STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215233	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Riverside	1123 Belcamp Garth Belcamp, MD 21017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to ensure sanitary practices were followed in accordance with professional standards for food service safety, and ensure the dishwasher reached adequate temperature according to the manufacturer's guideline. This was evident during the surveyor's tour of the facility's kitchen and 1 out of 1 nutrition room observed by the surveyor on the first floor of the facility during the survey. The findings include: 1. During the surveyor's tour of the facility's kitchen on 8/14/25 at 8:57AM the surveyor observed a closed container with a clear lid on it, of thickener powder in which a plastic handled scooper was observed laying within the thickener powder with the handle of the scooper touching the thickener powder. At the time of the observation, the surveyor informed the facility's Director of Dining Services #30 who, after surveyor intervention, observed and acknowledged the surveyor's concern and was then observed reaching into the container and they removed the scooper. At this time, the surveyor conducted an interview with Director of Dining Services #30 who confirmed with the surveyor that the handle of the scoop should not be touching the food container contents and showed the surveyor where the scoops were to be hung, at which time, other scoops for other similar containers were observed to be hanging. After surveyor intervention, Director of Dining Services #30 reported to the surveyor that they would begin educating the facility kitchen staff regarding not leaving the handled scoop in the container. On 8/15/25 at 1:55PM the surveyor shared concerns with the facility's Administrator and the Director of Nursing who acknowledged understanding of the surveyor's concern. On 8/15/25 at 2:16PM the surveyor observed the first floor nutrition room refrigerator which contained a carton of creamer with a plastic bag on it observed to have spots of dark green matter/growth on it which was sitting next to a tray of peanut butter and jelly sandwiches. On 8/15/25 at 2:16PM the surveyor requested a dual observation of the concern with Unit Manager #26, who observed and acknowledged the surveyor's concern and stated the following to the surveyor: Okay, I'll take care of it. After surveyor intervention, Unit Manager #26 was then observed removing the carton of creamer with the plastic bag and throwing it away into the trash can. On 8/19/25 8:19AM the Director of Dining Services #30 informed the survey team of the following information with the facility's Director of Nursing present: We committed an error with the scooper and the handle so I just wanted to show you that we corrected this by in-servicing the staff and the thickener, I threw away and more thickener was ordered. 2. On 8/19/25 2:04PM the surveyor conducted an observation of the conveyor dishwashing process, at which time the surveyor observed dishwashing staff on the dirty side of the dishwashing area continuing to push dirty dishes through, and no staff was present on the receiving side of the dishwashing line to receive dishes after sanitization. At this time, the surveyor observed the dishwashing process in operation, and the wash temperature gauge was observed to not be moving and displayed 138F, and the rinse temperature gauge was observed to be at 154F. Observation of the manufacturer placard on the machine stated the following information: This machine is currently in hot water sanitizing mode, Hot water sanitizing: 160F minimum wash temperature, 180F minimum final rinse temperature. The dishwashing line was further observed to be backing up with dishes due to no one being on the receiving side of the dishwashing line, dishes were (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observed stuck and unable to appropriately move through the machine due to there being no room to leave the dishwasher. Upon further observation of the receiving side of the dishwasher line, food debris was observed on the designated clean side where the dishes were sitting after they had been through the dishwashing process. On 8/19/25 at 2:05PM the surveyor requested a dual observation with Director of Dining Services #30, who reported to the surveyor: The dishwashing company was here this morning and everything was fine. Regarding the food debris, Director of Dining Services #30 reported to the surveyor that the food debris just happened, and they were sure that Dietary Aide #31 would know that the food debris sitting there had just happened. At this time, orange food debris was additionally observed by the surveyor within the clean rack of dirty dishes that had been through the dishwashing