

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Riverview		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Eastern Boulevard Essex, MD 21221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews, it was determined that the facility failed to provide adequate linen for residents. This was evident for two ([NAME] and Swan) out of four units observed during the recertification survey. The findings include: On 06/08/2026 at 8:26 AM, an interview with Resident #253 was conducted. They reported that the facility staff did not have enough linen and there were not enough bed sheets. The resident alleged that they were put in wheelchairs in the morning due to lack of bed sheets to make clean beds. On 06/08/2026 at 1:26 PM, an interview with Resident #128 was conducted. They reported that there were no sheets to make their bed and that the facility had a shortage of linen. At this time, the surveyor observed Resident #128's bed without any sheets. On 06/11/2026 at 12:37 PM, the surveyor observed room [ROOM NUMBER] bed 1 ([NAME] unit) with no bed sheets on and the resident was sitting in a wheelchair. A brief interview with Staff #28, Geriatric Nursing Assistant (GNA), was conducted. She reported that she had called the laundry department and requested for bed sheets to be delivered to the unit. She also added that in the morning, the linen carts are delivered late, and it is not enough, which affected the GNAs workflow. The surveyor also observed [NAME]'s linen cart and closet without any linens in storage. On 06/11/2026 at 1:09 PM, another interview with Staff #29, GNA, on swan unit was conducted. She reported the unit did not have enough linens for residents. The staff showed the surveyor the linen closet which had no towels or bed sheets. Similarly, the linen cart on the swan's unit hallway had no linens or towels. On 06/11/2026 at 1:15 PM, an interview with Staff #30 was conducted. When asked if they were aware of the linen shortage in the units, the staff reported that the GNAs were hiding linens and was unsure why. On 06/11/2026 at 1:19 PM, an interview with Staff #34, Environmental Services Director, was conducted. He reported that each resident is supposed to have 3 flat sheets, 3 fitted sheets, 3 pillowcases and 6 wash clothes per day. On 06/11/2026 at 1:24 PM, a review of the facility's document titled, linen par level, failed to show that linen supplied to all units were sufficient for residents. According to the document, Heroin unit had 31 beds, however, the sheets sent to the unit for the 7am- 3pm shift were for 30 beds. On 06/12/2026 at 9:42 AM, an interview with the facility administrator was conducted. She reported that the document submitted was for delivery schedule. When asked what the par levels for linen were supposed to be, she reported that she was unsure, however, she had identified that the linen shortage was an ongoing problem for the facility.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observation and interview, it was determined that the facility failed to maintain infection prevention and control regarding enhanced barrier precautions while providing high contact care. This was evident for four (Resident #12, #24, #147 & #223) out of seven residents reviewed for respiratory care. The findings include: Enhanced Barrier Precautions (EBP) are infection control measures, primarily for nursing homes, requiring healthcare workers to wear gloves and gowns during high-contact resident care activities (like bathing, dressing) to prevent spreading multidrug-resistant organisms (MDROs) to hands and clothing, even if blood/body fluid exposure isn't expected, extending standard precautions for residents with multidrug-resistant organisms (MDROs) or at high risk (wounds, devices). Personal Protective Equipment (PPE) refers to specialized gear like gloves, gowns, masks, and goggles that create a barrier to protect healthcare workers from infectious materials (blood, body fluids, germs) and prevent them from spreading infections to patients or others. 1) On 06/08/2026 at 10:08 AM, Geriatric Nursing Assistant (GNA#25) was observed providing a bed bath to Resident #12 while wearing gloves only. Observation revealed Enhanced Barrier Precautions signage was posted on the resident's door and at the bedside, indicating that both a gown and gloves were required during high-contact care activities. GNA #25 was not wearing a gown while performing the bed bath. When asked what precautions Resident #12 was on, GNA #25 stated she did not know. When asked whether appropriate PPE was required during bathing and direct resident care, GNA #25 stated she was not sure. On 06/08/2026 at 10:14 AM, Registered Nurse (RN #26) and Licensed Practical Nurse (LPN #27) were interviewed regarding facility expectations for caring for residents on Enhanced Barrier Precautions. RN #26 stated staff were expected to wear gowns and utilize appropriate PPE when providing direct care to residents on EBP. During a concurrent observation, RN #26 and LPN #27 confirmed that GNA #25 was not utilizing the required PPE while providing care to Resident #12. On 06/09/2026 at 10:22 AM, review of Resident 12's clinical record revealed an active physician order for Enhanced Barrier Precautions. 