

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Overlea		STREET ADDRESS, CITY, STATE, ZIP CODE 6116 Belair Road Baltimore, MD 21206	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, it was determined that the facility failed to maintain a safe and functional environment for residents, staff and visitors. This deficient practice was evident for 3 (Residents #63, #74, and #76) out of 32 residents reviewed for the physical environment and during a observation of the resident's smoking area conducted during the annual survey. The findings include: 1) At 1:30 PM on 6/30/2026 the surveyor observed the blinds opened to the three (3) windows in Resident room G-5. In the middle window looking out to the facility's parking lot was a large crack that extended from the top right-hand corner of the window which curved diagonally to the left-hand side towards the bottom 1/3 of the window. The crack in the middle window appeared to be on the inside panel of the double-panel window as surveyor touched a chip of glass in the cracked window. Residents #63, #74 and #76 occupied room G-5. Interview with the Nurse Manager #5 at 1:35 PM on 6/30/2026 revealed that she was not aware of the cracked window and she notified the Licensed Nursing Home Administrator (LNHA) and the Maintenance Director. Nurse Manager #5, Maintenance Director and LNHA observed the cracked window in room G-5. LNHA and Maintenance Director were not aware of the cracked window. LNHA stated that the window would be repaired. On 7/2/2026 at 12:25 PM the surveyor followed up on the large crack in the middle window of Resident room G-5 and the crack in the middle window remained visible with clear heavy tape on the crack. At 4:00 PM on 7/2/2026 the LNHA provided the surveyor with a copy of the proposal dated 7/1/2026 from [NAME] Brothers Inc. Glass Company for repair of the cracked window. 2) On 7/02/2026 at 10:30 AM the surveyor conducted an observation of residents who smoked on the smoking porch. Observation of the designated smoking porch revealed large areas with water pooling on the floor and water actively dripping from the top of the ceiling. The area which was slightly carved inwards measured approximately 2.5 feet long. The floor of the entire porch also had areas with multiple cracks located throughout exposing the concrete underneath. Most of the residents smoking on the porch were wheelchair bound while some ambulated with walkers. About 11 residents were out smoking at the time. The smoking porch is also where non-smokers can routinely come out for fresh air, socialize or hang out with visitors. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/02/2026 at 11:46 AM The Nursing House Administrator (NHA) was made aware of the unsafe condition of the Porch with water pooling on the floor and cracks everywhere exposing the concrete underneath. He confirmed that it needed to be fixed and is a fall risk for the residents. He stated that he will go up with the maintenance director to take a look. On 7/02/2026 at 12:06 PM The NHA came back to say that they have roped off the areas with exposed holes/concrete with tapes and cones and that maintenance will start working on them.		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on record review and staff interviews it was determined that the facility failed to comply with employee training for staff related to Resident Rights. This was evident for 6 (Staff #16, # 17, #18, #19, #20 and #21) of 6 staff records reviewed during the annual survey. The findings include: On 07/01/2026 at 11:00 AM Staff #13, the Human Resource Director (HR), was interviewed and ask for employee records for Staff #16, # 17, #18, #19, #20 and #21. HR stated those records would be with the Nursing Home Administrator, (NHA). On 07/01/2026 at 1:45 PM the NHA provided employee training for Staff # 16, #17, #18, #19, #20 and #21 for Abuse, Dementia, Infection Control, and Quality Assurance Program Improvement (QAPI) but no employee training for Resident Rights. The NHA then provided a packet dated 3/17/2026 for Resident Rights however, the attached in-service sign-in sheet was titled, Be mindful of the conversations and language used in patient care areas and hallways, rather than Resident Rights. Later that day at 2:10 PM, the NHA provided a second Resident Rights packet that lacked a defined topic. The first page was dated 11/3/2025, while the second page was undated. Neither page included documentation identifying the trainer or topic. It remained unclear what the training was and who the trainer was. On 07/02/2026 at 9:47 AM a review of the facility records revealed that in the facility's Facility Assessment for Staffing training/education and competencies confirmed that Resident rights and facility responsibilities is listed as the primary education requirement, alongside Abuse, Neglect, Exploitation, Dementia, Behavioral Health, Customer service, Infection Control, Cultural competency, Disaster planning, and Health Insurance Portability and Accountability Act (HIPAA). No additional documentation regarding Resident Rights training was provided by the time of exit.		