process, and at this time, the surveyor shared their observation with Director of Dining Services #30. On 8/19/25 at 2:06PM the surveyor conducted an interview and dual observation of the concern with Dietary Aide #31 and inquired as to how long the food debris had been present on the receiving end of the dishwashing line, to which they replied: That's been here since I came in, I keep telling them not to put food over there, it was there since after lunch. After surveyor intervention, Director of Dining Services #30 was observed removing the dishes from the receiving side and and placing them on the other side to be put through the dish machine again, and poured sanitizer over the area where the food debris was. Director of Dining Services #30 reported to the surveyor that the temperature of the dish machine was not rising because it was full of dishes and no one to remove the clean dishes coming out. Director of Dining Services #30 stated to the surveyor: I will re-wash the dishes. On 8/19/2025 at 2:14PM the surveyor observed the dish machine log for August 2025 which revealed the dish machine log temperatures on the dates of 8/10 and 8/11/25 were crossed out and written over with the following information written: Repaired and was good! Ecolab was called 8/10/25. On 8/19/25 at 2:19PM the Director of Dining Services stated to the surveyor that the food debris observed was not food. At this time, the surveyor observed the dishwashing machine process and observed the wash temperature gauge was not moving during the process and read 132F. On 8/19/2025 2:21PM the surveyor conducted another observation of the dishwashing machine process and the was temperature gauge was again, observed to be at 132F. On 8/19/25 at 2:40PM the surveyor requested and conducted a dual observation of the dishwashing temperature concern with the facility's Administrator during the dishwashing process and the wash temperature gauge dial was observed to not be moving and read 130F. On 8/19/25 at 2:47PM the surveyor conducted an interview and shared concerns with the facility's Administrator who acknowledged and confirmed understanding of the surveyor's concerns. On 8/19/2025 at 2:54PM, after surveyor intervention, the facility Administrator informed the surveyor: The three compartment sink will be utilized and the dishwasher will be taken out of service and signs for out of use will be placed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews, medical record reviews, and observations it was determined that the facility failed to provide dignity and respect to residents dependent for activities of daily living assistance. This was evident for two residents (#7 and #43) out of 8 residents observed at mealtimes during the recertification survey.The findings include:On 08/14/25 at 0745 AM the surveyor initiated a tour of the second floor clinical unit. Resident#43 was observed at 08:35 AM eating breakfast in bed without staff assistance. Resident #43 had pureed and ground food items on the tray. There was a black handled adaptive spoon in the resident's contracted right hand. The surveyor observed the Resident #43 using the utensil to feed themself however, the resident was also spilling some food on her/his neck and chest. Resident #43 did not have any protective clothing covering the resident's neck, chest and/or bedsheets from spills. At the time of the observation there were no nursing clinical staff in Resident #43's room or in the hallway available to assist the resident. On 08/14/2025 at 08:39 AM the surveyor observed Resident #7 being spoon fed by GNA, #8. Additionally, GNA #8 was standing at the residents bedside while feeding the resident. There was guest chair available in the resident's room at the time of the observation. At 08:49 AM on 08/14/2025 the second-floor unit manager, RN #6 was interviewed by the surveyor and was informed of the surveyor's observations related to Resident #7 and Resident #43 in regard to staff assistance with residents meals and resident dignity. RN #6 stated that she would address the issues with the staff and that nursing staff are expected to sit while feeding residents. On 08/14/2025 at 1:10 PM a review of the electronic medical record revealed that Resident #43 had a diagnosis of status post cerebral infarction, hemiplegia, and right arm contracture. Additionally, Resident #43's Activities of Daily Living care plan included the intervention of nursing staff to assist with feeding the resident at mealtimes.On 08/18/2025 at 08:30 AM the surveyor observed Resident #43 with a pillowcase under their chin. Resident #43 stated that she/he had just finished breakfast. The surveyor observed that crumbs and bits of food were on the resident's face and neck, and the breakfast tray had been removed from the resident's room.