2) On 06/08/2026 at 10:57 AM, GNA #22 was observed providing a bed bath to Resident #24 while wearing gloves only and without a gown. When asked about the required process for providing direct care to a resident on Enhanced Barrier Precautions, GNA #22 stated she was supposed to wear a gown and acknowledged that appropriate PPE should have been utilized. On 06/09/2026 at 10:29 AM, review of Resident #24's clinical record revealed an active physician order for Enhanced Barrier Precautions. On 06/12/2026 at 8:50 AM, during an interview, the Infection Preventionist (IP), when asked about the facility's expectation regarding PPE, she stated staff were expected to follow precaution signage posted on resident doors and at the bedside. The IP further stated that staff providing direct care (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities, including bathing and incontinent care, were expected to wear both gowns and gloves when caring for residents on Enhanced Barrier Precautions. When informed of the surveyor's observations, the IP acknowledged the concerns. On 06/12/2026 at 8:58 AM, the Director of Nursing (DON) was informed of the concerns. The DON acknowledged the observations and stated staff re-education would be provided. 3) On 06/09/2026 at 2:12 PM, surveyor observed Staff #21 changing soiled linens on Resident #223's bed. On 06/09/2026 at 2:20 PM, an interview with Staff #21 was conducted. She reported that she was not aware that the Enhanced Barrier Precautions (EBP) were for Resident #223, she thought it was for the roommate. Staff acknowledged that she did not wear the indicated personal protective equipment. Staff also acknowledged that she had not seen the sign above Resident's #223's bed that indicated EBP precautions were to be followed when changing soiled linens. On 06/09/2026 at 2:35 PM, an interview with Staff #6, Unit Manager, was conducted. She reported that all Geriatric Nursing Assistants (GNAs) had been trained to wear a gown and gloves when bathing and changing linens of residents who had EBP signs. On 06/11/2026 at 11:18 AM, a review of the facility provided list of residents on EBP precautions failed to include Resident #223. The review of Resident #223's medical record revealed an active order for EBP precautions. On 06/11/2026 at 11:20 AM, an interview with Staff #20, facility's infection prevention nurse, was conducted. She reported that Resident #223 should be on the list of residents on EBP precautions and that staff are expected to wear gown and gloves while changing soiled linens. On 06/11/2026 at 11:33 AM, the facility administrator was notified of the concerns. 4) On 6/10/26 at 8:28 AM, the surveyor observed GNA #15 providing Resident #147 a bed bath while not wearing a yellow PPE (personal protective equipment). It should be noted that GNA#15 was wearing gloves while providing this care. The surveyor did observe an EBP sign on Resident #147's door and a PPE bag with both gloves and gowns hanging on Resident #147's door. A review of Resident #147's EMR (electronic medical record) on 6/10/26 at 9:27 AM revealed that Resident #147's EMR (electronic medical record) contained an order for Enhanced Barrier Precautions (EBP) for a history of ESBL (extended-spectrum beta-lactamase, a group of bacterial enzymes that make bacteria resistant to many common antibiotics) infection.		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on family interview, record review, and Staff interviews, it was determined that the facility failed to provide quarterly statements to the Resident's Representative. This was evident for one (Resident #7) out of two residents reviewed for personal funds. The findings include: On 6/8/2026 at 12:29 PM, an interview with Resident #7's Representative (RP) was conducted. When asked if they received quarterly statements from the facility, the RP stated that they have not been receiving them. On 6/8/2026 at 12:45 PM, a review of Resident #7's chart was conducted. Resident #7's RP was charted as the responsible party. Resident #7's Brief Interview for Mental Status (BIMS) was noted as 99. A BIMS (Brief Interview for Mental Status) is the standardized test which measures orientation and recall skills on a scale from 0 to 15. The number 99 is an administrative code used by care teams to indicate that the patient was unable to complete the interview. On 6/11/2026 at 12:45 PM, an interview with Business Office Manager (Staff #33) was conducted. When asked how Quarterly statements are provided to residents or representatives, Staff #33 stated they hand statements to residents that are capable in the building and mailed to RP's if the RP is the Power of Attorney (POA). When asked if Resident #7's RP was provided a quarterly statement, Staff #33 stated no because Resident #7's RP is not the POA. When asked if Resident #7 got the statement, Staff #33 stated nobody got the statement because Resident #7 does not have cognitive capacity. On 6/11/2026 at 1:30 PM, an interview with Nursing Home Administrator (NHA) was conducted. When asked if Resident #7's family given a quarterly statement, the NHA stated no because the RP is not a POA. This surveyor stated that regulation text does not specify RP requisite of being POA to be provided Quarterly Statements. NHA stated that the facility has been following this practice for years.