12/05/25 around 11:00 AM, the surveyor shared the above findings. He validated the concerns.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on resident interview and observation of a test tray, it was determined that the facility staff failed to ensure residents are served hot and palatable meals. This was evident for 5 (Residents #2, 9, 50, 98, 110) out of 47 residents in the survey sample.The findings include:An interview with Resident #2 on 12/3/25 at 9:15 AM revealed that the resident was not happy with the quality of the food. Four residents (#9, #50, #98, and #110) were interviewed on 12/4/25 as part of the Resident Council task. This surveyor asked if the food served was good and/or served hot. They said the food is often cold. They said they have requested microwaves, but the administration has said microwaves are against company policy. They added that the administration said they may revisit the issue in the future. One resident added that the rumor was that a staff member got burnt but another resident chimed in and said the administration initially blamed the state. Two test trays were ordered from the kitchen for the last service of the day on 12/8/25. The two trays would be one with pureed food and the other would be a regular diet. Trays went up to the unit at 12:30 PM. This surveyor opened the first meal at 12:55 PM after ensuring all other meals had been served. The temperatures were: Lasagna 128 Fahrenheit(F) and the broccoli 118F. The food service director asked to get his thermometer to ensure temperatures were accurate. The cover was placed back on the hot food. Upon return the temperatures were checked again and found to be .4 degrees colder. The lemonade and milk were checked: the lemonade 54F and milk 53F. The food service director asked to get another thermometer to ensure the temperatures were accurate. He returned with a thermometer and tested the liquids which were now one degree warmer. The regular food was tested at 1:17 PM (the cover was on the entire time). The lasagna was 132F, broccoli was 110 F, lemonade 56 F, and milk 54F. The hot foods were not hot enough except for the regular lasagna. The milk should be served at 41F or below. The hot food should be served at 130F or above.The Dietary Director (Staff #2) was interviewed on 12/8/25 at 1:20 PM. He acknowledged the food temperatures that were either too cold or too warm. This surveyor asked about residents requesting their meals be reheated. He said he gets 1-2 trays returned each day. He said they don't reheat the food, they scrape off the old food and replace with a new plate of food. He said he was unaware of why they can't have microwaves but was sure it was a corporate decision.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to 1) maintain a medical record in the most accurate form for residents and 2) ensure that residents' indication of medication was documented. This was evident for 3 (Resident #7, #8, and #11) out of 27 residents reviewed during the facility's recertification/complaint survey.The findings include: 1) On 12/4/25 at 11:15 AM while reviewing Resident #7's paper chart on the unit, Resident #35's face sheet and 11/7/25, 8 page discharge summary from Northwest Hospital was observed. On 12/4/25 at 11:23 AM in an interview with Unit Manager (UM #12), when asked if resident records stored in charts should be accurate and reflect that specific resident, she stated, The resident's information should be stored in their chart. No other resident's information should be in there. During the interview, a dual observation of Resident #7's chart was conducted. When asked whose chart it was, UM #12 stated, [Resident #7's first and last name]. When asked to flip to the green, Progress Notes tab, the surveyor flipped a few pages and stopped on the documents of Resident #35. When asked whose records they were, UM #12 stated, They're for another resident in room [room number of Resident #35]. When asked if these were accurate records for Resident #7, she stated, No and said she would move them to the correct chart. The surveyor shared this was a concern and she acknowledged the concerns. 2) On 12/3/25 at 12:08 PM review of Resident #11's medial record revealed the resident was ordered Seroquel Oral Tablet 25mg (milligrams) (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for schizophrenia and Quetiapine Fumarate Oral Tablet 50mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for schizophrenia. Continued review failed to reveal a diagnosis of schizophrenia. On 12/5/25 at 9:11 AM in an interview with the Regional Director of Nursing and DON, when asked if all active diagnoses are listed in the diagnoses tab in PCC (Point Click Care, the facility's electronic medical record) and if not, why and where else would diagnoses be listed/found, the Regional Director of Nursing stated she would find out. On 12/5/25 at 11:44 AM in an interview with the Regional Director of Nursing she stated that all active diagnoses for a resident are listed in PCC under the Diagnosis tab and they were confirmed by a provider. Additionally, she stated there may be inactive or resolved diagnoses that may not show but stated those could be revealed by clicking the plus sign. On 12/10/25 at 2:31 PM in an interview with the DON when asked should each medication order have an indication, he stated, Yes or a related diagnosis. During the interview when asked if residents should have the corresponding diagnosis listed in their diagnoses list in PCC that aligns with the indication for the medication he stated yes. In a dual observation with the Director of Nursing of Resident #11's two medication orders, when asked to read the orders and indication, he stated, Seroquel Oral Tablet 25mg (milligrams) (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for schizophrenia and Quetiapine Fumarate Oral Tablet 50mg (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for schizophrenia. In a dual observation of the resident's face sheet and the resident's