STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215230	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and interview it was determined that the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected a resident's current status. This was found to be evident for one (Resident #28) out of three residents reviewed for pressure ulcers.The findings include:The Minimum Date Set (MDS) is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. Review of Resident #28's medical record revealed a wound specialist note, dated 3/11/26, that documented the presence of an unstageable deep tissue injury (DTI) on the resident's right lateral foot. A DTI is a pressure injury resulting from intense and or prolonged pressure and shear forces at the bone-muscle interface. It presents as intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue. Review of the Minimum Data Set (MDS), with an assessment reference date of 3/13/26, revealed staff documented in Section M0210 that the resident had no unhealed pressure ulcers or injuries. On 3/31/26 at 2:15 PM surveyor interviewed the MDS Nurse #18 about the 3/13/26 MDS assessment regarding the presence of pressure ulcers. After looking up the information in the electronic health record, Nurse #18 reported that the resident has a DTI on the foot and stated: I'll have to modify that in regard to correcting the MDS assessment. Later in the survey, Nurse #18 provided documentation to indicate a correction was submitted that included documentation that the resident has a one unhealed, unstageable pressure injury presenting as a deep tissue injury.

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 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. Based on interview and medical record review it was determined that the facility failed to ensure an interdisciplinary care plan meeting was held to review and revise the resident's care plan after the completion of a Minimum Data Set (MDS) assessment. This was found to be evident for one (Resident #6) out of two resident's reviewed for urinary catheter use.The findings include: Care Conferences, also known as care plan meetings, are interdisciplinary team meetings that are to occur following the completion of Minimum Data Set (MDS) assessments. The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. On 3/31/26 at 2:19 PM social worker (SW) #6 was interviewed in regard to the process for scheduling care plan meetings. SW #6 reported that the MDS nurses send out a schedule and that social work usually schedules the meeting 14 days after the assessment date. She went on to report that there is documentation of these meetings in the electronic health record. On 4/1/26 at 10:31 AM review of Resident #6's medical record revealed a MDS, with an assessment reference date of 1/9/26. On 4/1/26 further medical record review revealed documentation that a care conference had occurred on 10/15/25, but failed to reveal documentation to indicate a care conference had occurred after the 1/9/26 assessment was completed. On 4/1/26 at 11:51 AM SW #6 was asked if there was documentation to indicate that a care conference had occurred since October 2025. At 12:32 PM SW #6 and the Nursing Home Administrator (NHA) confirmed that there was no care plan meeting since October. The NHA indicated this was due to the resident transitioning from long term care to skilled care. Cross reference to F 690.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on medical record review, observation and interview it was determined that the facility failed to ensure the provision of activities to meet the needs of residents with dementia. This was found to be evident for 2 (Resident #122 and #9) out of 5 residents reviewed for dementia care.The findings include1.Review of Resident 122's medical record revealed the resident has resided at the facility for more than 6 months, was legally blind and had dementia. The resident resided on the secured unit, in which a code was required to gain access to the elevator to leave the unit. On 3/30/26 at 11:09 AM Resident #122 was observed ambulating in the hallway, dressed for the day. There was no formal activity occurring at this time on the nursing unit.On 3/30/26 at 12:40 PM, Resident #122 was observed standing in his/her room alone, leaning over the foot of the bed. Surveyor did not observe the television or music to be on in the resident's room. On 3/31/26 at 1:39 PM, observation made on Resident #122's unit failed to reveal an organized activity at this time. Resident #122 was not in the hall at this time. At 1:42 PM, the resident was again observed in his/her room.On 3/31/26 at 2:02 PM, Resident #122 was sitting in the hallway near the nursing station. Bingo was being called at this time in the hallway, but Resident #122 was not participating. The resident was drinking a container of milk at this time.On 4/01/26 at 1:57 PM, Resident #122's door was shut. After entering the room, Certified Medicine Aide (CMA #5) and surveyor observed the resident reclining on the bed crossway. CMA #5 assisted the resident with a position change and asked the resident if s/he would leave the door open.Further review of the medical record revealed an interview was conducted with Resident #122 for the Minimum Data Set (MDS) assessment, dated 