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on record review and interview, it was determined that the facility failed to complete Quarterly Minimum Data Set (MDS) assessments within 14 days after the assessment reference date. This was evident for one (Resident #185) out of three residents reviewed for resident assessments. The findings include: The Minimum Data Set (MDS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames the Quarterly MDS is to be completed no later than 14 days after the Assessment Reference Date (ARD). On 6/10/26, a surveyor review of the clinical record of Resident #185 revealed that the quarterly MDS had an ARD date of 2/4/26. Staff was required to complete the annual MDS by 2/18/26. This MDS for Resident #185 is documented as completed on 3/25/26 (Z0500B- question location in the MDS), which was 35 days after the required completion date. Of note, RN (registered nurse) #35 (Corporate MDS Coordinator) signed that this MDS as complete on 5/14/26 (Z0500); however, in section Z0400 for eleven sections RN #35 signed as the signature of person completing the assessment or entry on 6/8/26 and dietician #36 signed one section in Z0400 on 6/4/26. During an interview on 6/11/26 at 9:32 AM, LPN (licensed practical nurse) #14 (MDS Coordinator) confirmed that the February 2026 Quarterly MDSS for Resident #185 were completed late. LPN #14 also confirmed that RN #35 was the Corporate MDS coordinator and worked remotely.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, it was determined that the facility failed to transmit MDS assessments within 14 days of completing the assessment. This was evident for one (Resident #185) out of three residents reviewed for resident assessments. The findings include: According to the RAI (Resident Assessment Instrument) (2018), the MDS (Minimum Data Set) is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. That information must be encoded in the form of an MDS assessment within 7 days of when an assessment of a resident is completed. It is also a requirement that MDS information be transmitted to the Centers for Medicare and Medicaid (CMS) System within 14 days after an assessment of a resident is completed. On 6/10/26, a surveyor review of the clinical record of Resident #185 revealed that Resident #185's Quarterly MDS that had an ARD (Assessment Reference Date) date of 4/30/25 was completed on 5/14/26 (Z0500B) and required to be transmitted to CMS by 5/28/26. This MDS for Resident #185 was transmitted on 6/8/26, which was 11 days after the mandated transmission due date. During an interview on 6/11/26 at 9:32 AM, LPN (licensed practical nurse) #14 (MDS Coordinator) confirmed that the April 2026 quarterly MDSs for Resident #185 was transmitted late.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, it was determined that the facility failed to accurately document health status in the admission Minimum Data Set. This was evident for one (Resident # 50) out of 35 residents reviewed during the survey. The findings include: The Minimum Data Set (MDS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. During a review of Resident #50's clinical records on 6/9/26 at 8:50AM, it was noted that Resident #50 was admitted to the facility for rehabilitation on 5/26/26 after spinal surgery and with a percutaneous gastrostomy tube (PEG- a flexible feeding tube placed directly into the stomach through the abdominal wall) in place. Further review of the clinical record revealed that in the admission MDS (dated 6/1/26), Resident #50 was inaccurately coded in Section H Bowel and Bladder as having an ostomy (an opening in the abdomen to allow waste-urine or stool to leave the body) (H0100C- question location in the MDS). During an interview on 6/11/26 at 9:12 AM, LPN (licensed practical nurse) #14 (MDS Coordinator) stated, No, gastrostomy (PEG) tubes are not considered an ostomy. Gastrostomy tubes should be coded in Section K. During an interview on 6/11/26 at 9:32 AM, LPN #14 stated, I checked that MDS. Resident #50 has his/her PEG coded in Section K (K0520B). Coding that Resident #50 had an ostomy (H0100C) was an error. That resident does not have an ostomy.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interviews, it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan to address identified pressure injuries. This was evident for one (Resident #75) out of two residents reviewed for pressure injury during the facility's recertification/complaint survey. The findings include: On 06/11/2026 at 8:18 AM, review of Resident #75's clinical record revealed multiple pressure injuries. Review of wound assessments and treatment documentation revealed ongoing wound care interventions. However, review of the resident's care plan failed to reveal a care plan addressing the resident's identified pressure injuries, including the location of the pressure injuries, associated risks, goals, and individualized interventions. On 06/11/2026 at 8:56 AM, in an interview with the Unit Manager, Licensed Practical Nurse (LPN #12), when asked who was responsible for initiating and updating care plans, she stated that baseline care plans were initiated upon admission by all the nurses and that she was responsible for updating resident care plans. When asked whether a resident with pressure injuries a targeted pressure injury care plan should