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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 interview it was determined the facility failed to ensure a homelike environment and maintain the resident environment in a safe, clean, and homelike manner. This was evident for 1 out of 1 outdoor resident patio spaces and 5 of 15 resident rooms observed during the facility's recertification survey. The findings include: 1.) On 8/15/25 at 14:07PM the surveyor conducted an observation of the facility's first floor dining room at which time the surveyor observed from the dining room, two metal beds and two bed headboards sitting within the outdoor patio space and various weeds and overgrowth of plants protruding through the fence surrounding the outdoor patio space. Weeds were observed protruding upward from sections of the cement in the outdoor patio space. An overgrowth of weeds along the front parking area spaces was additionally observed by surveyors. On 8/15/25 at 14:09PM the surveyor requested a dual observation with the Director of Nursing (DON) and observed and shared the concerns with them. At this time the surveyor conducted an interview of the DON who confirmed with the surveyor that the outdoor patio space was utilized by residents of the facility for activities and for sitting out to get fresh air and for family visits with residents. At this time the DON acknowledged the surveyor's concerns and reported the following information to the surveyor regarding the weeds and metal beds and headboards: I will get someone to take care of that. The surveyor subsequently shared the concern with the facility's Administrator who acknowledged the surveyor's concerns and confirmed that they had made contact with a lawn company prior to the survey for a quote, however, nothing had been scheduled yet for the care of the weeds or removal of the bedframes and head boards. On 8/19/25 at 12:28PM the surveyor conducted an interview with a facility visitor who communicated to the surveyor that the parking lot was observed by them to be overgrown by weeds during previous times they had visited the facility. On 8/25/25 at 2:01PM the surveyor again shared the concern during the facility's exit conference. 2.) On 8/14/2025 at 7:49AM, during the initial tour of the unit, observations revealed that 5 of 15 resident rooms had damaged walls, including unpainted portions and unsanded drywall patches. These areas were visibly unfinished and detracted from providing a clean, homelike environment for the residents. The rooms with damaged walls were 118, 123,125.127, and 128. On 08/14/2025 at 1:35 PM, the Nursing Home Administrator (NHA) and Regional Director were made aware of the findings.

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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 observation, interview, and record review, it was determined the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #10) out of 5 residents reviewed for pressure ulcers during the facility's recertification survey. The findings include: On 8/21/2025 at 8:06AM the surveyor observed LPN #22 perform a dressing change for Resident #10 for their pressure ulcers. On 8/21/2025 at 10:57AM the surveyor conducted a review of Resident #10's medical record which revealed an admission date to the facility in December 2024, and admission history documented by Physician #23 which indicated Resident #10 was admitted to the facility with a pressure ulcer. On 8/21/2025 at 10:57AM during the surveyor's review of Resident #10's medical record it was observed that an admission MDS assessment was completed for Resident #10 in December 2024 indicating under Section M- skin conditions, that the resident had pressure ulcers present. MDS section M0100 Determination of Pressure Ulcer/Injury Risk, question A asks the following information: Resident has a pressure ulcer/injury, a scar over bony prominence or a non-removable dressing /device and directs the person completing to select all that apply. Resident #10's MDS section M0100 question A was observed to coded with no documented as signed by Staff #24. On 8/21/2025 at 10:57AM during the surveyor's review of Resident #10's medical record it was observed that a quarterly MDS assessment was completed for Resident #10 in May 2025 and then again in August 2025 which were both documented as signed by MDS Coordinator #25. Section M-skin conditions, was observed to be documented that Resident #10 had pressure ulcers present. MDS section M0100 Determination of Pressure Ulcer/Injury Risk, question A asks the following information: Resident has a pressure ulcer/injury, a scar over bony prominence or a non-removable dressing /device and directs the person completing to select all that apply. Resident #10's MDS section M0100 question A was observed to coded with no documented as signed by MDS Coordinator #25. On 8/21/25 at 11:53AM the surveyor conducted an interview with MDS Coordinator #25 who confirmed they had completed the May and August 2025 MDS section M0100 for Resident #10 and acknowledged the surveyor's concern and stated the following to the survey team: This was a mistake, and yes it should be coded, it was an oversight on my part. On 8/21/25 at 11:54AM the surveyor shared the concern with the facility's Director of Nursing who stated the following to the survey team in response to the surveyor's concern: There will be an audit of the MDS to review for accuracy. On 8/25/25 at 2:01PM the surveyor again shared the concern during the facility's exit conference.