Med Diag (medical diagnosis) tab in PCC, when asked if he saw a diagnosis of schizophrenia for Resident #11, he stated no. When asked why this resident had 2 medications ordered for schizophrenia when the resident was not diagnosed with schizophrenia he stated, Let me look at the psych notes. The surveyor shared that the Regional Director of Nursing had verified and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed any active diagnoses for residents would be listed in the diagnoses tab in the PCC. The surveyor shared this was a concern and the DON verbalized and acknowledged understanding. On 12/10/25 at 2:47 PM in an interview with the Call Taker for Answering Service with HealthDrive (formerly Five Star Physicians), she stated she could leave a message for the Nurse Practitioner (NP #17) to return the surveyor's call. On 12/11/25 at 9:33 AM in an interview with NP #17 when asked about the 2 orders for medications for Resident #11 with the indication as schizophrenia but no schizophrenia diagnosis, she stated, This has come up at the facility before as well. According to his/her discharge summary from when he/she came to the facility that was uploaded on 1/9/25 and on page 6 of 15 on the left hand side you'll see a note under psych (psychiatry) history that per notes, history of schizophrenia, daughter could not confirm. During the interview when asked what notes, NP #17 stated, I'm guessing they're referring to previous psych notes from Levindale which I don't have access to. Additionally, she stated, When the daughter came to the facility and I spoke with her she said she was unaware of a schizophrenia diagnosis. He/she came to us on those meds and that's why we continued. 3) In a review of Resident #8's medical records on 12/04/25 at 8:52 AM, it was revealed that the resident had diagnosis of Bipolar since his/her admission, never diagnosed schizophrenia. However, the Seroquel order from 7/08/25 to 9/23/25 was indicated for Schizophrenia. During an interview with the Director of Nursing (DON) on 12/05/25 at 1:43 PM, he confirmed that Resident #8 has a diagnosis of bipolar disorder, but not schizophrenia. The surveyor reviewed the resident's order with the DON, and the DON verified that the Seroquel order was incorrectly indicated for Schizophrenia.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interviews and a review of medical records and facility documentation, it was determined that the facility failed to properly monitor and track antibiotic usage and resistance data. Specifically: 1) the facility's antibiotic stewardship log failed to include essential elements of antibiotic use, and 2) an antibiotic was initiated for a resident before the infecting organism was identified by the laboratory. This deficiency affected one of five residents (Resident #7) reviewed for antibiotic use and the antibiotic stewardship program during the recertification/complaint survey.Findings include:1) On 12/07/25, as part of the Infection Control task, the surveyor requested copies of the antibiotic stewardship logs from January 2025 to the present.On 12/08/25 at 8:54 AM, the surveyor reviewed the facility's log, which was a spreadsheet including resident names, room numbers, infection sites, and prescribing clinicians. However, the log failed to consistently list the duration of antibiotic use, and several entries in the organism identified section were either left blank or marked as no.During an interview on 12/08/25 at 9:00 AM, the Director of Nursing (DON), who also serves as the Infection Preventionist (IP), stated that the facility discusses new antibiotic orders daily with unit managers and the IP, as well as during monthly meetings with the Medical Director. The surveyor reviewed the log with the DON and shared concerns that the documentation failed to address essential elements of antibiotic tracking. The DON validated these findings.2) On 12/08/25 at 9:30 AM, the surveyor reviewed Resident #7's antibiotic use. Records showed the resident had been receiving Cephalexin 250mg daily for UTI prophylaxis since November 2023. Additionally, a new order for Bactrim 800-160mg for a Urinary Tract Infection (UTI) was initiated on 10/22/25 for three days. The October 2025 Medication Administration Record (MAR) showed the first dose of Bactrim was administered on the evening of 10/22/25.However, a review of the medical record revealed the urine culture was collected on 10/19/25, but the results were not reported until 10/23/25 at 10:08 AM. This indicates the antibiotic was started before the infection was confirmed or the organism identified.During an interview on 12/08/25 at 1:36 PM, the DON stated that the facility typically contacts the physician and starts antibiotics only after culture results are received. When the surveyor pointed out that Resident #7 received Bactrim prior to the diagnosis, the DON suggested it may have been for prophylaxis. The surveyor noted that the resident was already on a year-long prophylactic dose of Cephalexin. On 12/09/25 at 8:53 AM, the DON confirmed there was no provider documentation to justify the Bactrim order prior to the lab report and validated the surveyor's concern.