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that facility staff failed to identify a surrogate decision maker who is authorized to exercise the rights of a resident that lacks decision making capacity in a timely manner. This deficient practice was evident for 2 (, Resident #13, Resident #114) of 4 resident's reviewed for representative rights during the annual survey. The findings include: On 06/29/2026 at 10:13 AM, a review of Resident #114's medical record revealed the resident was admitted to the facility in June 2024 with multiple diagnoses, including dementia. At the time of admission, the resident was identified as lacking decision-making capacity. Further review of the records identified the resident's children as the resident's point of contact, however, the records failed to indicate who is responsible for making health care decisions. On 06/29/2026, a review of Resident #13's medical record revealed the resident was admitted to the facility in February 2024 with multiple diagnoses, including dementia. At the time of admission, the resident was identified as lacking decision-making capacity. Further review of the records identified the resident's child and two other family members has the point of contact, however, the records failed to indicate who is responsible for making health care decisions. On 06/30/2026 at 9:08 AM, the Director of Social [NAME] (DSS) #6 stated that advance directives are reviewed with the resident or the resident's representative upon admission. For residents who lack decision-making capacity, she contacts the family to determine whether an advance directive exists. If no advance directive is in place, the family is informed, a surrogate decision maker affidavit must be completed. At 9:19 AM, the surveyor informed the DSS #6 that the medical records for Resident #13 and Resident #114 did not clearly identify the family member authorized to make healthcare decision on behalf of the resident. The DSS #6 stated she would review the records and follow up with the surveyor. On 07/02/2026 at 12:06 PM, the DSS #6 provided a copy of surrogate decision maker affidavit forms for Resident #13 and Resident #114. Review of the records revealed that Resident #13's family member signed the affidavit in March 2026, approximately two years after the resident's admission to the facility. Further review showed that Resident #114's family member signed the affidavit in May 2026, nearly two years after the resident was admitted. The surveyor asked the DSS #6 how staff determined who was authorized to participate in care plan meetings and make healthcare decisions for residents who did not have a completed surrogate decision maker affidavit. The DSS #6 stated that staff contacted the individual listed as the resident's primary emergency contact or the first family member listed in the resident's contact information. On 07/02/2026, the Administrator was informed of the concern on multiple occasions throughout the survey.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Number of residents sampled: Number of residents cited: Based on record review and staff interviews, it was determined that the facility staff failed to ensure consent for psychotropic medications was obtained and maintained in the resident's medical records. This deficient practice was evident for 1 (Resident #2) of 5 residents reviewed for psychotropic medications during the annual survey. The findings include: Psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. On 07/01/2026 at 9:49 AM, a review of Resident #2's medical record revealed the facility identified the resident's family member as a surrogate decision maker in January 2026. In April 2026, two physicians certified that the resident lacked decision-making capacity due to cognitive impairment. In May 2026, the resident's dosage of psychotropic medication Seroquel (Quetiapine) increased. Further review of the records failed to show documented evidence that the resident's surrogate decision maker provided consent for the increased dosage of the psychotropic medication. On 07/01/2026 at 12:47 PM, the surveyor presented the psychotropic medication consent concern for Resident #2 to the Director of Nursing (DON) #2 and regional staff. The DON #2 stated that she reviewed the resident's medical records and was unable to locate documentation showing that the resident's surrogate decision maker provided informed consent for the increased dosage of the psychotropic medication.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Number of residents sampled: Number of residents cited: Based on record review and staff interviews, it was determined that facility staff failed to verify whether an existing advance directive was in place at the time of admission for residents who lacked decision making capacity. This deficient practice was evident for 4 (Resident #2, Resident #13, Resident #114, and Resident #141) of 6 residents reviewed for advance directives during the annual survey. The findings include: An Advance Directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness. An advance directive may also give a person (such as spouse, relative, or friend) authority to make medical decisions. On 06/29/2026 at 10:13 AM, a review of Resident #2's medical record revealed the resident was admitted to the facility in February 2024 with multiple diagnoses, including dementia. At the time of admission, the resident was identified as lacking decision-making capacity. Further review of the medical record revealed documentation dated 02/09/2024, indicating that an advance directive was currently in place. However, the medical records failed to include a copy of the advance directive or documented evidence that facility staff made attempts to obtain the existing advance directive. On 06/29/2026, a review of Resident #13's medical record revealed the resident was admitted to the facility in February 2024 with multiple diagnoses, including