STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215236	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	1454 Fairfield Loop Road Crownsville, MD 21032

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and facility staff interviews it was determined that the facility failed to provide a safe, clean, comfortable, homelike environment for Residents. This finding was found to be evident in 6 out of 33 Resident rooms and common areas reviewed for safe/clean/comfortable/homelike environment.The findings include: 1. On 11/17/2025 at 7:45 AM during tour of the facility the surveyor observed items in Resident rooms that were not in good repair. The following rooms were observed with items that were not in good repair: room [ROOM NUMBER] – bedside dresser marred and chipped; room [ROOM NUMBER] – baseboard behind head of bed loose and not affixed to the wall, bedside dresser with two broken drawers not affixed to the dresser tracks; room [ROOM NUMBER] – severely marred and chipped wall behind the head of the bed, closet curtain not affixed on the curtain rod; room [ROOM NUMBER] – baseboard molding marred and paint chipped; room [ROOM NUMBER] – no window blinds, hole in wall behind door knob; shower room on long-term care (LTC) unit – marred and chipped door, gap towards the bottom half of door between the door and the door frame; long-term care (LTC) unit hallway – hole in wall above the baseboard by the hallway phone. In an interview with the Maintenance Assistant at 8:10 AM on 11/21/2025 the surveyor conveyed the areas of repair needed on the long-term care (LTC) unit in the 5 Resident rooms and common areas. The Maintenance Director acknowledged the surveyor and stated that he was aware of some of these items that needed repair and had already begun fixing these needed repairs. No additional information was provided by the facility by the time of survey exit. 2. On 11/17/2025 at 10:24 AM, surveyors observed Resident #69's room and noted drywall dust on the top of the headboard and significant scrapes in the paint and drywall behind the headboard of the bed. On 11/18/2025 at 9:16 AM, surveyors showed Maintenance Assistant #9 the wall behind the bed. He (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he was not aware of the damage and he would repair it with spackle and paint. When asked how he received reports of needed repairs, he stated that the nurses either call him or write in in the book at the nurses station. The Administrator acknowledged the concern about the wall on 11/21/2025 at 7:04 AM and stated that the facility would fix the damage behind the bed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with facility staff it was determined that the facility failed to store and prepare food in accordance with professional standards. This was evident of 2 of 3 kitchen observations and 1 of 2 unit refrigerator observations during the annual survey. The findings include:On 11/17/25 at 7:41 AM, the surveyor performed an initial tour of the facility's kitchen. On 11/17/25 at 7:44 AM, the surveyor viewed the walk-in refrigerator labeled #2. During the observation the surveyor noted a takeout container not labeled or dated with what appeared to have a chili like substance it in. [NAME] #26 stated that the container should not be in there and that she would discard it. On further observation of the refrigerator there a see-through container with a piece of cake (not labeled or dated), an opened jelly jar (not dated on open), a fastfood soft drink cup (ice in the cup), brown lunch bag dated 11/17/25 with a first name on it, and an additional lunch bag with what appeared to be a personal lunch inside (no name or date). Next the surveyor observed, a container of baked bean labeled 11/9/25 with no used by date, container of ziti labeled 11/8/25 with no used by date (both well over 7 days old) and sandwiches in baggies and no label to indicate type of sandwich or date to note the date they were made. Additionally next to the shelf was a cardboard box of ground beef packages. One package within the box was opened with cellophane over the opened end. The beef had an open date of 11/14/25 with no date written to discard and appeared to have the potential for juices to leak into the box. On 11/17/25 at 7:57 AM, the surveyor observed the walk-in freezer. During this observation it was noted that a box labeled onion rings was opened and contained three different food times. None of them were labeled and none appeared to be onion rings. Next to the box was a bag of what appeared to be chicken tenders on top of another box. The bag had no label. On exiting the freezer the surveyor noted that the afternoon freezer temperature checks were missing from the 13th and 14th and both morning and afternoon temperatures were missing on the 15th and 16th. On further observation in the room exterior to the freezer it was noted that a yellow container labeled eccolab was on a storage shelf. Within the same room where the shelf was there was also a tray that contained multiple bread bags. On 11/18/25 at 8:32 AM, the surveyor reviewed the concerns with the Certified Dietary Manager (CDM). The CDM confirmed that personal food items from employee should not be stored in the kitchen refrigerator and