7/17/26, related to activity preferences. According to this assessment it was very important for the resident to have books, newspapers and magazines to read; listen to music s/he likes; be around animals such as pets; keep up with the news; to do things in groups; go outside to get fresh air when the weather is good and to participate in religious services.Review of Resident #122's care plan revealed the resident was independent after set up assistance for meeting emotional, intellectual, physical and social needs related to being legally blind. The interventions reflected the MDS assessment and included but not limited to offer resident audiobooks of thriller and mystery stories; staff to offer assistance with reading mail and other information sheets; and staff will offer one-to-one visits for socialization and assistance with audio equipment.Review of a Care Conference note, dated 1/14/26 revealed the resident's representative would like for [her/him] to be more engaged with activities.On 4/2/26 at 3:38 PM, interview with the Activity Director (#27) revealed that prior to COVID she had a full-time activity person for the secured unit. Currently she has one full-time staff member plus two part-time staff, and she also supervises the bus driver, who when not driving the bus can assist with activities as needed. She reported the full-time person conducts the activities on the Activity Calendar and that one of the part-time staff conducts the one-on-one visits. She confirmed that the residents on the secured unit are able to attend any of the activities in the facility and that they do have documentation of activity participation.In regard to Resident #122, the Activity Director reported that the resident goes to some music activities and that a church lady comes in on Wednesdays. She confirmed that the resident would have to leave the unit in order to attend most activities offered.Review of the Activity Participation sheet for January 2026 revealed self directed active socialization on 29 out of 31 days reviewed and two days were documented as passive. There was documentation of walking in the halls as an activity for 30 out of 31 days. Interview with the Activity Director on 4/2/26 at 4:22 PM revealed that the socialization documented is not a 1:1 intervention; and that the walking in the halls is an independent activity. Further review of the January participation log revealed the resident attended Bingo on one occasion, attended two socials; and participated in snacks/hydration on two occasions. There was only one instance of the resident refusing to participate in an activity but was found to be unable to participate on five occasions. There was one notation about the resident receiving mail, but staff documented that the resident was asleep, so they did not get a chance to (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	read the mail to the resident. No further documentation was found to indicate the mail was read to the resident at a later date.Review of the Activity Participation sheet for February 2026 revealed self-directed active socialization on 26 out of 28 days reviewed, and two days were documented as passive socialization. There was documentation of walking in the halls on 7 days and actively participating with snack/hydration on one day, and one occasion that the resident was unable to participate with the pet visit. No documentation was found to indicate the resident attended a party, a religious event, or had staff read to her/him or otherwise engage with the resident during the month of February. There was no documentation to indicate activities were offered and the resident refused.Review of the Activity Participation sheet for March 2026 revealed self-directed active socialization on 29 out of 31 days reviewed and two days were documented as passive. Walking around was documented as an activity on 30 out of 31 days reviewed. There were four occasions when the resident actively participated in an activity: once with fresh baked cookies; once with the snack/beverage cart; once with some mail; and once went to the barber/beauty shop. The resident refused to participate on one occasion when offered an arts and crafts activity, no other refusals were documented. Staff documented that the resident was unable to participate with the snack & beverage cart on five occasions and the movie & popcorn on one occasion. No documentation was found to indicate the resident attended, or was offered to attend an entertainment event, religious activity or had staff read to him/her or engage in a one-on-one activity.2) Review of Resident #9's medical record revealed the resident had resided at the facility for more than one year and had a diagnosis of dementia with severe cognitive impairment as evidenced by a March 2026 Brief Interview for Mental Status (BIMS) score of 1/15. The resident resided in the secured unit.Review of the 8/4/25 MDS assessment for activity preferences revealed the resident was interviewed in regard to his/her preferences. This assessment revealed it was very important to the resident to go outside to get fresh air when the weather is good; and somewhat important to have books, newspapers and magazines to read. The resident indicated it was not very important to listen to