dementia. At the time of admission, the resident was identified as lacking decision-making capacity. Further review of the medical record revealed documentation dated 02/26/2024, indicating that an advance directive was currently in place. However, the medical records failed to include a copy of the advance directive or documented evidence that facility staff made attempts to obtain the existing advance directive. On 06/29/2026 at 10:13 AM, a review of Resident #114's medical record revealed the resident was admitted to the facility in June 2024 with multiple diagnoses, including dementia. At the time of admission, the resident was identified as lacking decision-making capacity. Further review of the medical record revealed documentation indicating no advance directive document. The remaining advance directive screening questions were left blank. The medical records failed to document evidence that facility staff made attempts to determine if an advance directive existed. During an interview on 06/30/2026 at 9:08 AM, the Director of Social Services (DSS) #6 explained that, upon admission, advance directives are reviewed with the resident and/or the resident's representative. If a resident has an existing advance directive, she requests a copy and documents the request in the resident's medical record. For residents who lack decision-making capacity, she stated that she contacts the resident's family member to determine whether an advance directive exists. If a resident lacking decision-making capacity does not have an advance directive, she informs the family that a surrogate decision maker affidavit must be completed. At 9:19 AM, the surveyor requested documented evidence of the existing advance directives for Resident #2, Resident #13, and Resident #114, as well as documented attempts made by the facility to obtain the required advance directive records. On 06/30/2026 at 10:45 AM, the DSS #6 stated she was unable to locate the resident's advance directives or documentation of attempts to obtain existing advance directives. The Administrator #1 stated the facility identified concerns related to advance directives and conducted a facility wide audit in March 2026. He explained that residents without a completed advance directive (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were screen for decision making capacity and if they lacked capacity, family members were asked to complete a surrogate decision maker affidavit. When asked whether the facility first contacted family members to determine if an existing advance directive was already in place, the Administrator #1 was unable to provide an answer. On 07/06/2026 at 11:29 AM, a review of Resident #141's medical record revealed the resident was admitted to the facility in May 2026 with multiple diagnoses, including Alzheimer's disease. On 05/12/2026, the resident was identified as lacking decision-making capacity. Further review of the medical record revealed an advance directive screening was completed on 05/14/2026 indicating the resident was unable to participate in the screening. Further review of the resident's medical record failed to show evidence the facility made attempts to determine if the resident had an existing advance directive. On 07/06/2026 at 12:43 PM, the surveyor inquired about Resident #141's advance directive. The DSS #6 stated there is no documented evidence that the resident's family member were asked about an existing advance directive. On 07/06/2026, the Administrator was informed of the concern on multiple occasions throughout the survey.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment for Residents. This finding was found to be evident in review of the physical environment of the facility during the annual recertification survey. The findings include: 1) On 06/29/2026 at 9:10 AM, during an initial observation, Resident #146's three-drawer bedside table was observed with a large tear in the top veneer. The tear was significant enough for the resident's entire hand to fit underneath. On 06/30/2026 at 10:35 AM, the Maintenance Director (Staff #4) was interviewed regarding the facility's process for reporting damaged items. Staff #4 stated that staff are instructed to use TELS, an electronic system for reporting broken or damaged equipment. Once a request is entered into TELS, the maintenance department receives the notice on their computer and addresses the issue. On 06/30/2026 at 1:30 PM, a follow-up observation was conducted with a Licensed Practical Nurse, (LPN) Staff #11, who was shown the condition of the bedside table. At that time, the torn section of the veneer had fallen behind the nightstand, and a large, dark area—which appeared to be mold—was visible on top of the table. Staff #11 put on gloves and retrieved the loose piece of veneer. Staff #11, LPN stated they would coordinate with the Nursing Home Administrator to ensure the bedside table is replaced and removed the large loose piece of veneer. 2) In Resident room G-7 at 8:27 AM on 6/29/2026 the surveyor observed a clock on the wall above the sink that indicated 2:30. Resident #10 stated that the clock needed batteries. Nursing staff on the unit were notified of the clock without the correct time and stated that they would notify Maintenance department. Licensed Nursing Home Administrator (LNHA) was notified of Resident #10's concern at 11:20 AM on 6/30/2026. On tour of the Ground-TCU Nursing Unit on 6/29/2026 at 8:53 AM the surveyor observed a ceiling vent without an attached cover/panel at the nursing station. Observed in the ceiling vent was an opening. At 2:20 PM on 7/2/2026 the Regional Licensed Nursing Home Administrator (LNHA) was notified of the ceiling vent without cover at the nursing station on Ground-TCU nursing unit. Regional LNHA stated that he was aware of this and that it was not a vent, but a heater in the ceiling and he had been unable to locate a cover that would fit the heater.		