that the items were removed. The CDM stated that the food items that were over 3-5 days were discarded. He further stated that floor cleaner should not have been left in the room with bread. On 11/21/25 at 8:57 AM, the surveyor observed that the dishwashing sanitize log was not filled out on 11/20/25 for breakfast, lunch and dinner. The surveyor reviewed the findings at the time with the CDM. He stated that it is the responsibility of the dietary aides and they must have forgotten to document their findings. On 11/21/25 at 9:08 AM, the surveyor observed the nourishment refrigerator on the Atlantic unit. Within the refrigerator it was noted that a re-used Gatorade bottle contained a milky white substance. No label was on the container to indicate what it was the bottle was dated 11/20. Next the surveyor asked the Unit Manager (UM) #6 about the unlabeled reused container. UM #6 did not know what or why the substance was in the refrigerator or who it belonged to and took the bottle out. Both the UM and the surveyor reviewed the concern with the Director of Nursing (DON).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete documentation. This was evident in 4 (Resident # 69, #10, #33 & #25) out of 33 residents reviewed during the survey. The findings included:1. During a record review on 11/18/2025 at 11:30 am, the surveyor found no physician notes were found for Resident #69 from the current admission. The Director of Nursing (DON) was asked to show the location of provider notes in the electronic medical record (EMR). She stated the surveyor was looking in the correct location, but the facility had not uploaded any physician notes from the current admission for Resident #69. The surveyor requested access to notes for Resident #69. The DON provided twenty provider notes that had been faxed to the facility that were not available in the EMR. The notes were dated from 9/4/2025 through 11/17/2025. The DON stated the notes were found in the Medical Records office and the facility had not yet uploaded to the EMR. On 11/18/2025 at 1:29 PM, the DON acknowledged the concern that the EMR does not include the provider's notes. The DON stated the nurses always read the plan and followed up when they received the notes, but acknowledged the back log was a concern and stated the facility was trying to catch up. 2. On 11/18/25 at 11:57AM, the surveyor reviewed Resident #10's medical record. The review revealed that Resident #10 had a past medical history that included, but not limited to, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, emotional deficit following cerebral infarction and cognitive communication deficient. The surveyor next reviewed Resident #10's psychiatric note written by physician #25. The most recent progress note written was dated 1/13/25. The note stated that the resident should be follow up monthly. No additional notes were located in Resident #10's electronic medical record. Also, in Resident #10's electronic medical record was a psychological services progress note written on 1/4/25. The note stated the plan was to meet weekly to work on the resident's goals. The surveyor requested all 2025 psychiatric notes for Resident #10. On 11/19/25 at 11:32 AM, the surveyor reviewed additional psychiatric notes that were provided by the facility written by Staff #25. The notes were dated, 5/1/25, 6/30/25, 9/30/25 and 11/13/25. Two of these notes stated Resident #10 should be seen monthly, however the facility was only able to provide 5 notes from Staff #25 from January 2025- November of 2025. Additionally, psychological services progress note dated, 9/13/25, 10/11/25,10/18/25, and 10/25/25 were provided. No other notes were provided even though all notes stated that Resident should be seen 1-5 times per month. On 11/19/25 at 12:33 PM, the surveyor conducted an interview with the Unit Manager (UM) #6. During the interview UM #6 stated that these were the only records she could find. She further stated that some notes were found in the backlog of medical records that needed to be scanned, and other documents were requested by reaching out to the providers. At the time of exit the surveyor relayed the concern that Resident #10's medical record was not complete. 3. On 11/18/25 at 10:04 AM, the surveyor reviewed Resident #33's medical record. The review (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed that Resident #33 had a past medical history that included, but not limited to, schizophrenia, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, obsessive-compulsive disorder, and bipolar. The surveyor next requested Resident #33's psychiatry note. There was only one note, dated 3/10/25, in Resident #33's electronic medical record. The surveyor requested all psychiatric notes from 2025. On 11/18/25 at 1:09 PM, the surveyor reviewed Resident #33's psychiatry notes provided. Physician #25 wrote a progress note on 9/10/25 and 10/01/2025. Both notes had a time stamp when the fax was sent at the top of the page. The time stamp on both notes were dated 11/18/25 at 1PM. Additionally psychological services noted dated, 9/13/25, 9/20/25, 9/27/25, 10/10/25, 10/17/25, 10/24/25 11/1/25, 11/7/25 and 11/8/25 were provided. Even though the plan documented in all of the notes to have Resident #33 seen 1-5 times per week no additional notes were provided for earlier months. On 11/19/25 at 12:33 PM, the surveyor conducted an interview with the Unit Manager (UM) #6. During the interview UM #6 stated that these were the only records she could find. She further stated that some notes were found in the backlog of medical records that needed to be scanned, and other documents were requested by reaching out to the providers. At the time of exit the surveyor relayed the concern that Resident #33's medical record was not complete. 