music, keep up with the news, participate in religious activities or to do things in groups.Review of the care plan addressing activities revealed Resident #9 was dependent after set up assistance for meeting emotional, intellectual, physical and social needs. The most recent evaluation of this care plan was completed by the Activity Director on 2/18/26 and included the following: .has been offered pet visits, up front in reclining chair, guessing games, television up front. Interventions include, but are not limited to: Staff will invite, make arrangements, offer materials, or assistance to facilitate participation in music interests such as country; staff will offer to read mail and other materials to [name of resident] as s/he is not able to see well.Review of the activity participation logs for January 2026 revealed Television upfront was included as an activity and there was documentation of active participation for this activity on 23 out of 31 days reviewed.Observations made throughout the survey revealed there was a large television located at the back of the nursing station which had a movie playing throughout the day during the course of the survey. Several residents were frequently observed sitting near the nursing station while the movies were playing. However, residents sitting in the hallway needed to look past the nursing station counter, and any staff at the nursing station, in order to actually view the movie that was playing. Additionally, there was a room at the end of the unit that appeared to be a dining room; however, no observations were made during the survey of this room being utilized for dining or activities. During an interview with Nurse #16, she reported that there was no specific activity person assigned to the secured unit. She reported that the room at the end of the hall is currently a staff training room and that the residents are never taken down there for activities. Nurse #16 did report that they always have music or a movie, referencing the tv playing at the nursing station.Further review of the January activity participation log revealed active self-directed socialization on 29 out of 31 days, with passive socialization documented on two dates. The resident did participate in a guessing game on one occasion and had mail read to her/him on two occasions, attended one party and had one pet visit over the course of the month. The daily chronicle (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided on 8 days.Review of the February 2026 participation documentation revealed Television upfront was documented as an activity on 27 out of 28 days reviewed. No documentation was found to indicate the daily chronicle was provided to the resident during February. Self-directed socialization was documented for all 28 days. The mail was read to the resident on one occasion, and a pet visit also occurred on one occasion; the resident refused to participate in a word game when offered on one occasion. Five family visits were also documented as activities. No additional documentation was found to indicate other individualized activities were offered to the resident in February.Review of the March 2026 participation documentation revealed self-directed socialization was documented for 25 days and passive socialization on 6 days. The resident had the mail provided on one occasion; attended a movie & popcorn on one occasion and had fresh baked cookies on one occasion. The staff documented two family visits as activities. The resident refused the offer of music on one occasion, but no other refusals were documented. Staff documented the resident was unable to participate in the pet visit on one occasion and was unable to participate with snacks & beverage cart on 6 occasions. No documentation was found to indicate the daily chronicle was offered or read to the resident; no documentation to indicate the resident was offered to participate in any games or other activities.During the interview with the Activity Director on 4/2/26 at 4:22 PM surveyor reviewed the concern regarding the provision of activities. The Activity Director acknowledged the concern.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to develop a care plan to address the resident's needs related to the use of an indwelling urinary catheter and failed to ensure that a resident was assessed for the possible removal of the urinary catheter. This was found to be evident for one (Resident #6) out of two residents reviewed for indwelling urinary catheter usage.The findings include:On 4/1/26 review of Resident #6's medical record revealed the resident has resided at the facility for more than a year and was sent to the hospital in late December 2025. Review of the discharge Minimum Data Set (MDS) assessment for the December discharge to the hospital revealed the resident was frequently incontinent of urine (unable to control their bladder) and did not have an internal or external urinary catheter in place. The resident was re-admitted to the facility from the hospital in early January 2026.An internal urinary catheter is a medical device consisting of a tube that is inserted through the urethra into the bladder to empty urine. A Foley catheter is an indwelling urinary catheter that remains in place after insertion for