STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215234	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Bethesda	5215 Cedar Lane Bethesda, MD 20814

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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 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 interview and record review, the facility failed to ensure that a resident's right to make his/her own decisions, including the right to participate in and direct his/her personal and financial affairs, and the right to refuse services, was honored. The facility also failed to obtain the resident's consent prior to submitting a Medicaid application and inaccurately represented the resident's decision-making capacity. This deficient practice was identified for 1 of 1 resident (Resident #69) reviewed for resident rights.Findings include: During an interview conducted on 3/24/25 at approximately 11:00 AM with Resident #69 and the resident's daughter regarding complaint #2719381, Resident #69 stated that he/she had previously informed the social worker that he/she did not want to apply for Medicaid and planned to return home. The resident and the resident's daughter further stated that the facility submitted a Medicaid application without the resident's knowledge or consent. Resident #69 stated, I don't know how they could do that without my information and my permission.During an interview with the Administrator (Staff #1) on 3/24/25 at approximately 1:00 PM, the Administrator confirmed that a Medicaid application had been submitted on behalf of the resident, stating it was done to help him/her.During an interview with the Business Office Manager (Staff #13) on 3/25/25 at approximately 1:30 PM, she stated she had been advised by the facility that it was acceptable to submit the Medicaid application on the resident's behalf.Upon request, the surveyor reviewed the Medicaid application submitted for Resident #69. Review revealed the application was completed under the designation applicant without representative who lacks capacity to appoint a representative. However, review of the resident's medical record revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact and capable of making his/her own decisions.These findings demonstrate the facility failed to honor the resident's right to make informed decisions and to refuse services and failed to accurately represent the resident's decision-making capacity.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews with residents and facility staff it was determined the facility failed to ensure that residents' call lights used to notify staff that assistance is needed were within reach. This was found to be evident for 3 (#60, #107, # 67) of 105 residents observed during the initial tour conducted during the facility's annual Medicare/Medicaid survey.Findings include:Screening and observation rounds were conducted on the second unit hallway on 3/18/26 at 8:15 AM and the following concerns were identified:Resident # 60 was observed in the resident's room, and the resident call light was observed on the floor at 8:20AM. The nurse (staff # 12) was notified at this time and came into the room and picked up the call light off the floor.Resident #107 and #67 were observed in their room. Resident #67s call light was on the floor and resident #107's call light was hanging from the top of the bed onto the floor, out of reach of the resident.Both residents #107 and #67 complained of pain. The nurse (staff # 12) who came into the room to retrieve the call bells and placed them within the residents' reach attended to the resident's needs.The DON was made aware of the surveyor findings on 3/18/27 at 11:30 AM

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on observation and interview, the facility failed to ensure residents were permitted to receive visitors at any time in accordance with resident rights, by imposing facility-wide visiting hours. This deficient practice had the potential to affect all residents residing in the facility.Findings include: On 3/23/26 at approximately 7:30 AM, during entrance into the facility, a sign was observed taped to the glass entrance door which read, Sorry for the inconvenience, visiting hours have ended Monday-Sunday (8:00 AM-8:00 PM) All holidays 9:00 AM-5:00 PM. This signage indicated the facility imposed restricted visiting hours, limiting visitation outside of the posted times.During an interview on 3/23/26 at 7:50am, the Administrator (Staff #1) stated residents are allowed visitors at any time and reported being unaware of the origin of the posted sign.During interviews on 3/23/26 at approximately 11:00 AM, multiple residents confirmed the posted visiting hours reflected the facility's current practice for visitation.During an interview on 3/23/26 at 1pm, Receptionist (Staff #41) stated she places the sign on the door each evening at 8:00 PM when she leaves the building and removes it upon her return at 8:00 AM. She further stated that the front entrance door is locked after 8:00 PM. When asked how visitors would gain entry to the building outside of the posted visiting hours, she stated there is a doorbell located on the side wall. When asked if signage was posted to inform visitors of the doorbell, she stated there was no such signage.