4. On 11/18/25 at 1:09 PM, the surveyor reviewed Resident #25's medical record. The review revealed the last note written by a provider was September of 2025. The surveyor requested the last provider note for Resident #25. On 11/18/25 at 1:45 PM, the surveyor was provided with additional provider notes for Resident #25. The surveyor asked the Director of Nursing (DON) where the notes were located. The DON stated that the Assistant Director of Nursing (ADON) was able to obtain the physician progress notes but was not sure where she got them. On 11/18/25 at 2:11 PM the surveyor interviewed ADON. The ADON stated that she obtained the notes from medical records from the provider visits from 9/18/25 and 10/14/25. She stated that the documents were faxed over on 9/18/25 and 10/17/25 from the visit respectively. She further stated that both notes had not been scanned and placed into the resident's electronic medical record yet. On 11/19/25 at 8:14 AM, the surveyor reviewed the concern that Resident #25's medical records were not complete.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on medical record review and interviews, it was determined that the facility failed to involve and inform a resident on treatment changes. This was found evident in 1 (Resident #39) out of 33 residents reviewed during the survey. The findings include: On 11/17/25 at 9:58 AM, the surveyor interviewed Resident #39. During the interview Resident #39 stated that he/she had requested the ointment that was prescribed to him/her and was told by the staff he/she could no longer have it. On 11/21/25 at 7:48 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked why Resident #39 could no longer have his/her ointment and if this was the situation why the resident was not informed on the decision to discontinue the ointment. The DON stated she would look into the matter. On 11/21/25 at 11:18 AM, the surveyor conducted a follow-up interview with the DON. The DON stated that Resident #39 went out to the hospital and when he/she returned were evaluated to not need the ointment. The surveyor asked if Resident #39 was involved and aware of the plan to discontinue the ointment. The DON stated she was not sure. On 11/21/25 at 11:38 AM, both the surveyor and DON interviewed Resident #39. During the interview the resident confirmed that he/she was not informed of the decision to discontinue the ointment and stated that he/she had used the ointment his/her whole life and did not understand why it was discontinued. The DON stated she would reach out to the provider to discuss reordering the ointment. Following the interview the surveyor discussed the concerns that the Resident was not involved or informed on regimen changes.

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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 interviews, it was determined that the facility failed to attempt a gradual dose reduction or have documented contraindication rationale for a resident receiving a psychotropic medication. This was found evident in 2 (Resident #10 & #33) out of 5 residents reviewed for unnecessary medications. The findings include: Psychotropic medications are used to treat mental health disorders and are considered any drug that affects behavior, mood, thoughts, or perception. There are five main types of psychotropic medications, and each type has its own specific uses, benefits, and side effects. The five main types are: antidepressants, anti-anxiety, stimulants, antipsychotics and mood stabilizers. Quetiapine (also known as Seroquel) - an atypical antipsychotic medication used to treat mental health conditions like schizophrenia, bipolar disorder, and major depressive disorder. Gradual Dose Reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. 1. On 11/18/25 at 11:57AM, the surveyor reviewed Resident #10's medical record. The review revealed that Resident #10 had a past medical history that included, but not limited to, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, emotional deficit following cerebral infarction and cognitive communication deficient. On further review it was noted that Resident #10 was prescribed Seroquel. The surveyor next reviewed Resident #10's psychiatric note written by physician #25. The note was dated 1/13/25 and documented Staff #25 recommendation Resident #10 start Seroquel for mood and agitation. It further stated that the resident should be followed up monthly. No additional psychiatric notes were located in Resident #10's electronic medical record. The surveyor requested all 2025 psychiatry notes for Resident #10. On 11/19/25 at 11:32 AM, the surveyor reviewed additional psychiatric notes provided by the facility from Staff #25. A note