continuous drainage of urine. The Foley catheter is held in the bladder by a water-filled balloon which prevents it from falling out.The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. Review of the hospital Discharge summary, dated [DATE], revealed that the resident was noted to have urinary retention during the hospitalization and that a Foley catheter was placed by urology. The note also indicated that the catheter would remain in place at discharge and the resident would follow up in the outpatient setting with urology.Review of the facility's policy regarding Catheter - Urinary Catheter, Cleaning and Maintenance revealed it consisted of a reference to Lippincott Nursing Procedures 9th Ed. (a nursing text book), pages 432 - 435. The facility did not have a facility specific policy regarding catheter use or addressing a plan to discontinue catheters when no longer needed. Review of the referenced [NAME] pages did reveal: Inappropriate or unnecessary use of an indwelling urinary catheter can result in catheter-associated urinary tract infection (CAUTI). Complications associated with indwelling urinary catheter use include CAUTI, genitourinary trauma, bladder fistula (an unusual opening between the bladder and another part of the body), bladder stone formation and incontinence.Continued review of the medical record on 4/1/26 revealed the resident had current orders, in place since January 2026, for an indwelling foley catheter and for catheter care to be provided every shift. Review of the progress note, written by primary care provider physician assistant (PA #23) for a visit on 1/3/26, revealed in the history of present illness section: .Foley catheter placed for Urinary retention. Urology had to placed it due to atrophy and difficult placement. [S/he] is to follow with urology outpatient.Review of a progress note, written for a visit completed by primary care physician (PCP #24) on 1/5/26, revealed in a section titled Interval History, which addressed events that had occurred during the recent hospitalization, included: .[S/he] also had a Foley catheter placed with difficulty and to follow with urology.On 4/1/26 at 10:31 AM review of Resident #6's medical record revealed an MDS, with an assessment reference date of 1/9/26. This assessment included documentation that the resident had an indwelling urinary catheter.Review of the care plan, on the morning of 4/1/26, failed to reveal documentation to indicate the presence of a urinary catheter or interventions to address the resident's needs related to catheter use. Further review of the medical record on 4/1/26 failed to reveal an order for a urology appointment or documentation to indicate the resident was seen by a urologist since the re-admission in January. No documentation was found to indicate there was an attempt to discontinue the use of the indwelling urinary catheter since the resident's re-admission.Review of a progress note written by primary care provider nurse practitioner (NP #25) for a visit on 3/2/26 revealed the resident was seen that day due to a report by nursing of hematuria (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(blood in the urine). The note revealed an indwelling Foley catheter was in place and some bloody urine was observed in the tubing.On 3/2/26 there was an order to flush the foley catheter with 60 cc sterile water every 6 hours for 24 hours. On 3/3/26 there was an order for an antibiotic to be administered twice a day until 3/10/26 for cystitis with hematuria. Cystitis is inflammation of the bladder due to an infection.Further review of the resident's care plans, on the morning of 4/1/26, revealed a plan for occasional bladder and bowel incontinence, which was last reviewed/revised on 3/11/26 by Registered Nurse #21. The 3/11/26 update failed to address the use of the indwelling urinary catheter or that the resident had recently been treated with an antibiotic for a possible urinary tract infection and blood in the urine. On 4/01/26 at 12:34 PM the Director of Nursing (DON) was interviewed about the process when a resident returns from a hospitalization with an indwelling urinary catheter still in place. The DON reported that they look to see if the resident was seen by urology while in the hospital, if there is an appropriate diagnosis for the use of the catheter, and any follow up to see if it should be removed. The DON also reported that they are able to complete bladder scans at the facility.After removal of an indwelling urinary catheter there are often orders to complete a bladder scan after the resident voids to assess if the resident is continuing to retain significant amounts of urine.Further review of the current order for the indwelling foley catheter revealed it was for Obstructive and reflux uropathy, unspecified. Obstructive uropathy is a blockage that makes it difficult or impossible to urinate. However, further review of the January hospital discharge summary and the primary care provider progress notes for 1/3/26, 1/5/26 and 3/2/26 failed to reveal documentation of a diagnosis of obstructive uropathy.During the 4/1/26 interview with the DON the surveyor reviewed the concern that there was no documentation found to indicate there was an attempt to remove the catheter after the January re-admission