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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 interviews and record reviews, it was determined that the facility staff failed to code Minimum Data Set (MDS) assessments accurately for a resident, and failed to accurately code a resident's dental status on the admission assessment. This deficient practice was evident for 2 (Resident #14, Resident #5) out of 8 residents reviewed for tube feeding, nutrition services, and dental during the annual survey. The findings include: Minimum Data Set (MDS) is a federally mandated standardized assessment tool that measures health status in nursing home Residents including functional, medical, psychosocial and cognitive status. MDS assessments are completed on admission, quarterly, annually, and upon significant changes in Resident conditions. MDS assessment is designed to collect data to guide care planning and monitoring for Residents in long term care settings. The data is used to compute indicators of care quality. MDS assessments are completed by the clinical interdisciplinary team and coordinated by a Registered Nurse (RN) in the nursing facility. Care Plan is a personalized document that summarizes a Resident's health conditions, specific care needs and current treatments. Developed by the clinical interdisciplinary team, the care plan maps out targeted interventions to achieve specific, measurable goals for the Resident in the long-term care facility. Medication Administration Record (MAR) is a critical tool that ensures safety and accuracy for Residents in healthcare settings. MAR is used to document medications that Residents receive, including dosage and time, and it provides a comprehensive, organized record of each medication administered to a Resident. This vital document supports healthcare providers by tracking doses, preventing errors, and providing a clear record of care. Intravenous therapy (IV) is a way to give fluids, medicine, nutrition, or blood directly into the bloodstream through a vein. IV therapy uses a type of tiny plastic tubing (cannula) that goes into the vein, a needle, and plastic tubing that connects the set-up to a bag of fluid. A percutaneous endoscopic gastrostomy (PEG) is a feeding tube that allows a patient to receive enteral nutrition through the stomach. A PEG is placed if a Resident has difficulty swallowing or cannot receive all the nutrition needed by mouth. 1) The surveyor conducted a record review of Resident #14's medical record at 6:45 AM on 7/2/2026 who was admitted to the facility on [DATE]. Review of the physician orders revealed that Resident #14 had a PEG tube and received a therapeutic enteral diet. Review of the medication administration records revealed that Resident #14 received intravenous (IV) therapy for hydration on 3/4/2026, 3/5/2026, 3/9/2026, 3/10/2026 and 3/11/2026. Review of the 3/10/2026 Annual MDS assessment for Resident #14 revealed that Section K (Nutritional Approaches) was coded for IV feeding and (continued on next page)		

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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 record review and interviews, it was determined that the facility staff failed to implement and develop comprehensive care plans for residents. This deficient practice was evident in 3 (Resident #4, Resident #11, and Resident #5) of 5 residents reviewed for comprehensive care plans during the annual survey. The findings include: 1). Resident #4 diagnoses include Dementia, Major Depressive Disorder Mood Disturbance and Anxiety. On 07/02/26 at 3:36 PM a review of Resident #4's clinical record revealed a Quarterly Activity Review dated 5/19/26 which referenced an existing Activities care plan. The document stated that the goals, interventions and approaches were effective in keeping with that care plan. However, further review of Resident #4's clinical record failed to reveal an active Activities care plan existed. On 07/06/26 at 8:23 AM during an interview, the Activities Director reviewed Resident #4's clinical record and stated that she could not find an Activities Care Plan I cannot find one, I do not know why (resident) does not have one. During an interview on 07/06/26 at 10:35 AM the Director of Nursing (DON) provided the surveyor with a copy of Resident #4's Activities care plan which stated that the Goals and Interventions were RESOLVED. There was no date on the document. When asked if there was an active care plan in place for Resident #4 the DON responded, this is what we have on record. 2). On 07/02/26 at 8:39 AM a review of Resident #11's clinical record revealed that the resident had an active physician's order dated 12/03/25 for anticoagulant medication, Eliquis. The resident's medication administration record confirmed that the resident was receiving the medication. The clinical record failed to reveal a care plan on the risks and interventions associated with anticoagulation therapy. On 07/02/26 at 1:32 PM during an interview with Unit Manager #11 (UM#11), the surveyor asked whether there was a care plan for anticoagulant therapy for Resident #11. UM#11 reviewed the clinical record and stated, I do not see any monitoring or care plans for anticoagulant, it is not here, I will take care of it. On 07/02/2026 at 1:44 PM the DON who was made aware of the surveyor's findings. 