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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 interview and record review it was determined the facility failed to ensure medications were timely administered to a resident (#68). This was evident during the surveyor's review of a complaint during the facility's recertification survey. The findings include: On 8/14/25 at 1:26PM a review of complaint 357933 that was received by the State Survey Agency, alleged that Resident #68's medications were delayed several hours. During an interview 8/18/25 at 2:43PM conducted by the surveyor of the facility's Director of Nursing (DON), they stated the following information to the surveyor regarding Resident #68: No, I am not aware of any issues relating to medication administration. On 8/19/25 at 8:47AM the surveyor conducted an interview with the DON who reported they were not aware of any med pass delays regarding Resident #68, at which time the surveyor requested the Medication Administration Audit Report for Resident #68 to be provided for 6/18/24 and 6/19/24. On 8/19/25 at 13:55PM the surveyor was provided with the Medication Administration Audit Report for 6/18/24 and 6/19/24 for Resident #68 by the DON. On 8/20/2025 at 7:30AM the surveyor conducted a review of the Medication Administration Audit Report for 6/18/24 and 6/19/24 which revealed documentation indicating the following medications were not timely administered to Resident #68:1.) Oxycodone HCl Oral Tablet 10MG scheduled for 12:00PM on 6/18/24 with an administration time of 15:39PM by Licensed Practical Nurse (LPN) #29,2.) Oxycodone HCl Oral Tablet 10MG scheduled for 18:00PM on 6/18/24 with an administration time of 20:55PM by LPN #29,3.) Alprazolam Oral Tablet 0.25mg scheduled for 9:00AM on 6/19/24 with an administration time of 13:27PM by LPN #29,4.) Oxycodone HCl Oral Tablet 10mg scheduled for 12:00PM on 6/19/24 with an administration time of 14:52PM by LPN #29,5.) Gabapentin Oral Capsule 100MG scheduled for 17:00PM on 6/19/24 with an administration time of 19:02PM by LPN #29,6.) Alprazolam Oral Tablet 0.25MG scheduled for 17:00PM on 6/19/24 with an administration time of 22:57PM by LPN #29,7.) Oxycodone HCl Oral Tablet 10MG scheduled for 18:00PM on 6/19/24 with an administration time of 19:02PM by LPN #29,8.) Oxycodone HCl Oral Tablet 10MG scheduled for 00:00AM on 6/18/24 with an administration time of 1:16AM by Registered Nurse (RN) #10,9.) Oxycodone HCl Oral Tablet 10MG scheduled for 00:00AM on 6/19/24 with an administration time of 2:27AM by RN #10. On 8/20/25 at 7:40AM the surveyor conducted an interview of the DON who reported to surveyors that their expectation is for nurses to document at the time of medication administration to the resident, and nurses have one hour before, up until one hour after the scheduled medication order time to be considered passing the meds timely. At this time, the surveyor shared the concerns and observed the concerns with the DON on the Medication Administration Audit Report to which the DON replied: They should not be waiting until the end of their shift to sign medications off, we might have some medication administration timing audits to show you. On 8/20/25 at 9:37AM the surveyor conducted an interview with the DON who acknowledged and confirmed understanding of the surveyor's concerns. At this time the DON reported to the surveyor that the facility pulls reports of late medication administration for review. When the surveyor inquired to the DON as to how the facility determines if the medication pass was late, they stated to the survey team that they go by the scheduled time and compare it to the documented administration time, and showed the surveyor the Oxycodone order scheduled and administration times on the Medication Administration Audit Report.