or that the continued use of the catheter was addressed in the care plan.On 4/02/26 at 8:40 AM, after reviewing the section of the hospital discharge summary that addressed the need for urology follow-up with the surveyor, the DON reported that the resident does have an appointment with urology in May. The DON also reported that the resident has had an indwelling urinary catheter in the past that was removed.On 4/02/26 at 8:50 AM the Appointment Coordinator (#22) reported that the appointment with the urologist was just scheduled the day before. She went on to report that it appears it was missed during the resident's re-admission by nursing.On 4/2/26 at 10:34 AM surveyor reviewed the concern with the corporate nurse (#26) that in addition to the hospital discharge summary, the primary care notes from January 2026 also indicated the need for follow up with urology.On 4/2/26 continued review of the medical record revealed that a care plan to address indwelling catheter use was initiated on 4/1/26. Registered Nurse #18 documented that this plan was reviewed/revised on 4/1/26 at 2:31 PM.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview, and record review it was determined that the facility failed to ensure nursing staff were evaluated for competence. This was evident for 2 of 2 Registered Nurses (Staff #11, #13) employee files reviewed for skills and competency.The findings include: On 04/02/26 at 10:25 AM an interview was conducted with the Human Resources Coordinator (Staff #19). When asked how staff performance was monitored she said that this was done annually and that she gave a form to the Director of Nursing (DON) who would then give them to the corresponding unit manager and that the form included a section for skills/competencies. She was then asked to provide employee files for 2 Registered Nurses (Staff #11, Staff #13). On 4/02/26 at 10:47 AM an interview was conducted with the DON and a review of Nurse #13's employee file was done together but the review failed to reveal any skills/competency for the nurse. The DON said Nurse #13 was part time and was hired only to do wound care, so she may not have had a skills checklist done. During the interview the Facility Assessment was also reviewed with the DON and she confirmed that the assessment indicated multiple resident care activities for which staff were expected to demonstrate competence. On 4/02/26 at 11:06 AM a review of Nurse #11's employee file was conducted and revealed 2 competencies dated 3/18/21, one for Blood Glucose Monitoring and one for Medication Administration. No more recent competencies were found in the file. On 4/02/26 at 12:01 PM, in another interview with the DON, she said that nursing staff should have competencies done during orientation and annually. She confirmed that Nurse #11 and Nurse #13 did not have their skills/competence evaluated.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) had their performance evaluated. This was evident for 2 (Staff #14, #15) of 2 GNAs reviewed for performance evaluation.The findings include: On 4/01/26 another surveyor requested the employee files for Staff #14 and Staff #15.On 4/02/26 at 9:08 AM a review of the employee files for Staff #14 and Staff #15 failed to reveal any evidence that they had performance evaluations.On 4/02/26 at 3:57 PM an interview was conducted with the Director of Nursing and she confirmed the deficiency that the facility did not complete performance evaluations for either Staff #14 or Staff #15.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, it was determined that the facility failed to ensure the accuracy and integrity of controlled substance reconciliation records. This deficient practice was identified in 1(3rd floor south cart) of 3 medication storage areas observed. The findings include: On 04/02/26 at 11:45 AM, during an observation of the 3rd floor medication storage room and 3rd floor south medication cart, Licensed Practical Nurse (LPN) #16 provided the narcotic count verification sheet utilized for shift-to-shift reconciliation of controlled medications. Review of the narcotic reconciliation documentation revealed the following: The 6:00 AM shift reconciliation for 04/02/26 contained signatures of two licensed nurses; however, there was no documented evidence that an actual count of controlled medications was performed, including: total number of narcotic blister pack cards total number of medication bottles, including refrigerated medications total number of transdermal patches The reconciliation record did not demonstrate that controlled substances were verified by two licensed nurses at the time of shift change, and signatures alone do not constitute evidence of an actual count. The 2:00 PM shift reconciliation for 04/02/26 was signed in advance of the shift change by LPN #16, prior to the required reconciliation time and prior to completion of a narcotic count with another licensed nurse. On 04/02/26 at 11:45 AM, during the surveyor's observation, LPN #16 confirmed that the 2:00 PM reconciliation had been pre-signed and stated this was done due to working a 16-hour shift. LPN #16 further confirmed that the narcotic count for the 2:00 PM shift change had not yet occurred at the time the signature was entered. This practice resulted