have, LPN #12 stated that such a care plan should be in place. On 06/11/2026 at 8:58 AM, after review of Resident #75's care plan by LPN #12, she stated that the resident did not have a care plan specifically addressing the resident's pressure injuries. LPN #12 acknowledged that a pressure injury care plan should have been developed. LPN #12 further stated that the resident had transferred from another unit and that a pressure injury care plan identifying the specific wounds and corresponding interventions should have been implemented. On 06/11/2026 at 11:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that Unit Managers were responsible for updating care plans. When asked whether a resident with pressure injuries should have a corresponding care plan, the DON acknowledged that such a care plan should be in place. When informed that Resident #75 did not have a care plan addressing the resident's pressure injuries, the DON acknowledged the concern. On 06/11/2026 at 11:52 AM, following surveyor inquiry, the Unit Manager (LPN #12) developed a care plan addressing the resident's pressure injuries, including wound locations and corresponding interventions.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure participation of a resident in the care planning process. This was evident for one (Resident #12) out of three residents reviewed for care plan during the facility's recertification/complaint survey. The findings include: The care plan provides an opportunity to see if it meets the residents' needs by reviewing what strategies are working and which are not. It can also identify changes in the resident's condition or behavior that will require revisions of the care plan. Care conferences are usually held on a regular basis, often quarterly, but can be scheduled more frequently if needed based on the resident's condition. MOLST stands for Medical Orders for Life-Sustaining Treatment. It is a bright, easy-to-read medical form that turns one's end-of-life care wishes into real doctor's orders. It must be signed by a licensed doctor, nurse practitioner, or physician assistant. MDS stands for Minimum Data Set. It is a standardized, federally mandated clinical assessment tool used in Medicare and Medicaid-certified nursing facilities. It evaluates a resident's physical, psychological, and psychosocial well-being to determine their care needs and drive facility funding. BIMS stands for Brief Interview for Mental Status. It is a standardized screening test used by healthcare providers, primarily in nursing homes, long-term care, and post-acute care facilities to evaluate a patient's cognitive function. BIMS is a quick baseline check to monitor memory, attention, and orientation over time. On 06/08/2026 at 9:47 AM, during an interview, Resident #12 stated that he/she received notification of a care plan meeting scheduled for April 2026 and expected to participate. The resident stated the meeting did not occur and he/she was not informed of the reason it was not held. On 06/09/2026 at 10:22 AM, review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE] in his/her electronic health record (EHR) revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating he/she was cognitively intact. On 06/09/2026 at 10:45 AM, further review of the resident's electronic health record (EHR) revealed a care plan documentation entry dated 04/15/2026 at 11:21 PM stating, Resident #12 and family were invited but not in attendance. Resident prefers to remain in bed. Resident is social, one-on-one. All care plans and MOLST were reviewed and no changes at this time. Resident remains Long Term Care. Continue to monitor and support. On 06/09/2026 at 10:55 AM, in an interview with the Social Worker Assistant (Staff #5), when asked about the process for care plan meetings, she stated care plan meetings were conducted quarterly and residents were notified by invitation. Staff #5 also stated residents and/or family members were expected to respond to the invitation and select a meeting time. When asked why Resident #12 was not present at the meeting, she stated that because Resident #12 did not respond to the invitation, a care plan meeting time and venue were not scheduled. When asked how the facility determined the resident did not wish to participate, Staff #5 stated that if a resident did not respond, it was assumed the resident was not interested in attending the meeting. On 06/09/2026 at 11:22 AM, in an interview with the Unit Manager (RN #7), when asked about the process of care plan meeting, she stated that stated that Social Services department distributed a list of residents due for care plan review and identified residents who responded to invitations. When asked about Resident #12's care plan meeting that was scheduled for April 2026, RN #7 stated the list did not indicate Resident #12 wanted a care plan meeting. RN #7 further stated previous care plan meetings for Resident #12 had been conducted in the resident's room because the resident preferred to remain in the room and was unsure why the resident did not participate in the April 2026 care plan review. On 06/09/2026 at 12:28 PM, the Director of Nursing was informed of the concern and acknowledged the facility's process as a concern.