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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 observation and staff interviews, it was determined that the facility failed to ensure that all residents were free from accident hazards and supervision. This was evident for 4 (Resident #2, 4, 73, and 22) out of 4 residents observed in the dining room area after breakfast time during the survey.The findings include:On 8/14/2025 at 8:47 AM, during the initial observation of the second floor, the surveyor went to the dining area and saw that there were several residents in the area talking amongst themselves. One of the residents (Resident #73) had finished their breakfast at the table and was trying to eat the aluminum lid from their apple juice container. As the surveyor was looking around, they heard a residents say, Don't eat that baby. You're not supposed to eat that. I don't know why they are eating that. Another resident (Resident #22) did not have any socks on and was in their wheelchair, moving around, using their feet to maneuver. The surveyor looked around the room to see if any staff were available to assist the residents. However, the surveyor did not see anyone in the room. The surveyor checked the nurse's station, which was right next to the room, but the nurse's station was empty at that time. The surveyor then looked down the hall to see if they could find a staff member to assist. The surveyor waved to a staff member (LPN #14) down the hall and asked them to come to the dining area. LPN #14 came and was notified that Resident #73 was eating an aluminum lid from their apple juice container. LPN #14 stopped the resident from eating the lid. LPN #14 was then asked if it was normal for residents to roam the hall in their bare feet. LPN #14 replied, No, I don't know why they don't have any socks on. LPN #14 was then asked if it was customary for the residents to be in the dining area without any supervision. LPN #14 replied that the staff were bringing the residents to the dining area for their coffee social hour and that someone from activities would be in there with them.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined the facility failed to: 1.) follow an active medical order in place for continuous oxygen for a resident, 2.) ensure the resident's care reviewed by the physician reflected the medical order in place, and 3.) ensure the respiratory care plan accurately reflected the medical order for oxygen. This was evident for 1 out of 1 resident (Resident #68) reviewed for respiratory care during the surveyor's review of a complaint and during the facility's recertification survey. The findings include: During the surveyor's review of investigation into a complaint, Resident #68 was observed by the surveyor on 8/18/25 at 10:53AM laying in bed with their oxygen concentrator on and set at 5 liters being delivered via nasal cannula to the resident. Review of the medical record at this time revealed Resident #68 had the following active medical order dated as beginning on 5/1/25: Respiratory: Oxygen- Continuous 4L via NC (nasal cannula), every shift. On 8/18/25 at 10:54AM the surveyor requested a dual observation of the concern with Unit Manager #26 who observed the oxygen concentrator of Resident #68 set at 5 liters, acknowledged the surveyor's concern, and after surveyor intervention, Unit Manager #26 was observed turning the oxygen concentrator from 5 liters down to 4 liters. On 8/18/25 at 10:56AM the surveyor shared the concern with the facility's Director of Nursing who acknowledged understanding of the concern. On 8/18/25 at 12:30PM the surveyor reviewed the medical record which revealed a progress note for Resident #68 documented by Nurse Practitioner #27 which indicated the resident was on oxygen via nasal cannula as needed on physical exam, and documented that the resident's assessment and plan included the resident being on chronic oxygen via nasal cannula at 3 Liters. On 8/18/25 at 12:30PM the surveyor reviewed the medical record which revealed a progress note for Resident #68 documented by Nurse Practitioner #27 which indicated the resident was on oxygen via nasal cannula as needed on physical exam, and documented that the resident's assessment and plan included the resident being on chronic oxygen via nasal cannula at 3 Liters. On 8/18/25 at 12:45PM the surveyor reviewed the care plan of Resident #68 and observed the following two simultaneous care plan interventions: 1.) Oxygen settings: 02 via 4L via NC, and 2.) Oxygen Settings: Humidified 02 via nasal prongs 3 L continuously. On 8/18/25 at 12:54PM the surveyor shared concerns with the Director of Nursing who acknowledged and confirmed understanding of the surveyor's concerns.