in narcotic reconciliation documentation that did not reflect verification of an actual count at the time of shift change, and did not ensure that controlled substances were accurately accounted for by two licensed nurses. On 04/02/26 at approximately 1:30 PM, the Nursing Home Administrator and Director of Nursing acknowledged the concern related to narcotic count reconciliation practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215230	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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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. Based on observation, interview, and record review, it was determined that the facility failed to ensure the accuracy of clinical records, specifically the electronic medication administration record (eMAR). This deficient practice was identified for 1 (Resident #15) of 3 resident medication administration observations. The findings include: On 04/01/26 at 9:30 AM, during a medication administration observation, Registered Nurse (RN) #11 was observed preparing to administer medications to Resident #15.Resident #15 had diagnoses that included, but were not limited to, Parkinson's disease, Repeated falls, and Muscle weakness. Resident #15 had an order for amantadine, a dopaminergic medication used to manage symptoms of Parkinson's disease. Failure to administer this medication as ordered may result in increased rigidity, decreased mobility, and impaired functional status. Review of the resident's eMAR revealed that the resident's amantadine HCl 100 mg, scheduled for 8:00 AM, was documented as administered.On 04/01/26 at 9:32 AM, during the observation, RN #11 confirmed that the medication had not yet been administered, despite being documented as given in the eMAR.On 04/01/26 at 9:35 AM, with surveyor observation, RN #11 administered the medication at approximately 9:40 AM and corrected the eMAR entry to reflect a late administration prior to delivering the medication to Resident #15.During an interview at the time of the observation, RN #11 stated they were unsure how the medication was documented as administered prior to giving it.On 04/01/26 at 11:00 AM, both the Nursing Home Administrator and Director of Nursing acknowledged the concern that a medication for Resident #15 had been documented as administered in the eMAR prior to actual administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to use infection prevention strategies. This was found to be evident during two out of two observation of the laundry facility; the review of the water management plan to prevent Legionella; and review of one (Resident #16) out of three residents reviewed for pressure ulcer care.The findings include: 1) On 3/31/26 at 1:13 PM an observation of the facility laundry rooms was conducted. A laundry aide (Staff #10) was observed as she held and folded a flat sheet which touched the floor as she held it up to fold it. There was a metal table in the room that was partially covered with supplies, and about 3 feet of the table was clear. The overall table length appeared to be shorter than the length of the flat sheet that was being folded. When interviewed, Staff #10, described the process for sorting, washing, drying, folding, storing and stocking linens for the facility. When she described how she sorted dirty linens and how she placed dirty linens in the washer, she said she wore gloves but did not wear a gown or an apron. On 3/31/26 at 1:40 PM an interview was conducted with the Maintenance Director (Staff #9) who said his responsibilities included management of housekeeping and laundry. When he was informed of the observation and interview of Staff #10 who was observed to allow clean linen to touch the floor when she folded it, and that she said she did not wear a gown or apron when she sorted dirty linens, he acknowledged the deficient practice and said he would talk to his staff that day. On 4/01/26 at 9:12 AM another observation of the dirty laundry room was conducted. Laundry aide (Staff #7) was observed and interviewed. She took dirty linens from a reusable cloth bag and sorted the white linens from resident clothing and dark colors and place them in separate dirty linen carts. Some of the linens appeared to be wet and smelled of urine. Staff #7 wore gloves but did not wear an apron or gown over her personal clothing while she sorted the dirty laundry. When asked, she said she did not wear an apron or gown when she sorted dirty linens or when she put dirty linens in the washer, and that she processed the linens in the way that she was taught. On 4/01/26 at 9:19 AM an interview was conducted with the Nursing Home Administrator (NHA) regarding the observation that Staff #7 was observed and interviewed and failed to wear the proper personal protective equipment (PPE) to sort dirty linens and failed to describe the proper process. The NHA said that staff had been re-educated yesterday, but she acknowledged the observation of deficient practice that day despite the facility's staff education. 