2.) On 06/29/2026 at 9:08 AM, during an interview, Resident #5 stated, they were recommended to have their remaining teeth removed in August 2025 but were hospitalized for a month. During the interview, the surveyor observed that the resident had only two small tooth fragments remaining. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/30/2026 at 3:35 PM, a review of Resident #5's medical record revealed a dental care plan initiated in July 2024 that identified cracked teeth as a dental concern. The dental care plan directed staff to coordinate and arrange dental care, including transportation as needed, and as ordered. Further review of the medical records revealed that, in August 2025 a Doctor of Dental Medicine ordered preoperative lab testing and extraction of remaining root tips under general anesthesia. The medical records failed to show evidence of dental care coordination. During an interview with Medical Record (MR) #8 staff on 06/30/2026, she provided an email dated 05/05/2026 regarding follow up for the resident's tooth extraction. When asked about follow up attempts from August 2025 through the present, she stated that follow up had occurred; however, she was unable to provide documented evidence. The surveyor presented the concerns to the Director of Nursing, who acknowledged the findings.		

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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 staff interviews and surveyor record reviews it was determined that the facility staff failed to update and revise a comprehensive care plan for a Resident. This finding was found to be evident in 1 (Resident #30) out of 7 Residents reviewed for care plans. The findings include: Care Plan is a personalized document that summarizes a Resident's health conditions, specific care needs and current treatments. Developed by the clinical interdisciplinary team, the care plan maps out targeted interventions to achieve specific, measurable goals for the Resident in the long-term care facility. Care plans are updated and revised as Resident's condition warrants and at least quarterly. Medication Administration Record (MAR) is a critical tool that ensures safety and accuracy for Residents in healthcare settings. MAR is used to document medications that Residents receive, including dosage and time, and it provides a comprehensive, organized record of each medication administered to a Resident. This vital document supports healthcare providers by tracking doses, preventing errors, and providing a clear record of care. Diuretic (water pill) is a medication that helps the body eliminate salt and water through the urine. Diuretics are primarily prescribed to treat high blood pressure, heart failure, and edema (swelling) by reducing fluid volume in the bloodstream. The surveyor conducted a record review of Resident #30's medical record on 7/1/2026 at 7:15 AM who admitted to the facility on [DATE]. Review of Resident #30's comprehensive care plan revealed a plan of care for diuretic therapy, The Resident is on diuretic therapy related to edema, initiated on 9/24/2025 with a target date of 4/8/2026. Review of the physician orders for Resident #30 did not reveal an active order for a diuretic medication. Review of the discontinued physician orders revealed that diuretic therapy (Lasix/Furosemide) was discontinued on 10/1/2025 for Resident #30. Review of the medication administration records (MARs) for September 2025, and October of 2025 revealed that Resident #30 received diuretic therapy (Lasix/Furosemide) and that the last dose was received on 10/1/2025. In an interview with the Director of Nursing (DON) at 10:35 AM on 7/1/2026 the surveyor conveyed that Resident #30 was no longer receiving diuretic therapy (Lasix/Furosemide) as the medication was discontinued on 10/1/2025. Surveyor further conveyed that there was a plan of care on Resident #30's comprehensive care plan which indicated that Resident was on diuretic therapy. Surveyor stated that Resident #30's care plan was not revised and updated when diuretic therapy was discontinued on 10/1/2025. DON acknowledged the surveyor and indicated that she would review and follow-up. At 11:15 AM on 7/2/2026 DON provided surveyor with copies of Resident #30's physician orders (active and discontinued), MARs (September 2025 and October 2025), and care plan and confirmed that Resident was no longer receiving diuretic medication. Licensed Nursing Home Administrator (LNHA) and Regional Administrator were notified at 4:00 PM on 7/2/2026 of the concern with care plan update and revision.