written on 5/1/25 that stated that no Gradual Dose Reduction (GDR) was recommended, however there was no rationale as to why. On 6/30/25 Staff #25 wrote, continue on Seroquel for mood and agitation. On 9/30/25 Staff #25 wrote, no need for gradual dose reduction, stable on current regiment, followed by, Resident #10 needs reassurance to take medications. The note did not give the rationale as to why Resident #10 was clinical contraindication for a GDR. On 11/13/25 Staff #25 wrote, Resident # 10 was being followed monthly for cognitive impairment, depressed mood, and generalized anxiety and appeared to be doing well on current medication. The plan was documented to continue current medication and psychotherapy. Next the surveyor reviewed the Minimum Data Set (MDS) assessment for Resident # 10 with the Assessment Reference Date of 10/31/25. In section N it is documented that Resident #10 regularly takes an antipsychotic. In this section it is also documented that no GDR was attempted. If further is documented there was no documentation that the GDR was clinically contraindicated. On 11/20/25 at 7:45 AM, the surveyor reviewed the concerns with the Director of Nursing (DON). At the time of exit no additional documents were provided. 2. On 11/18/25 at 10:04 AM, the surveyor reviewed Resident #33's medical record. The review revealed that Resident #33 had a past medical history that included, but not limited to, schizophrenia, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, obsessive compulsive disorder, and bipolar. On further review it was noted that Resident #33 was prescribed Mirtazapine (antidepressant) and Risperdal (antipsychotic). The surveyor next requested Resident 33's psychiatric notes. Only one note dated 3/10/25 was in Resident #33's electronic medical record. On 11/18/25 at 1:09 PM, the surveyor reviewed Resident #33's psychiatry notes provided. Physician #25 wrote a progress note on 3/10/25 that stated no changes in mediations. On 9/10/25 Staff #25 wrote, .wanting to have his/her medications discontinued, said that it's excessive. Staff #25 continued and documented Resident #33 was on minimal medications. No changes in mediations. On 9/10/25 Staff #25 wrote that the patient maintained that he/she had been sleeping excessively and wanted the medications reduced. Staff #25 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that he informed Resident #33 that he/she was on the bare minimum amount of medication and GDR failed recently. The plan stated no need for GDR. On 10/01/2025 Staff #25 wrote Resident #33 appeared stable. He further stated that any further reduction will lead to change of symptoms and psychosis as it has in the past. Next the surveyor reviewed the Minimum Data Set (MDS) assessment for Resident # 33 dated 9/4/25. In section N it is documented that Resident #33 regularly takes an antipsychotic. In this section it is also documented that no GDR was attempted. Below it documented that the date the physician documented it was clinically contraindicated 3/10/2025, however there was no documentation to when the last GDR was attempted and failed. The surveyor requested documentation to demonstrate that Resident #33 had a gradual dose reduction attempt to support the documentation.At the time of exit no additional documentation was provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record reviews, it was determined that the facility failed to accurately document Minimum Data Set (MDS) assessments on Residents. This finding was found to be evident in 3 (Resident #4, #3 & # 33) out of 33 Residents reviewed for accuracy of MDS assessments.The findings include: 1. Fall mats are a safety cushion placed on the floor, typically next to a bed or in other high-risk areas, to reduce the risk of injury from a fall. They are made of high-density, shock-absorbing foam with non-slip backing and beveled edges to minimize tripping hazards and allow wheelchairs to roll over smoothly. These mats are used in hospitals, nursing homes, and homes to protect people at risk of falling, such as the elderly or those with cognitive impairments. On the initial tour of the facility on 11/17/2025 at 7:45 AM, the surveyor observed fall mats on the floor on each side of the bed in Resident #4's room. At 10:44 AM on 11/17/2025 Resident #4 stated to the surveyor that I have had 2 falls in the past, but it has been a while since I have fallen. The Minimum Data Set (MDS) assessment is a standardized assessment tool used to evaluate the health and functional capabilities of nursing home Residents. It is a federally mandated process for all Medicare and Medicaid certified nursing homes. MDS assessments are performed by trained clinicians at admission, discharge, and other intervals, such as quarterly or annually. The MDS gathers information on physical, psychological and psychosocial functioning, comorbidities, medical diagnoses, treatments, medications, and therapies. It also covers aging-related areas like cognitive status, geriatric syndromes, and life care wishes. MDS assessments help nursing home staff identify health issues and provide a valuable resource for studying disability and function in older adults. The Centers for Medicare and Medicaid Services (CMS) collect and make MDS data