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record reviews, it was determined that facility staff failed to:1. Honor residents' rights to file grievances anonymously, and failed to provide blank Grievance forms in prominent locations throughout the facility. This was evident for 4 (#4, #25, #74, #83) out of 6 residents from 3/23/26 Resident Counsel meeting.2. Ensure that residents were provided with prompt follow-up responses to their grievances. This was found to be evident for 1 (Resident # 55) of 2 residents reviewed for care concerns during the facility's annual Medicare/Medicaid survey.Findings include:1. During a facility tour on 3/19/26 at 9:40 AM, it was observed that the facility did not post blank grievance forms to be made available in prominent areas. In an interview on 03/20/26 at 9:35 AM, the Administrator stated that a 24/7 care concern line is available for residents to report grievances via a voicemail system. However, the facility's corporation handled the care concern line concerns; the Administrator could not know for sure how concerns were circled back to the facility staff. He further stated that blank grievance forms are at the front lobby counter and at the nursing stations' counters. Once completed, residents may submit grievance forms to the Administrator, the Director of Nursing, or Social Work Staff #4 and #16. After submitting the forms, the appropriate department heads processed the investigations. While the standard turnaround time for resolutions is five business days, the Administrator held and expedited cases involving concerns of abuse, neglect, or injury. Additional observations were made from 03/20/26, at 10:15 AM, Signage: Both Social Workers' offices lack identification. In contrast, other staff offices, such as those for the Activity Coordinator and Business, are properly identified. No grievance forms were available at the lobby front desk counter nor the Nurse-stations' counters. Staff members had to retrieve the blank forms from the back areas upon request. A record review conducted on 03/20/26 at 10:33 AM, regarding the facility's Grievance/ Residents Monthly Counseling binder, revealed that a paper system was used prior to October 2025. It was noted that Social Worker staff initiated all grievance forms, rather than residents initiating them directly or through anonymous submissions. Additionally, there was no record of Grievance resolution statements provided back to the residents. In a subsequent interview, the Administrator confirmed that blank grievance forms were inaccessible to residents at this time. During a Resident Council meeting on 03/23/2026 at 11:38 AM, most residents reported they were unaware of the grievance process or where to access the grievance blank forms. 2. During the initial screening of residents on 3/18/26 at approximately 8:30 AM, residents on the 100-unit hallway reported to members of the state survey team that they fear reprisal of making complaints regarding care concerns. This information was discussed with the administration team on the same date at approximately 12:00PM and the administrator stated that they would investigate. On 3/20/26 at approximately 9:00AM the Administrator reported to the survey team that they were continuing audits with residents in reference to the concern reported by the survey team and provided (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updates. During follow-up interviews with residents on the 100-hallway following the audit, resident # 55 was asked if s/he was asked about any concerns. At this time the resident told the surveyor that approximately 2 weeks ago, s/he reported during a resident council meeting that a staff member was rough while transporting him/her in a wheelchair. The resident stated that the Administrator was present during the council meeting. The resident stated that s/he also told the Administrator about this incident once again on the previous evening of 3/19/26, when he came in to speak to the resident roommate about a concern. On 3/20/26 the resident council president gave authorization for the survey team to review resident council minutes. Upon review, a resident council minutes form dated 3/10/26, on the bottom of page 3, indicated that there were no concerns for Administrator. During an interview on 3/20/26 at 12:15 PM with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the NHA was asked about resident #55 reporting during a resident council meeting earlier this month, a concern regarding a staff being rough while transporting him/her in a wheelchair. The Administrator stated that on 3/10/26, he attended a resident council meeting, and the resident did report a concern. He further stated that resident # 55 reported that staff need to be more careful during transfer. He was asked was a follow-up was done regarding the concerns the resident presented at the council meeting and he stated, no. At this time the surveyor asked the Administrator if he spoke to resident # 55 on yesterday evening (3/19/26) about the same concern that was mentioned at the resident council meeting and he confirmed, yes. He stated that when he spoke to the roommate yesterday (3/19/26) resident # 55 asked about his/her concerns that s/he spoke about at the council meeting, and that is when he remembered that he did not follow-up. The Administrator explained that when grievance is filed, the administration team follows up on all concerns, and he acknowledged that he had forgotten. He stated that he would immediately address the residents' concerns.