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and surveyor record review it was determined that the facility failed to maintain services that meet professional standards of care. This finding was found to be evident in 1 (Resident #10) out of 3 Residents reviewed for oxygen administration. The findings include: The surveyor observed Resident #10 in bed, in no distress at 8:25 AM on 6/29/2026 with oxygen therapy in use. Resident #10 was observed at 6:55 AM on 6/30/2026 in bed, in no distress with oxygen in use. Care Plan is a personalized document that summarizes a Resident's health conditions, specific care needs and current treatments. Developed by the clinical interdisciplinary team, the care plan maps out targeted interventions to achieve specific, measurable goals for the Resident in the long-term care facility. At 10:55 AM on 6/30/2026 the surveyor conducted a record review of Resident #10's medical record. Record review revealed that Resident #10 did not have a current physician order for oxygen usage. Review of Resident #10's comprehensive care plan revealed an intervention, give oxygen therapy as ordered by the physician with a date initiated 5/15/2026. In an interview with Nurse Manager #5 at 11:05 AM on 6/30/2026 surveyor reviewed with Nurse Manager #5 that Resident #10 was receiving oxygen and that there was no physician order for oxygen therapy. Nurse Manager #5 stated that Resident has been on oxygen since admission and confirmed that Resident did not have a physician order for oxygen. Resident #10 was admitted to the facility on [DATE]. Licensed Nursing Home Administrator (LNHA) was notified at 11:20 AM on 6/30/2026 of oxygen therapy in use for Resident #10 without a physician order. The surveyor reviewed the facility's policy for Oxygen Administration at 12:20 PM on 6/30/2026. The policy indicated that oxygen is administered to Residents who need it, consistent with professional standards of practice; under orders of a physician, except in the case of an emergency, and orders for oxygen are obtained as soon as practicable when the situation is under control. LNHA and Regional LNHA were notified of the oxygen administration concerns at 4:00 PM on 7/2/2026.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, clinical record review and interviews, it was determined that the facility failed to apply a hand splint on a resident as ordered by the physician. This was evident in 1 (Resident #43) of 1 resident reviewed for hand splints during the survey. The findings include: Resident #43's diagnoses include Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side and Contracture of Muscle, Right Hand. On 06/29/26 at 8:56 AM during the initial tour, the surveyor observed Resident #43 sitting in a wheelchair watching Television (TV) in their room. The resident's right hand was visibly contracted with the fingers curved towards the palm. The resident was not wearing a hand splint. A review of the resident's clinical record on 06/30/26 at 09:10 AM revealed a physician's order as follows: Patient to wear Resting Hand splint on right hand and wrist at least 8 hours daily; ON: after AM care and OFF: Before PM care. Please notify OT if skin breakdown is observed. Splint cover must be washed and dried when soiled. Order Date: 04/24/26 On 07/01/26 at 11:20 AM the surveyor again observed Resident #43 sitting in their room watching TV without a hand splint. A further review of the resident's clinical record on 07/01/26 at 11:20AM revealed the Treatment Administration Record (TAR) signed on 07/01/26 indicating that the splint was applied and in place on the resident's right hand. The surveyor brought the concerns to the attention of the Unit Manager LPN#11 (UM #11) on 07/01/26 at 11:33AM. UM #11 accompanied the surveyor to the resident's room where she observed the splint was not applied to the resident's hand. The splint was observed hanging on the wall over the resident's nightstand, in transparent bag. UM #11 reviewed the TAR and expressed concern that the nurse had signed the TAR indicating that the splint was applied to Resident #11's right hand when it was not. In an interview on 07/01/2026 at 1:00 PM the Director of Nursing was notified of the surveyor's concerns and she stated, If they are signing for the splint and not putting it on that is a problem.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review and interviews, it was determined that the facility failed to ensure that dependent residents' grooming needs were met. This was evident in 2 (Resident #11 and #43) of 3 residents reviewed for Activities of Daily Living during the survey. The findings include: On 06/29/26 At 8:50 AM Resident #11 was observed lying in bed. Fingernails were noted to be long and jagged with black material present underneath. At 8:56 AM Resident #43 was observed sitting in a wheelchair. The resident has a known contracture to the right hand. Fingernails on the right hand were observed to be long and curved towards the palm. On 6/29/26 at 12:00PM a review of Resident #11 and Resident #43's clinical record revealed that the residents were dependent on staff for personal hygiene. On 07/01/26 at 11:33 AM the surveyor again observed both Resident #11 and #43 with their fingernails in the same condition as observed on 06/29/26. In an interview on 07/01/26 at 11:33 AM the Unit Manager LPN#11 stated that they do not have a schedule for nail care, however the Geriatric Nursing Assistants are required to provide nail care on shower days and as needed. She accompanied the surveyor to the residents' rooms, examined the residents' hands and stated that she would arrange for the residents to have their nails trimmed. The Director of Nursing was notified of the surveyor's findings on 07/01/26 at 1:00PM. She stated that she was notified by the nurse and would address the concern.