2) On 3/31/26 at 1:25 PM an interview was conducted with the Maintenance Director (Staff #9) to review the facility's water management plan to prevent Legionella. He explained that the facility's water supply was from the city and that he checked the city's water report annually. When asked he said the facility did not test for Legionella. When asked about water temperature monitoring, he said he sometimes did random testing and said he would provide a report. On 3/31/26 at 1:40 PM the Nursing Home Administrator joined the interview and when asked about the facility's water management plan, she replied that it is something they have talked about, but she could not cite a professional reference they used or explain any process in place to monitor the water. On 3/31/26 at approximately 2:00 PM, a water temperature log document was provided and reviewed. The review revealed that the log was for the month of May 2025 and listed random resident rooms and corresponding water temperatures. No other evidence of resident room water temperature monitoring (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided. On 3/31/26 at 2:12 PM the NHA brought a copy of the facility policy titled Water Systems, Safety and Management which referenced Center for Disease Control (CDC) guidelines for the process to monitor and control water for Legionella. The NHA confirmed that the facility failed to have a program for Legionella management and did not follow their policy which referenced the CDC guidelines. 3) On 4/01/26 at 9:40 AM, Resident #16 was identified as having a stage 4 pressure ulcer on their lower back. Physician #12, the facility's contracted wound care provider, and Wound Care Registered Nurse (RN) #13 were completing the dressing change for Resident #16 at that time. According to the Centers for Disease Control and Prevention (CDC), Enhanced Barrier Precautions (EBP) in long-term care are infection control measures that require gowns and gloves during high-contact resident care and target multidrug-resistant organisms (MDROs) when standard precautions are insufficient. They apply to residents with chronic wounds, indwelling devices, or known MDRO infections to prevent transmission without completely isolating residents. This strategy, which applies to residents with unhealed wounds, bridges the gap between Standard and Contact Precautions without requiring room isolation. On 4/01/26 at 9:46 AM, the surveyor completed an observation of Resident #16's stage 4 pressure ulcer on the resident's lower back. Physician #12 and RN #13 provided the care to the resident. During the observation, Physician #12 prompted RN #13 to put on Personal Protective Equipment (PPE), including a gown. However, during the observation, Physician #12 did not properly don the gown, leaving it untied and unsecured, which caused it to drape off their arms and cuff around their hands while assessing and redressing Resident #16's stage 4 pressure ulcer. On 4/01/26 at 10:10 AM, the medical record revealed Resident #16 had an order for EBP; however, the order specifically stated that it was for a Foley Catheter dated 02/06/26. There was no evidence of an active order on Resident #16's record to reflect EBP for the Stage 4 pressure ulcer on the resident's lower back. On 4/01/26 at 11:30 AM during an interview with both the Nursing Home Administrator and the Director of Nursing, they acknowledged concerns about not providing proper EBP for Resident #16.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews, it was determined that the facility failed to ensure that the call system was accessible to meet resident needs. This was evident for 1 (Resident #46) of 1 residents observed for call system accessibility. The findings include: On 03/30/2026 at 11:22 AM, Resident #46 motioned for the surveyor to enter the room while holding a nasal cannula and requested assistance to place it back on. At that time, the surveyor observed that no call bell was within Resident #46's reach, and further observation of the room revealed the call bell was located on the floor under Resident #46's bed.On 03/20/26 at 11:26 AM, after the surveyor stood in the doorway to obtain staff attention, Geriatric Nursing Assistant (GNA) #17, who identified themselves as the assigned staff member for Resident #46, entered the room and retrieved the call bell from under Resident #46's bed. GNA #17 stated they had previously placed the call bell within the resident's reach on the bed during their last check of Resident #46. GNA #17 further indicated the call bell was not clipped, and the resident was seated in a wheelchair next to the bed at the time of observation.On 04/01/26 at 11:00 AM, the Director of Nursing acknowledged the concern regarding the accessibility of the call bell for Resident #46.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received the required 12 hours of annual training. This was evident for one (Staff #14) of two GNAs reviewed for annual training.The findings include:On 4/02/26 at 9:00 AM the Director of Nursing (DON) was interviewed and asked to provide training records for GNA #14. The DON reported that there were no training records for GNA #14. On 4/02/26 at 9:50 AM an interview was conducted with the DON and she was asked to provide any additional evidence of training for GNA#14. On 4/02/26 at 3:57 PM in an interview with the DON, she confirmed the finding that GNA #14 did not have 12 hours of annual training. No additional evidence was provided by the end of the survey on 4/3/26.