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure psychotropic medication use was supported by a clear, appropriate, and documented clinical indication in accordance with professional standards of practice. This deficient practice was identified for 1 (#21) of 5 residents reviewed for unnecessary medications.Findings include: A review of the medical record for Resident #21 was conducted on 03/23/2026 at approximately 1:00 PM. The review revealed a physician's order dated 03/16/2026 for Seroquel (quetiapine) 75 mg by mouth at bedtime (administered as one 50 mg tablet and one 25 mg tablet). Seroquel is an antipsychotic medication commonly indicated for the treatment of conditions such as schizophrenia and bipolar disorder.Further review of the medical record revealed the documented indication for use as psychotic symptoms. This entry did not reflect a specific, diagnosed condition and did not constitute a clinically appropriate or sufficient indication to support the use of an antipsychotic medication.An interview was conducted on 03/23/2026 at approximately 2:13 PM with the Psychiatric Nurse Practitioner (Staff #10). During the interview, Staff #10 stated that the indication for use had been entered into the electronic medical record incorrectly.Following surveyor inquiry, the resident's record was updated to include a diagnosis intended to reflect an appropriate clinical indication for the medication.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, it was determined the facility staff failed to ensure alleged abuse/neglect is reported initially no later than 2 hours to the regulator agency Office of Health Care Quality (OHCQ) after the facility's staff was made aware. This was found evident in 1 (Resident #117) out of 16 residents reviewed for abuse/neglect during an annual survey. The findings include: An interview conducted on 03/25/26, at 10:55 AM with the Administrator regarding a Facility Reported Incident #2807275 involving Resident #117. According to the Administrator, Resident #117 was allegedly hit on the back by Wound Nurse Staff #38 on 03/17/26. The Administrator stated that facility staff became aware of the incident at approximately 1:00 PM that day. The matter was subsequently reported to the Office of Health Care Quality (OHCQ) on 03/17/26, at 3:16 PM.A review of the facility's Facility Report Incident file on 3/25/26 at 1:12 PM revealed several concerns regarding this incident involving Resident #117. According to the Administrator's interview statement of 3/17/26, the resident voiced pain and discomfort, noting that Staff #38 did not respond when asked why they hit the resident on the back. Furthermore, an interview with the resident's family confirmed they were present during the incident and heard the resident ask the staff, Why did you hit me? Based on these statements, Staff #38 failed to report the incident immediately, ignored this resident's direct verbal concern, and walked out of the resident's room. This was noted alongside wound documentation date and time 3/17/26 at 11:44 AM. Regarding the final interview conducted on 03/26/26, at 12:55 PM with the Administrator. Based on interview statements from Resident #117 and their family, the resident asked, Why did you hit me? This occurred following a wound assessment on 03/17/26, at 11:44 AM. Staff #38 failed to immediately report this direct verbal concern, resulting in a reporting delay. Although the Administrator claimed the facility only became aware of the incident around 1:00 PM, the initial concern was raised significantly earlier. The initial report was not submitted to the Office of Health Care Quality (OHCQ) until 3:16 PM. The Administrator was made aware that this delay exceeds the required two-hour notification window for reporting such incidents to the regulatory agency, constituting a practice deficiency.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, medical record review, and staff interview, the facility failed to ensure that a resident received the planned breakfast meal and/or was provided an alternative meal or nutritional supplement after the original meal was not consumed. This deficient practice had the potential to result in inadequate nutritional intake for 1 (Resident #21) of 1 residents reviewed for nutritional status.Findings include: On 03/18/2026 at approximately 9:00 AM, during a breakfast meal observation, Resident #21 was observed propelling herself/himself in a wheelchair in the hallway. At that time, the resident's meal tray was observed on the bedside table inside the resident's room. The resident's plate was noted to be on the floor with oatmeal and eggs spilled. The amount of food observed on the floor indicated the meal had not been consumed.Review of the medical record revealed Resident #21 was cognitively impaired and had experienced recent weight loss, placing the resident at increased risk for inadequate nutritional intake.At the time of the observation, the Director of Nursing (DON) was present in the hallway and was made aware of the situation. The DON notified housekeeping staff to address the spilled food; however, there was no evidence the resident was assessed for meal consumption or offered a replacement meal, substitute tray, or nutritional supplement.During an interview on 03/18/2026 at 11:00 AM, the Certified Dietary Manager stated that no additional breakfast tray had been requested for Resident #21.During an interview on 03/18/2026 at 11:30 AM, Staff Nurse #15 stated she was not aware that the resident required a replacement meal.There was no documented evidence that the facility ensured the resident received adequate nutrition after the observed meal was not consumed.