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews, and surveyor record reviews, it was determined that the facility staff failed to follow professional standards of practice for oxygen administration and oxygen safety. This finding was found to be evident in 2 (Resident #10 and #99) out of 3 Residents reviewed for respiratory care and services. The findings include: Oxygen concentrator is a medical device that pulls ambient air, removes nitrogen, and delivers concentrated oxygen to individuals with respiratory conditions. The purified oxygen is delivered directly to the user via a nasal cannula. At 8:25 AM on 6/29/2026 the surveyor observed Resident #10 lying in bed, in no distress with oxygen therapy in use. Resident #10 had an oxygen concentrator at the bedside and a portable emergency tank of oxygen (etank) standing on the floor at the head of the bed. The etank was not secured in a cart, stand or bracket. Surveyor notified the Nurse Manager #5 who observed the etank in Resident #10's room that was not secured in a cart or stand and removed the etank from Resident room indicating that the etank should have been in a stand. Additionally, there was not an oxygen in use signage on the Resident room door. On 6/29/2026 at 9:00 AM surveyor observed Resident #99 sitting in bed, in no distress with oxygen therapy in use with an oxygen concentrator. There was not an oxygen in use signage on the Resident room door. The surveyor conducted a record review of the facility's policy and procedure for Oxygen Safety and Oxygen Administration on 6/30/2026 at 12:30 PM. Review of the policy revealed that No Smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply and will remain in place until oxygen administration has been discontinued; oxygen warning signs must be placed on the door of the Resident's room where oxygen is in use. At 4:00 PM on 7/2/2026 Licensed Nursing Home Administrator (LNHA) and Regional LNHA were notified of the concerns with oxygen storage and administration.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interviews, it was determined that the facility staff failed to document the action taken to address medication regimen review irregularity. This deficient practice was evident for 1 (Resident #5) resident reviewed for medication regimen review during the annual survey. The findings include: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the IDT, including the resident, their family, and/or resident representative. On 07/01/2026, a review of Resident #5's medical records revealed that a monthly MRR was completed in June 2026. The pharmacist's progress note stated, see report for comments and recommendations. At 1:37 PM, the surveyor requested a copy of the June 2026 MRR report from the Director of Nursing (DON) #2. At 3:35 PM, The DON #2 provided the June 2026 MRR report. Review of the report revealed a recommendation to consider increasing the resident's Methimazole dose and to monitor the thyroid stimulating hormone level in six weeks and every 6 months thereafter or clinically indicated. The Family Nurse Practitioner (FNP) #14 response on the report stated, I accept the recommendation above with the following modifications. However, the section designated to document the modification was left blank. The surveyor then reviewed Resident #5's medical record with the DON. No progress notes or other documentation describing the modifications or actions taken in response to the recommendation were found. The DON #2 stated she would further investigate the MRR recommendation and follow up with the surveyor. On 07/02/2026 at 8:24 AM, the DON #2 followed up with the surveyor and reported that she had spoken with the FNP. According to the DON #2, the FNP stated that he failed to document the rationale for his modification on the MRR form and also failed to document a rationale in the resident's medical record.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on clinical record review and interviews, it was determined that the facility failed to provide adequate side effects monitoring for a resident on anticoagulant therapy. This was evident for 1 (Resident #11) of 6 residents reviewed for monitoring of side effects. The findings include: On 07/02/26 at 8:39 AM a review of Resident #11's clinical record revealed that the resident was receiving anticoagulant medication, Eliquis from 12/03/25. The Physician Order stated as follows: Eliquis Oral Tablet 5 mg (Apixaban) Give 1 tablet via PEG-tube two times a day DVT Prophylaxis Order Date 12/03/25. Further review of the record failed to reveal a process for monitoring side effects associated with anticoagulant therapy. On 07/02/26 at 1:32 PM during an interview Unit Manager LPN#11 (UM #11) stated that it was the practice for the facility to monitor residents for side effects and document the monitoring on the resident's Medication Administration Record or Treatment Administration Record. UM #11 reviewed the clinical record and stated I do not see any monitoring or care plans for anticoagulant, it is not here, I will take care of it. The Director of nursing was notified of the surveyor's concerns and during an interview on 07/02/26 at 3:15 PM, she provided the surveyor with a copy of a physician's order dated 07/02/26 at 1:39 PM for monitoring of side effects for Resident #11. The surveyor noted that order was initiated after the surveyor's intervention.		