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews and record reviews, it was determined that the facility failed to ensure medications were administered within the facility's established medication administration time frames. This was evident for three (Resident #18, #231 & #252) out of seven residents reviewed for medication administration. The findings include:1) On 6/8/2026 at 8:43 AM, an interview with Resident #18 revealed that he/she did not receive their medications on time. On 6/10/2026 at 9:10 AM, record review revealed that there was an active order for Apixaban (blood thinner) 5 milligrams by mouth every 12 hours. At the same time, it was revealed that Apixaban was administered late on the following dates: -6/2/2026 - Scheduled for 8:00 AM; administered at 9:23 AM-6/3/2026 - Scheduled for 8:00 AM; administered at 9:26 AM-6/4/2026 - Scheduled for 8:00 AM; administered at 9:30 AM-6/5/2026 - Scheduled for 8:00 PM; administered at 9:42 PM-6/9/2026 - Scheduled for 8:00 AM; administered at 9:54 PM 2)On 6/8/2026 at 1:09 PM, an interview with Resident #231 revealed that he/she did not receive their medication on time. On 6/10/2026 at 9:15 AM, record review revealed an active order for Apixaban 5mg by mouth twice daily. At the same time, it was revealed that Apixaban was administered late on the following dates: -6/1/2026 - Scheduled for 8:00 AM; administered at 9:23 AM. -6/2/2026 - Scheduled for 8:00 AM; administered at 9:24 AM. -6/3/2026 - Scheduled for 8:00 AM; administered at 9:31 AM. -6/5/2026 - Scheduled for 8:00 PM; administered at 9:27 PM. -6/9/2026 - Scheduled for 8:00 PM; administered at 9:48 PM. On 6/11/2026 at 9:30 AM, review of the facility's medication administration policy revealed that scheduled medications were expected to be administered within one hour of the scheduled administration time. On 6/11/2026 at 9:39 AM, an interview with the Director of Nursing revealed that the expectation was that any medication administered more than one hour past the scheduled time was considered late. On 6/11/2026 at 9:49 AM, the concerns were brought up with the Director of Nursing and she indicated that she understood. 3) On 06/08/2026 at 11:34 AM, an interview with Resident #252 was conducted. They reported that medications were not given on time. On 06/08/2026 at 1:04 PM, a review of Resident #252's medical records was conducted. The review (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the Medication Administration Records revealed the following: On 06/05/2026 Metoprolol Tartrate Oral Tablet 25 MG was ordered for 8 AM, resident was given the medication at 11:22 AM, Aspirin Oral Tablet Chewable 81 MG (Aspirin) and Famotidine Oral Tablet 40 MG (Famotidine) was ordered for 9 AM, the medication were given at 11:22 AM. On 06/10/2026 at 12:46 PM, the administrator was asked to provide the facility's Medication Administrator Policy. The review of this policy indicated that medication should be administered within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. On 06/11/2026 at 9:39 AM, an interview with the Director of Nursing (DON) was conducted. She confirmed that any medication given an hour after the scheduled time is considered a late administration, unless the nursing staff had a note that indicated why the medication was given late. At this time, the DON was made aware of the concerns identified.		

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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 record review and interview, it was determined that the facility failed to provide necessary services. This was evident for one (Resident #253) out of five residents reviewed for ADLS (activities of daily living).The findings include:During screening on 6/8/26 at 11:53 AM, Resident #253 reported that he/she had only one shower since arriving at the facility on 5/29/26. Resident #253 stated, That was 10 days ago and the only reason I got that shower was I put up a fuss. I cannot shower on my own, especially washing my hair. I need help. I had a stroke. A review of Resident 253's EMR (electronic medical record) revealed that Resident #253 was admitted on Friday, May 29, 2026 with diagnosis including but not limited to, stroke with left-sided hemiplegia (paralysis).During a follow up interview on 6/9/26 at 1:29 PM, Resident #253 stated, I have had only one shower since I came here. I came on Friday, 5/29. I was told my shower day was Wednesday. Wednesday (6/3/26) came and I did not get a shower. On Thursday (6/4/26), when I complained about not getting a shower, GNA (geriatric nursing assistant) #9 gave me a shower. That place is like Grand Central Station. I made sure they pulled my curtain for privacy. No, I never refused a shower. I was begging them to give me one.During an interview on 6/9/26 at 1:41 PM, LPN (licensed practical nurse) #8 stated that the shower schedule is on the bottom of the unit assignment sheets. LPN # 8 stated, The facility has a shower refusal form that the staff fills out when a resident refuses a shower. Then the form is placed in the resident's chart. After reviewing Resident #253's medical record, LPN #8 confirmed there were no shower refusal forms in Resident #253's medical record.During an interview with GNA #9 on 6/9/26 at 2:34 PM, GNA #9 stated, I did shower Resident #253 on Thursday (6/4/26). It was not his/her scheduled shower day but I did it more for