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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 medical record review and interview, the facility and facility pharmacy services failed to identify incorrect indications/reasons for medications being administered. This was evident for 1 (#50) of 8 residents reviewed for medications during the annual survey. The findings include: During review of Resident #50's March 2026 Medication Administration Record (MAR) on 03/19/2026 at 10:30 AM revealed that on 03/09/2026 the physician ordered Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for seizures and on 03/26/2025 the physician ordered Lamotrigine Oral Tablet 25 MG Give 4 tablet by mouth one time a day for epilepsy. Further review of Resident #50's medical records revealed that resident has no history or current medical condition / diagnosis of seizures or epilepsy. During an interview on 03/19/2026 at 12:30 PM staff #2 stated, (The resident) Does not have epilepsy or seizures and there is nothing in the medical file that states he/she ever had a history of epilepsy or seizures. Staff #2 also stated, I will let the doctor know so this can be corrected. Staff #2 was unable to explain how the facility or pharmacy verified that the correct indication/reason was used for Resident #50's medication orders.

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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 medical record review and staff interview, the facility failed to ensure the consultant pharmacist identified and reported an irregularity related to an inaccurate and incomplete medication order. This deficient practice was identified for 1 (#21) of 5 residents reviewed for pharmacy services.Findings include: A review of the medical record for Resident #21 was conducted on 03/23/2026 at approximately 1:00 PM. The review revealed a physician's order dated 03/16/2026 for Seroquel (quetiapine) 75 mg by mouth at bedtime, to be administered as one 50 mg tablet and one 25 mg tablet.Further review revealed the documented indication for use as psychotic symptoms. This entry was nonspecific, did not reflect a diagnosed clinical condition, and did not constitute an appropriate or sufficient indication for the use of an antipsychotic medication, representing an irregularity in the medication order.On 03/23/2026 at approximately 2:13 PM, the Psychiatric Nurse Practitioner (Staff #10) stated during interview that the indication had been entered incorrectly in the electronic medical record. Following surveyor inquiry, the resident's record was updated to include a diagnosis intended to support the medication's use.There was no evidence that the consultant pharmacist identified, documented, or reported this irregularity, specifically the lack of an accurate and clinically appropriate indication for an antipsychotic medication, during the medication regimen review on 3/13/26.This deficient practice demonstrates a failure of pharmacy services to ensure the identification and reporting of medication regimen irregularities in accordance with regulatory requirements.

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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 record review and staff interview, it was determined that the facility failed to ensure a resident was free from unnecessary medication. This was evident for 1 (#132) of 5 residents reviewed for unnecessary medications during the annual survey. The findings include:A review of Resident #132's medical record on 03/26/2026 at 12:45 PM revealed that on 12/18/2025 the physician ordered Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation and on 12/22/2025 the physician ordered Colace Oral Capsule 100MG (Docusate Sodium) Give 1 capsule by mouth every 12 hours for Constipation. Review of January 2026 Medication Administration Record (MAR) revealed that Resident #132 received Colace on:01/01 once on day shift twice on evening shift01/03 twice on day shift and twice on evening shift01/04 twice on day shift01/05 once on day shift and twice on evening shift 01/06 twice on evening shift 01/07 twice on day shift and twice on evening shift 01/08 twice on day shift During an interview on 03/26/2026 at 1:00 PM with staff #2, Resident #132's Medication Administration Records were reviewed with surveyor and staff #2 agreed that the Colace orders were duplicated and administered in error.