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record reviews and staff interviews, it was determined that the facility failed to document the provision of education regarding the benefits, risks, and potential side effects of the COVID-19 vaccine to residents. Additionally, the facility failed to maintain required documentation related to staff COVID-19 vaccination status. These findings were evident for one resident (Resident #89) out of five reviewed, and four staff members (Staff #19, #51, #52, and #53) out of five reviewed during this recertification/complaint survey.The findings include:A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease.1) On 12/05/25 at 11:34 AM, the surveyor randomly selected five residents to review their immunization records. The review revealed that Resident #89, who was admitted in October 2025, did not have a COVID-19 vaccination record on file.In an interview on 12/08/25 at 8:54 AM, the Director of Nursing (DON), who also serves as the Infection Preventionist, stated that facility staff are required to review a resident's immunization status upon admission. This is typically done using hospital records or ImmuNet (Maryland's centralized immunization registry). The DON explained that based on this data, the facility offers or provides vaccinations and maintains the documentation in the resident's medical record.The surveyor shared the concern that Resident #89's medical record contained no COVID-19 vaccination status or evidence of education. The DON validated this finding.2) During a review of newly hired employees' health records on 12/08/25 at 8:31 AM, it was revealed that four out of five staff members (Staff #51, #19, #52, and #53) lacked COVID-19 vaccination status documentation in their employee health files.In an interview on 12/08/25 at 8:54 AM, the DON stated that the Human Resources (HR) department is responsible for reviewing new employees' vaccination status, including COVID-19, at the time of hire. Following the HR review, nursing staff are then expected to review the records. The surveyor presented these findings to the DON, who validated the lack of documentation.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview it was determined the facility failed to ensure residents had access to call bells. This was evident for 1 (Resident #12) resident observed during the surveyor's initial tour of the facility during the recertification survey.The findings include:Keeping the call bell within reach is a fundamental nursing standard of practice for patient safety, especially fall prevention, ensuring patients can summon help for needs like toileting, water, or repositioning, reducing risks from altered mobility or medication side effects, and improving satisfaction by providing timely assistance and patient empowerment. This involves ensuring the device is accessible (e.g., below grab bars in bathrooms, not obstructed), functional, and that patients know how to use it, with staff regularly checking and responding promptly to these signals. Upon the surveyor's initial tour on 12/1/25 at 11:20 AM, the call bell for Resident #12 was observed to be inaccessible, on the floor and behind the resident's bedside table. On 12/1/25 at 11:25 AM in an interview with Registered Nurse (RN#49) when asked if all residents should have an accessible call bell within reach, she stated, Yes. During the interview, a dual observation was conducted of Resident #12's call bell. The call bell was observed to be on the floor and behind the resident's nightstand. When asked if this call bell was accessible and within reach, she stated no. The surveyor shared this was a concern and RN #49 acknowledged and confirmed understanding of the concern.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on surveyor observation and interviews with facility staff, it was determined that the facility failed to include all the required staffing information daily and post the staffing information at the beginning of each shift. This was evident for 5 out of 5 days of staffing information reviewed and 1 out of 1 observations of the posted staffing information during the recertification/complaint survey. The findings include:On 12/9/25 at 2:04 PM review of the schedules for 12/5/25, 12/6/25, 12/7/25, and 12/8/25 provided by the facility revealed the documents did not include the facility name, resident census, and the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses (RNs), licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), and certified nurse aides. On 12/9/25 at 11:00 AM in an interview with the Staffing Coordinator/Medical Records (SC/MR #11) a dual observation of the aforementioned days of the schedule was conducted. During the interview when asked if the facility name appeared on the schedule, SC/MR #11 stated, No. Furthermore, when asked if the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs or LVNs and CNAs were included on the schedule, SC/MR #11 stated, No. Additionally, when asked if the schedules included the resident census, SC/MR #11 stated, No. The Director of Nursing (DON) and one of the Unit Managers (UM) were also present during the interview. On 12/9/25 at 11:02 AM in an interview with UM #12 a dual observation of the schedules was conducted. When asked if the 4 Nursing Schedules were the same schedule posted on the units, UM #12 verified and confirmed that they were the same schedules posted on the units. The surveyor shared the concerns with the DON who instructed SC/MR #11 to write down the required, missing information from the schedules. During the interview, the above findings were acknowledged and confirmed with the DON who verbalized understanding on 12/9/25 at 11:08 AM.On 12/10/2025 at 8:58 AM in the reception area of the facility's long term care building, the surveyor observed that the staffing information posted was dated 12/9/25 and took a picture. At that moment, the Regional Administrator (RA #5) approached the reception desk from the other side and stated, Is it not updated yet?. The surveyor stated no and showed RA #5 who confirmed it was not today's date (12/10/25). He stated, SC/MR #11called out today, I'm not sure if you heard, I'll get you an updated copy. On 12/10/2025 at 9:09 AM the Nursing Home Administrator (NHA) provided a copy of the current staffing information (12/10/25) and verified that the schedule was not posted by the beginning of the shift at 7:00 AM. Furthermore, he acknowledged and confirmed that the staffing information for today (12/10/25) did not have the required information such as facility name, resident census or the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs or LVNs and CNAs. He stated, I can go and get it changed right now. Can I do that? The surveyor shared that it was still a concern. The NHA verbalized understanding of the concerns.