the issue that she had not had a shower in a while.since prior to admission here.A review of [unit] Assignment sheets for Saturday, 5/30/26, Wednesday, 6/3/26, and Saturday, 6/6/26 revealed that Resident #253's room was assigned to have a shower on day shift on these days. A review of Resident #253's shower documentation revealed there was not documentation of Resident #253 having a shower at any time during his/her eleven day stay at the facility. A review of Resident #253's task schedule in the EMR confirmed that Resident #253 was documented as scheduled to shower on Wednesdays and Saturdays. A review of Resident #253's admission MDS (Minimum Data Set) assessment documented in Section F Preferences for Routines and Activities in response to the question How important is it to you to choose between a tub bath, shower , bed bath or sponge bath?, Resident #253 responded, Very Important. The resident had three scheduled opportunities to receive assistance with a shower. During these three opportunities, the facility failed to provide the necessary care and services to maintain good grooming and personal hygiene.Resident #253 was discharged from the facility on Tuesday, 6/9/26.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews, it was determined that the facility failed to ensure that a resident had a call bell near reach. This was evident for one (Resident #8) out of eight residents reviewed for call bells during the recertification survey. The findings include: On 06/08/2026 at 9:47 AM, during unit round, the surveyor observed Resident #8 without a call bell near reach. On 06/08/2026 at 11:58 AM, an interview with Resident #8 was conducted. Resident reported that since they moved into their room, they've not had a call bell. The surveyor looked around the resident's bed and was unable to locate a call bell. On 06/08/2026 at 12:01 PM, an interview with Staff #4 was conducted in the resident's room. Staff looked under the resident's bed and was unable to retrieve the call bell. On 06/09/2026 at 1:58 PM, an interview with Staff # 6, Unit Manager, was conducted. She reported that it was the facility's expectation that all residents should have a call bell near reach at all times. At this time, the surveyor discussed the call bell concerns with the unit manager. On 06/09/2026 at 2:08 PM, the Director of Nursing (DON) was notified of the concerns.		

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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. Based on record review and staff interview, it was determined that the facility failed to implement care plan interventions to report a significant weight loss to the physician and Registered Dietitian. This was evident for one (Resident #2) out of two residents reviewed for nutrition and hydration. The findings include: On 6/8/2026 at 12:46 PM, a review of Resident #2's records was conducted. Resident #2 had a decline of 9.2 lbs (5.7%) from 5/6/2026 (162.2 lbs) to 6/1/2026 (153.0 lbs). This weight was documented by Staff #7. On 6/9/2026 at 10:23 AM, a review of the progress notes revealed that there was no Dietician or Provider notes regarding the weight change. The last Dietician note was on 5/27/2026 and addressed a progressive weight gain over 3 months leading up to the 5/6/2026 documented weight. Dietician documented to monitor for weight changes, labs, and percent of meal intakes. On 6/9/2026 at 10:40 AM, an interview with Staff #7 was conducted. When asked when the nursing staff would notify a Dietician or provider of weight changes, Staff #7 stated the dietician is notified when there is a significant weight change. When asked about Resident #2's weight change, Staff #7 stated that in this case they might do a reweight because of inaccurate scales and if we see a discrepancy like this. When asked if they had notified the dietician, Staff #7 stated they have not notified the dietician because they are waiting for a reweight to verify the weight. When asked if the resident had been reweighed, Staff #7 stated not yet but they are due for one. On 6/9/2026 at 11:58 AM, a review of the care plans was conducted. Resident #2 has a nutritional problem care plan with an intervention to Monitor/record/report to medical doctor as needed for signs and symptoms of malnutrition including significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months. This care plan intervention was created and last revised on 12/1/2025. On 6/9/2026 at 12:17 PM, an interview with the Director of Nursing (DON) was conducted. When asked what the expectation is for when the weight is reviewed and recognized that there has been a significant change, the DON stated the weight is reweighed. When asked when the weight is entered in the Electronic Health Record (EHR) will it alert the care giver if the weight change is significant, the DON stated yes, it will. This surveyor made the DON aware of Resident #2's recent 5.7 % weight loss over the past month with no provider or dietician note addressing the change. On 6/10/2026 at 8:30 AM, an interview with DON was conducted. When asked if the Resident had been seen by the dietician, the DON stated no but the dietician would see the resident today (6/10/2026) and a reweight would be completed. On 6/10/2026 at 8:49 AM, a review of Resident #2's chart was conducted. The resident was reweighed and weighed at 153.6 lbs on 6/9/2026. There was no dietician or physician notes addressing the resident's weight.