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on resident medical record review and interview, it was determined that the facility failed to ensure that medications were administered as ordered. This was evident for 1 (#50) of 1 resident reviewed for significant medication errors during the annual survey. The findings include:1.During review of Resident #50's medical record on 03/23/2026 at 9:10 AM revealed that on 10/06/2025 the physician ordered Acetaminophen Oral Tablet 500 MG (Acetaminophen) give 2 tablet by mouth every 8 hours as needed for moderate pain do not give more than 3g within 24 hours. On 02/19/2026 the physician ordered Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) give 2 tablet by mouth three times a day for pain. Review of March 2026 Medication Administration Record revealed Resident #50 received the 3 times a day Acetaminophen and received as needed Acetaminophen totaling 4000 mg which exceeds 3g (3000 mg) on 03/05 and 03/17. During an interview on 03/23/2026 at 10:00 AM with staff #2, Resident #50's March 2026 Medication Administration Records were reviewed with surveyor. Staff #2 agreed that Resident #50 received over 3g of Acetaminophen on 03/05, 03/17 and would contact the doctor to have medication order corrected. 2.Review of Resident #50's medical record on 03/23/2026 at 9:20 AM revealed that on 09/11/2025 the physician ordered Oxycodone HCL Oral Tablet 5 MG (Oxycodone HCL) Give 1 tablet by mouth every 6 hours as needed for mild to moderate pain, and Oxycodone HCL Oral Tablet 7.5 MG (Oxycodone HCL) Give 7.5 mg by mouth every 6 hours as needed for severe pain rated 7 to 10. Review of March 2026 Medication Administration Records revealed on 03/18/26 Resident #50 received Oxycodone 5mg 1 tablet by mouth at 07:47 AM for pain level 5, and Oxycodone 7.5mg 1 tab by mouth at 09:37 AM for pain level 4.During an interview on 03/23/2026 at 10:05 AM with staff #2, Resident #50's March 2026 Medication Administration Records were reviewed with surveyor. Staff #2 agreed and verified that resident #50 was given an additional dose of Oxycodone 7.5 mg in error because it was before the 6-hour time frame. 3.Review of Resident #50's medical record on 03/23/2026 at 9:25 AM revealed that on 09/11/2025 the physician ordered Oxycodone HCL Oral Tablet 7.5 MG (Oxycodone HCL) Give 7.5 mg by mouth every 6 hours as needed for severe pain rated 7 to 10. Review of March 2026 Medication Administration Records revealed Resident #50 received Oxycodone 7.5mg 1 tab by mouth on 03/01, 03/02, 03/10, 03/15, 03/18 for a pain level of 4, on 03/14 for a pain level of 6 and on 03/18 for a pain level of 3.During an interview on 03/23/2026 at 10:15 AM with staff #2, Resident #50's March 2026 Medication Administration Records were reviewed with surveyor. Staff #2 agreed and verified that resident #50 was given Oxycodone HCL Oral Tablet 7.5 MG for resident pain levels that were not severe rated 7 to 10 per physician orders and was given in error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to procure, store, prepare, distribute, and serve food under sanitary conditions and in accordance with professional standards for food safety, thereby placing residents at risk for foodborne illness and contamination. This deficient practice was identified during the annual survey and had the potential to affect all residents receiving meals prepared by the dietary department.Findings include:On 3/18/26 at 9:00 AM, an initial tour of the facility kitchen was conducted in the presence of the Certified Dietary Manager. Observation of the dietary department revealed multiple breaches in sanitary food handling, storage, and environmental cleanliness, including:-Seven pre-poured syrup containers were observed stored on a visibly soiled utility table and were not labeled or dated, preventing identification and safe use.-A large plastic container of salad dressing was observed open and unlabeled in the walk-in refrigerator, failing to ensure proper food identification and protection from contamination.-Opened bread products were observed without labeling or dating, failing to ensure product integrity and safe consumption.-Multiple items in the dry storage room were observed unlabeled, indicating a systemic failure to follow safe food storage practices.-Food debris and a liquid substance were observed on the kitchen floor near the walk-in freezer, creating a risk for contamination and unsanitary conditions.-The walk-in freezer had a buildup of ice beneath storage racks where food was maintained, indicating failure to maintain equipment in a sanitary condition and increasing risk for contamination.-A red substance was observed spilled across metal shelving in the walk-in refrigerator, demonstrating failure to maintain clean and sanitary food contact and storage surfaces.-The three-compartment sink contained large pots; however, review of the 3 Compartment Sink Log (Chemical Sanitation) log revealed the last documented entry was dated 3/17/26.During an interview on 3/18/26 at 9:30 AM, the Certified Dietary Manager acknowledged the findings and confirmed the identified practices were not in accordance with facility policy or accepted food safety standards.A follow-up observation conducted on 3/23/26 at 10:44 AM revealed the previously identified concerns had been corrected; however, the deficient practices existed at the time of observation and constituted noncompliance.