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview, it was determined that the facility failed to ensure the services of a registered nurse were provided for at least 8 consecutive hours a day, 7 days a week. This deficient practice was evident on 1 of 8 days reviewed (08/10/2025) during the recertification survey.On 08/15/2025 at 1:07 PM, record review of staffing schedules and assignments revealed that no registered nurse was scheduled or present to provide coverage for the facility on 08/10/2025 for an 8-hour consecutive period.At 1:26 PM, during an interview with the Director of Nursing (DON), she confirmed there was no nurse coverage for the entire building during the overnight shift on August 9 and all day on August 10. She stated she lives close by and could come in if needed but was not in the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post nurse staffing information in a clear and visible manner as required. This deficient practice was evident for 1 of 2 floors during the recertification survey.The findings include:On 08/14/2025 at 7:39 AM, during observation of the first floor unit staffing board, the surveyor noted there was no clearly visible posting of the staff-to-resident ratio. The information could not be readily located or reviewed by residents, visitors, or staff. On 08/14/2025 at 1:35 PM, the Nursing Home Administrator (NHA) and Regional Director were made aware of the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to ensure that all items in the medication storage rooms were free from expired expiration dates. This was evident for 1 out of 2 medication storage rooms.The findings include: On [DATE] at 12:50 PM, the Surveyor arrived on the first floor to observe the medication storage room. A nurse (LPN #13) was asked for the location of the med room and to unlock it for them. LPN #13 had to first locate the person with the keys for the medication room to unlock the door. LPN #13 stood in the doorway while the surveyor reviewed the medications and supplies. It was noted that blue laboratory tubes for blood collection had expiration dates on them for [DATE] and [DATE]. The Eswab Collection & Transport System for Aerobic, Anaerobic & Fastidious bacteria had expiration dates on them for [DATE], and a Luer Lock Disposable syringe with 25G X 0.625 needles had expiration dates for [DATE], and [DATE]. All items were shown to LPN #13. She then stated that they would go through and make sure all expired items were removed from the medication storage rooms. On [DATE] at 1:30 PM, the DON #2 was notified of the findings and was shown the things found that had expired expiration dates on them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215233	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Riverside	1123 Belcamp Garth Belcamp, MD 21017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, record review, and staff interview, it was determined that the facility failed to ensure accurate information was placed in residents' records. This was evident for 2 (Resident #2 and #132) residents reviewed during the survey. 1) On 8/21/2025 at 2:13 PM, the surveyor spoke with the DON #2 and asked the question, Who is responsible for reviewing and implementing orders from the doctor after a doctor's appointment? DON #2 explained that the nurse should review the visit summary and update the orders when the resident returns, and the unit manager should also follow up to make sure that the orders are completed. DON #2 was notified that during the surveyor's record review, for Resident #2, there was no documentation of when the Foley was ever changed. DON #2 stated that she is not sure how they document it and that she would get back to the surveyor. When the DON #2 returned, she had brought the ADON #3 back with her. The ADON #3 explained that she had documented on 7/1/25 how Resident #2 had dislodged the Foley, and they needed to replace it after doing a bladder scan that showed a significant amount of urine in the Resident #2's bladder. However, her documentation was noted in the Care Plan Notes section and not under nursing or treatments. The surveyor then asked the ADON #3 to show the surveyor where the documentation would be for this task, of when the Foley should be changed or has been changed. The DON #2 left and returned 20 minutes later with an SBAR note of when the resident had his Foley changed on 6/30/25, and it was not noted on the TAR or the MAR. Further record review, revealed that the facility was documenting to change the Foley as needed on the Care Plan and in the resident's order summary. However, the orders from the Urologist on 7/16/25 and 8/13/25 stated that the Foley should be changed monthly. The progress notes dated 8/14/25, 8/8/25, and 7/31/25, all stated to change the Foley catheter every 3 weeks. 