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to be consistent with professional standards regarding supplemental oxygen requirement. This was found to be evident for two (Resident #15 and #147) out of four residents reviewed for Respiratory Care. The findings include: The facility's Oxygen Administration Policy: Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. (implemented 1/27/23) 1). Review of Resident #147's EMR (electronic medical record) revealed that the resident was admitted on [DATE]. During screening on 6/8/26 at 10:48 AM, Resident #147 was observed to be utilizing supplemental oxygen at 3 L (liters) of flow via a nasal cannula. On 6/10/26 at 8: 34 AM, Resident #147 was observed utilizing a nasal cannula supplying 3L of supplemental oxygen. A review of Resident #147's EMR (electronic medical record) revealed no active order for supplemental oxygen in Resident #147's active orders. During an interview on 6/11/26 at 8:49 AM, LPN (licensed practical nurse) #18 confirmed that Resident #147 was utilizing supplemental oxygen and that there was no active order in Resident #147's chart for this intervention. 2). On 6/8/2026 at 11:44 AM, an observation of Resident #15 was made. The resident was receiving 3 liters per minute of Oxygen via nasal cannula. On 6/10/2026 at 12:26 PM, a review of Resident #15's orders was conducted. The resident was ordered 2 liters per minute of Oxygen via nasal cannula continuously on 4/14/2026. On 6/10/2026 at 12:47 PM, a review of Resident #15's care plans was conducted. There are no care plans regarding Oxygen use. On 6/10/2026 at 1:22 PM, an interview with the Unit Manager (Staff #7) was conducted. When asked if they oversaw the care plans, Staff #7 said yes. When asked if a resident with orders for oxygen should have oxygen use care planned, Staff #7 said yes. This surveyor made Staff #7 aware of no oxygen use care plan for Resident #15. Staff #7 stated that they were not aware of oxygen use being new for this resident and did not realize that it had not been care planned yet. This surveyor made Staff #7 aware of Resident #15 being observed on 3 liters per minute of oxygen and not the ordered 2 liters per minute. Staff #7 confirmed this observation with the surveyor at this time.		

Department of Health & Human Services
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interviews and record reviews it was determined that the facility failed to ensure that residents received an annual dental visit. This was evident for two (Resident #13 and #85) out of four residents reviewed for dental services. The findings include: 1)On 6/8/2026 at 9:44 AM, an interview with Resident #13 revealed that he/she had not seen the dentist in a while. On 6/10/2026 at 12:16 PM, record review revealed that the resident was last seen by a dentist on 2/27/2024. 2)On 6/8/2026 at 9:08 AM, an interview with Resident #85 revealed that he/she had not seen the dentist in a while. On 6/10/2026 at 12:09 PM, record review revealed that the resident was last seen by a dentist on 4/2/2024. On 6/12/2026 at 10:40 AM, the concerns were addressed with the Director of Nursing.		

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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 record review and staff interview, it was determined that the facility failed to ensure the accuracy and completeness of the clinical record for one (Resident #119) of five residents reviewed for advance directives during the facility's recertification/complaint survey. The findings include: MOLST stands for Medical Orders for Life-Sustaining Treatment. It is a bright, easy-to-read medical form that turns one's end-of-life care wishes into real doctor's orders. It must be signed by a licensed doctor, nurse practitioner, or physician assistant. On [DATE] at 10:43 AM, review of Resident #119's paper medical record revealed a Medical Orders for Life-Sustaining Treatment (MOLST) form indicating that informed consent had been obtained from the resident's guardian of person as per authority granted by court and other legal authority in accordance with all provisions of the Health Care Decisions Act. Review of the paper medical record and electronic health record (EHR) failed to reveal documentation of a current court-appointed guardian or other legal authority for Resident #119. On [DATE] at 10:57 AM, further review of the EHR revealed a Nurse Practitioner's progress note dated [DATE] documenting communication with the resident's surrogate, identified as the resident's cousin. On [DATE] at 11:06 AM, an interview was conducted with the Social Work Assistant (Staff #5) in the presence of the Nursing Home Administrator (NHA) and Director of Nursing (DON). Staff #5 stated the resident's previous legal guardian had died prior to the resident's admission to hospice services. Staff #5 stated that the guardian's son subsequently became involved in the resident's care; however, no legal guardianship documents existed. Staff #5 further stated the resident's cousin was the next of kin and did not possess legal authority to act as guardian. When informed that the MOLST documented informed consent had been obtained from a legal guardian and other legal authority, Staff #5 stated the information was inaccurate and required correction. During the same interview, the NHA confirmed the resident's legal guardian was deceased and acknowledged that the documentation on the MOLST regarding legal guardian and legal authority involvement was inaccurate. On [DATE] at 1:03 PM, after the surveyor's intervention, a revised MOLST form was completed to correct the inaccurate information. The NHA stated education would be provided regarding the accurate completion of MOLST documentation.