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	215234	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Bethesda	5215 Cedar Lane Bethesda, MD 20814

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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 and staff interview, the facility failed to: 1. Maintain proper infection control practices to prevent the potential for cross-contamination by storing soiled linen in the same room as clean linen. This was evident in 1 (first floor) of 1 linen storage areas observed during environmental rounds and has the potential to affect all residents who rely on clean linen for care and services on the first floor.2. Maintain an infection prevention and control practice to provide a safe and sanitary environment in laundry service area. This was evident by 2 of 4 laundry service areas observed during the annual survey. Findings include:1. During observation rounds conducted on 3/18/26 at approximately 9:00 AM, a room labeled bath was observed to contain three large trash cans filled with soiled linen. In the same room, two carts containing clean linen were also stored. The co-mingling of soiled and clean linen in the same area has the potential to result in cross-contamination and does not align with accepted infection prevention and control practices. During an interview on 3/18/26, Housekeeping Staff #42 acknowledged awareness of proper infection control procedures and stated that soiled linen should not be stored in the same room as clean linen. During a separate interview, Geriatric Nursing Assistant (GNA) Staff # 43 stated they were unsure how the clean linen carts were placed in the room but indicated they would remove them. This practice is not in accordance with facility policy and accepted standards of infection control, which require the separation of clean and soiled linen to prevent the spread of infection. 2. On 3/19/26 at 3:15 PM, staff personal items were observed on the folding tables in the dryer room. Follow-up observations on 03/20/26, at 10:36 AM, while rounding with Laundry Supervisor Staff #6, revealed that personal lockers in the washer area were not being utilized. Additionally, staff personal belongings, including food and drinks, were found in two areas of the laundry service. Staff #6 agreed with these concerns and committed to redirecting staff immediately. Interview, on 3/20/26 at 1:06 PM, these findings were shared with the Assistant Director of Nursing/Infection Control Staff #8 and the Administrator as a deficiency practice concern.

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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 with facility staff it was determined the facility failed to ensure that a resident has access to a phone and a working television (TV) remote control in their room. This was found to be evident for 1 (#109) of 62 residents reviewed during the facility's annual Medicare/Medicaid survey.Findings include:Intake # 2959654 was reviewed on 3/20/26 for multiple concerns. One of the concerns was that resident # 109 did not have a phone in the room and that the television remote control was not working.An observation was made on 3/26/26 at 10:45 AM; there was one phone jack observed on the wall between Resident #109's bed and the roommate. There were two staff that came into the room upon surveyor request for dual observation. Staff #34, a Geriatric Nurse Assistant (GNA) and staff #35 a Registered Nurse (RN). Staff #35 confirmed that there was only one phone jack in the room and the only phone line is connected to Resident #109's roommate. The nurse (#35) confirmed that Resident #109 does not have a personal phone or a facility provided phone in his/her room. The surveyor asked both staff (#34, #35) how Resident #109 is able communicate with family privately, and they both stated that sometimes, Resident #109 will use the roommate's phone. The Nurse stated that she would contact maintenance regarding the phone line for Resident #109.On the same date at approximately 11:15 AM, the Administrator asked if this surveyor would accompany him to Resident #109's room. Upon entering the resident room, the Maintenance Director (MD) staff #5 was present and pointed out that there is only one phone jack in the room. The Administrator went on to explain that there are multiple rooms in the facility that have only one phone jack. He went on to explain that before acquiring the building, the rooms were considered private. He stated that the facility is currently working on resolving this. The Administrator stated that the charge nurse carries a phone that the resident can use in the interim but confirmed that the resident does not have access to a phone.Another observation was made at that time with the Administrator and the MD, of the resident TV remote control. The MD was asked if the resident remote control worked? The MD tried multiple times to get the television to come on using the remote control and it did not turn on. The MD manually turned the TV on. The Administrator instructed the MD to change the batteries in the TV remote control. The MD verbally agreed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident interviews, and staff interviews, it was determined that the facility failed to maintain a sanitary, pest-free environment to ensure residents reside in a safe and comfortable setting. This deficient practice affected 1 out 2 floors reviewed during the annual survey. Findings include: 1. During observation rounds conducted on 3/18/26 at approximately 8:00 AM, several residents reported the presence of ants in their rooms. Residents stated that the issue had previously been reported to maintenance; however, the concern remained unresolved at the time of observation. During an interview with nursing staff, it was revealed that the facility utilizes a TELS (electronic maintenance request) system in which staff input maintenance concerns, generating a work order slip for the maintenance department. There was no evidence provided that the reported pest concerns had been addressed in a timely manner. During follow-up observation rounds on 3/19/26 at approximately 11:00 AM, this surveyor observed ants present in multiple resident rooms on the 1st floor, confirming the ongoing presence of pests. Staff #13 was notified of the findings at the time of observation and stated she would address the issue. However, the continued presence of ants over multiple days indicated the facility failed to ensure prompt and effective corrective action to maintain a pest-free environment. 