2) On 8/14/25, the surveyors received a copy of the matrix for the facility. During the record review, it was noted that Resident #132 was in room [ROOM NUMBER] A; however, while during the surveyor's initial observation, the resident was actually in room [ROOM NUMBER] A. The documentation was incorrect on the matrix. The DON was notified and asked to give a corrected matrix with accurate information for all residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews the facility failed to: 1.) maintain optimal infection control and prevention precautions in one area of the laundry room and maintain a clean environment around the eye wash station and the laundry hopper, and ensure water pipes were not left exposed in the area next to and above the laundry hopper. This was evident for 1 out of 1 laundry area observed; 2.) ensure proper infection control/sanitization for any medical equipment that was shared among residents. This was evident for 1 out of 2 medication administration observations; and 3.) ensure oxygen equipment was properly dated to prevent potential infection control risks. This was evident for 1 (Resident #101) of 2 residents reviewed for oxygen use during the facility's recertification survey. The findings include: 1.) On 8/25/25 at 11:32AM the Administrator and the surveyor agreed to tour the laundry room on the ground floor of the facility. Laundry Supervisor #20 accompanied the surveyor and the Administrator into the dirty side of the laundry room. The surveyor observed that the laundry room's eye wash station was located next to the hopper bowl that is used to rinse off soiled clothing, linens, towels, etc. The eye wash/hand wash sink and the hopper were dirty and with areas of brown rust like material present on the sink, inside the sink, and on the outside and the inside of the hopper. Above the hopper the wall was exposed, a large portion of drywall was not present and the shut off valves were without knobs. On 8/25/25 at 11:52AM Maintenance Director #21 stated that maintenance department was responsible for the removal and replacing the portion of the drywall that normally covers the shut-off valves. On 8/25/25 at 11:54AM Maintenance Director #21, with Laundry Supervisor #20 present, stated that the plumbing for the building was [AGE] years old. Maintenance Director #21 stated that he was aware that the interior wall should not be left exposed but he was waiting to figure out where he could order the replacement parts for the shut off valve knobs. Maintenance Director #21 stated that currently the hose for the hopper has a mixture of hot and cold water that is adjusted with a plumber's wrench to maintain a warm temperature. 2.) On 8/19/25 at 9:30AM the surveyor asked to observe Licensed Practical Nurse (LPN) #17 while he started his medication administration. LPN #17 was observed reviewing the first resident's medications in the computer. LPN #17 unlocked his medication cart and checked to see if he had all the medications that he needed for the resident needed first. LPN #17 noted that he was missing Ensure Max. LPN #17 walked with the surveyor to the medication room to see if any were in there, but none were. LPN #17 walked with the surveyor to the kitchen to see if any were there, however, the kitchen attendant stated that they should be on the unit. Then LPN #17 asked a coworker if they could assist him with finding some. LPN #17 then returned to the medication cart and sanitized his hands first and then stated that he needed to check the resident's blood pressure before he gave them their blood pressure meds. LPN #17 and the surveyor walked to the resident's room, and the nurse introduced himself and asked if he could check his blood pressure. LPN #17 checked the resident's blood pressure and stated that the blood pressure was good and okay to give them their blood pressure medication. LPN #17 walked with the surveyor back to the med cart, which was outside the resident's room, and LPN #17 began to pull the resident's medications. LPN #17 returned to the resident and told him which medication he/she was receiving and administered the medications. LPN #17 then left the resident's room and returned to the medication cart with the blood (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure machine. LPN #17 sanitized his hands again and returned to the computer to see the next resident. LPN #17 saw that he needed to check the next resident's blood pressure prior to administering their meds. The surveyor followed LPN #17 to the next resident's room, where he introduced himself and asked to check their blood pressure. LPN #17 checked their blood pressure; however, he did not sanitize the blood pressure machine. When LPN #17 returned to the medication cart to pull the medications, the surveyor asked what the policy was for using the medical equipment between residents. LPN #17 replied, I was supposed to clean the blood pressure machine between each resident. During this observation of medication administration, it was noted that LPN #17 failed to sanitize the blood pressure cuff between residents who needed their blood pressures completed before the administration of blood pressure medications. 3.) On 8/14/25 at 7:53AM, Resident #101 was observed to be using oxygen tubing that was not dated. At 7:56AM, Registered Nurse (RN) #10 was located and confirmed that the tubing and humidifier bottle were undated. RN #10 stated it was the responsibility of the registered nurse to ensure oxygen equipment was dated. RN #10 subsequently obtained new tubing and humidifier bottle for Resident #101 and ensured the date was applied. On 8/14/2025 at 1:35PM, the Nursing Home Administrator and Regional Director were made aware of the findings.