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interview, it was determined that the facility's designated hospice interdisciplinary team member failed to ensure documentation regarding hospice care was available and communicated with the facility staff. This was evident for one (Resident #147) out of to residents reviewed for hospice. The findings include: A review of Resident #147's electronic medical record (EMR) on 6/10/26 at 10:04 AM revealed Resident #147 was admitted to [Hospice] services on 5/12/26 for metastatic colon cancer. Further review of Resident #147's medical record revealed the record did not have evidence of Resident #147's most recent hospice care plan, the hospice election form, the physician certification, and the names and contact information for the hospice personnel involved in Resident #147's care. During an interview on 6/10/26 at 10:47 AM, RN (registered nurse) #16 (hospice nurse) stated, We have a [hospice] IDT (interdisciplinary team) meeting every Thursday at our [the hospice] office and that is what generates the weekly care plan. I then bring the print out to the building. We used to put it in the chart but the charts were getting too big. Now we take it directly to Medical records because the charts were getting too big. I'll bring it [Resident #147's care plan] tomorrow. During an interview on 6/10/26 at 11:27 AM, the NHA (Nursing Home Administrator) and DON (Director of Nursing) confirmed that these documents were missing from Resident #147's chart.		

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F 0807 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on interviews, observations and record review, it was determined that the facility failed to serve residents meals that matched their tickets. This was evident for seven (Resident #74, #115, #146, #171, #193, #203 & #251) out of thirty-three residents observed during dining. The findings include: The findings include: On 06/08/2026 at 9:20 AM, during breakfast dining observation, review of meal tickets revealed coffee was listed as part of the beverages for residents. Observation revealed coffee was not served. Geriatric Nursing Assistant (GNA #24) stated that dietary unit had informed nursing staff that coffee was unavailable because the kitchen did not have coffee cups. 1) On 06/08/2026 at 9:22 AM, Residents #74, #115, #171, #193, and #203 stated they had not received coffee with their breakfast meals. Observation of the residents' meal trays confirmed coffee was not present. Review of each resident's meal ticket revealed coffee was listed as the assigned breakfast beverage. Geriatric Nursing Assistant (GNA#24), who was present during the observation, stated the residents had not received coffee for the past two days despite routinely requesting coffee with breakfast. 2) On 06/11/2026 at 9:23 AM, during a follow-up dining observation, Resident #146's breakfast tray contained cranberry juice. Review of the resident's meal ticket revealed orange juice was listed as the ordered beverage. When asked about the discrepancy, Resident #146 stated a preference for cranberry juice and reported not liking orange juice. GNA #24 confirmed Resident #146 routinely drank cranberry juice and stated family members had previously requested cranberry juice for the resident. On 06/11/2026 at 10:12 AM, when the Director of Nursing (DON) was informed of the concerns, she stated staff had reported that coffee had not been consistently available on the units. When informed that Resident #146's meal ticket did not reflect the resident's beverage preference, the DON stated the concern would be investigated. On 06/11/2026 at 11:34 AM, the DON provided an updated meal ticket for Resident #146 reflecting cranberry juice as the resident's preferred beverage. 3) On 06/08/2026 at 8:56 AM, an interview with Resident #251 was conducted. They reported that the meals served do not match what they ordered. They showed the surveyor their breakfast tray and reported that they were not served coffee, even though they had ordered it. A review of the meal ticket was conducted. The review revealed that the resident had requested coffee. On 06/11/2026 at 10:12 AM, an interview with the Director of Nursing (DON) was conducted. She reported that it was brought to her attention by staff that residents are not served coffee regularly (continued on next page)		

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F 0807 Level of Harm - Potential for minimal harm Residents Affected - Some	because it was not being delivered to the units. Additionally, the DON reported that she had identified that some menu tickets did not have sections for residents to request certain items such as hot tea. DON was made aware of the concerns identified by the survey team.		