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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, observations, and record reviews, it was determined that facility staff failed to assist a resident in arranging follow up for dental care in a timely manner. This deficient practice was evident for 1 (Resident #5) of 2 residents reviewed for dental services during the annual survey. The findings include: On 06/29/2026 at 9:08 AM, during an interview, Resident #5 stated, they were to have their remaining teeth removed but were hospitalized for a month. Since returning to the facility in October 2025, there has been no follow up on the extraction. During the interview, the surveyor observed that the resident had only two small tooth fragments remaining. A review of the resident's medical records on 06/30/26 at 10:03 AM revealed an August 2025 dental consult recommending extraction of remaining root tips. The resident returned from the hospital in October 2025. Records failed to show documented evidence of follow up. On 06/30/26 at 11:16 AM, the Director of Nursing (DON) #2 explained that that after dental appointments, follow up instructions are given to medical records staff to arrange further appointments. The surveyor informed the DON #2 of the missing follow up since August 2025. The DON #2 stated she would review the records and follow up with the surveyor. On 06/30/2026, the Medical Record (MR) #8 staff presented a email dated 05/05/2026 related to the following up for the extraction. When asked about the follow up from August 2025 consult, she stated that follow ups were made, however, there was no documented evidence she could provide. The surveyor presented the concerns to the DON #2 who acknowledged the concern.		

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

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations, staff interviews, and surveyor record review it was determined that the facility failed to install a handrail in the hall on the Ground-TCU Nursing Unit. This finding was found to be evident in review of the physical environment during the annual recertification survey. The findings include: The surveyor observed at 12:25 PM on 7/2/2026 on the Ground-TCU Nursing Unit a gap/space in the handrail on the wall on the right side of the hall. The gap/space was observed to be approximately 30 long, and there were four (4) holes in the wall which appeared to be from a missing piece of the handrail. The gap/space was located between the utility room and medication room and across from Resident room G-9. Residents were observed to be ambulatory, using walkers and wheelchairs. At 12:35 PM on 7/2/2026 the surveyor notified the Nurse Manager #5 of the missing handrail. Nurse Manager #5 observed gap/space in the handrail on the wall with the four (4) holes between the utility room and medication room. Nurse Manager #5 indicated that she would notify Maintenance. Environmental Services staff in the hall stated that there used to be a water fountain in that space. Record review at 1:00 PM on 7/2/2026 revealed that the Resident census on Ground-TCU nursing unit was 15, and capacity was 17. At 2:10 PM on 7/2/2026 the surveyor notified the Regional Licensed Nursing Home Administrator (LNHA) of concern with the handrail on the Ground-TCU Nursing Unit. Regional LNHA observed the gap/space and the four (4) holes in the wall. Regional LNHA stated that there used to be a water fountain on the wall that was removed and indicated that he was aware that a handrail needed to be installed in that space. On 7/2/2026 at 4:00 PM the Licensed Nursing Home Administrator (LNHA) provided the surveyor with an email time stamped at 2:46 PM on 7/2/2026 to an individual at inprocorp.com that indicated a request to order a handrail that was needed to be replaced in the facility.		