2. An observation was made during rounds on 3/20/26 at 11:00AM and while talking to Resident #55 in their room, there were several ants crawling on a bag that was sitting on top of the nightstand in the resident's room. The resident stated that the ants boldly march along the window sill looking for food. The Administrator was made aware of the concern on 3/25/26 at 3:00PM.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on administrative record reviews and staff interviews it was determined that the facility failed to provide evidence that part-time and PRN geriatric nursing assistants (GNA) received education on abuse prevention, neglect, and exploitation training annually. This was evident for 7 (#17, # 21, #22, #24, #30, #39, #40) of 8 GNA employee and education files reviewed during the annual survey. The findings included:On 03/25/2026 at 02:09 PM the surveyor interviewed the assistant director of nursing (ADON) and staff educator, staff #8 regarding the annual clinical training requirements of the geriatric nursing assistants (GNAs). The ADON stated that she works closely with the HR director regarding ensuring that employees are up to date with their competency training annually. The surveyor inquired whether the annual training provided was different for PRN, agency, and Full time GNA staff. The ADON responded yes. The human resources director, staff #9 also stated that part-time and PRN GNAs are not required to demonstrate compliance with annual clinical training by facility.The surveyor asked the ADON whether the requirements for compliance with the 12-hour annual clinical competency training were different for the PRN, part-time, and/or full time GNAs and the ADON responded, yes. ADON stated that the part-time and PRN GNA staff are not required to meet the annual clinical competency and /or annual Relias online training requirements. The ADON further stated that she and the HR Director use a spreadsheet to track the due dates for the competency training of the GNA staff. The ADON stated the annual hands-on clinical competency training is usually offered during the months of January through March. The 2026 competencies have not been offered yet.On 03/26/2026 at 11:30 AM the review of the human resource files and the list of PRN and part-time GNA staff revealed the facility' failure by the DON and the administrator to ensure that annual abuse, neglect, and exploitation clinical training was completed.On 03/26/2026 at 12:26 PM the surveyor discussed the findings related to deficit practice related to the facility's lack of evidence related to the required compliance with the provision of annual abuse, neglect, and exploitation training for part-time and PRN GNA staff.

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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 review of employee human resource records, education training records, spreadsheets, and interviews it was determined that the facility failed to have a system in place to ensure that PRN and part-time geriatric nursing assistants (GNAs) received at least 12 hours of clinical in-service training annually. This was found to be evident for 7 (#17, # 21, #22, #24, #30, #39, #40) of 8 part time or PRN GNAs employee files and educational files reviewed during the annual survey.Findings include:On 03/25/2026 at 02:09 PM the surveyor interviewed the assistant director of nursing ADON and staff educator, staff #8 regarding the annual clinical training requirements of the geriatric nursing assistants (GNAs). The ADON stated that she works closely with the HR director, staff #9 in regard to ensuring that GNA employees are up to date with their annual clinical competency training. The surveyor asked the ADON whether the annual training provided was different for PRN, agency, and Full time GNA staff. The ADON responded no.The surveyor asked whether the requirements for compliance with the 12-hour annual clinical competency training were different for the PRN, part-time, and/or full time GNAs and the ADON responded, yes. ADON stated that the part-time and PRN GNA staff are not required to meet the annual clinical competency and /or annual Relias online clinical training requirements. ADON further stated that she and the HR Director use a spreadsheet to track the due dates for the competency training of the full-time GNA staff.On 03/26/2026 at 08:30 AM the surveyor requested the HR files of nine PRN and part-time GNA employees. Based on the list of PRN and part-time employee list provided by the facility, seven out of eight part-time or PRN GNA staff did not have evidence of the regulatory/mandatory 12- hour annual clinical training required for geriatric nursing assistants.On 03/26/2026 at 12:11 PM the administrator brought the three policies requested: abuse, neglect, exploitation, with last review date of 09/02/2024, HR-024, Orientation, and Continuing Education. The facility did not provide a policy which included the exemption of PRN and part time GNA staff from mandatory annual clinical in-service training.On 03/26/20226 at 12:26 PM the surveyor spoke with the DON and the ADON regarding the facility's inability to demonstrate that all PRN and Part-time GNA staff are being held to the same standard of completing 12 hours of clinical education each year as the full time GNA staff. The DON and the ADON agreed that currently they are not requiring the PT and PRN GNA staff to acquire the same annual mandatory clinical education hours of training as the full-time staff. The facility administrator was made aware of the deficient practice as well.