available. The surveyor conducted a record review of Resident #4's medical record on 11/19/12025 at 10:15 AM. Review of the medical record revealed that Resident #4 had a fracture of the right tibia and fibula (2 bones of the lower leg) on 7/6/2025. Further review of the medical record for Resident #4 revealed that the Discharge Minimum Data Set (MDS) assessment dated [DATE] Section J – Health Conditions – J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment was coded 1 No injury. Additionally, Section I – Active Diagnoses – I8000. Additional active diagnoses did not list fractures of the right tibia and fibula. The Director of Nursing (DON) was notified on 11/19/2025 at 10:25 AM of the inaccurate coding on the MDS for Resident #4, reviewed the MDS and acknowledged the surveyor. In an interview with the LPN MDS Coordinator at 10:55 AM on 11/19/2025 the surveyor conveyed that Resident #4's Discharge MDS dated [DATE] was coded 1 No injury Section J1900. Number of Falls. Additionally, the surveyor conveyed that Section I8000. Additional active diagnoses did not list the fractures of the right tibia and fibula. The LPN MDS Coordinator reviewed Resident #4's Discharge MDS dated [DATE], acknowledged the surveyor, and stated that the diagnoses were an oversight and the fall should have been coded as Major injury because Resident had a fall in the facility with an x-ray report of acute right tibia and fibula fractures. The LPN MDS Coordinator stated that she would make the correction to the Discharge MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN MDS Coordinator on 11/19/2025 completed a correction to Resident #4's Discharge MDS dated [DATE] which now was coded 1 Major injury under Section J1900. Number of Falls, and a copy was provided to the surveyor by the Director of Nursing (DON) at 3:40 PM on 11/19/2025. 2. On the initial tour of the facility on 11/17/2025 at 7:45 AM, the surveyor observed fall mats on the floor on each side of the bed in Resident #3's room. At 3:00 PM on 11/19/2025 the surveyor conducted a record review of Resident #3's medical record. Review of the medical record revealed that Resident #3 had documentation of falls on 5/29/2025 and 6/8/2025. Further review of the medical record for Resident #3 revealed that the Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section J – Health Conditions – J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment was coded 1 No injury. The Director of Nursing (DON) was notified of the inaccurate coding on the MDS for Resident #3 on 11/19/2025 at 3:45 PM, reviewed the MDS and acknowledged the surveyor. In an interview with the LPN MDS Coordinator on 11/21/2025 at 11:30 AM the surveyor conveyed that Resident #3 had falls on 5/29/2025 and 6/8/2025 and that the Quarterly MDS dated [DATE] Section J1900. Number of Falls was coded 1 No injury. The LPN MDS Coordinator reviewed Resident #3's falls and the Quarterly MDS dated [DATE], acknowledged the surveyor, and stated that the Quarterly MDS dated [DATE] was coded inaccurately as Resident #3 had falls on 5/29/2025 and 6/8/2025 and the Quarterly MDS dated [DATE] should have been coded 2 No injury. In a follow-up interview with the LPN MDS Coordinator at 11:50 AM on 11/21/2025, she stated to the surveyor that she was conducting a facility audit for falls and in the process of making modifications and corrections to the Resident MDS assessments as indicated. No additional information was provided by the facility at the time of survey exit. 3. On 11/18/25 at 10:04 AM, the surveyor reviewed Resident #33's medical record. The review revealed that Resident #33 had a past medical history that included, but not limited to, schizophrenia, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, obsessive-compulsive disorder, and bipolar. On further review the surveyor noted that the Minimum Data Set (MDS) assessment dated [DATE] did not include any psychiatric/mood disorders in section I (Active Diagnoses). On 11/18/25 12:51 PM, the surveyor conducted an interview with the MDS coordinator Staff #13. During the interview the surveyor showed the schizophrenia diagnoses located in Resident #33's medical record and asked if schizophrenia should have been coded in the active diagnosis section. Staff #13 stated that Resident #33 should have been coded and that the diagnosis was missed in error.

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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 interviews, and record review, it was determined that the facility failed to review and revise a Resident's care plan after a Resident's situation changed. This was found evident of 1 (Resident #10) out of 2 Residents reviewed for care planning during the survey.The findings include:On 11/18/25 at 11:57AM, the surveyor reviewed Resident #10's medical record. The review revealed that Resident #10 had a care plan that stated, Resident #10 has an Activities of Daily Living (ADL) self-care performance deficit related to muscle weakness, left sided weakness from a Cerebral Vascular Accident (CVA). It further stated that Resident #10 had left upper extremity contracture and required a left upper extremity splint. The care plan was initiated on 10/2/23 and last updated 10/30/25.On 11/19/25 at 1:39 PM, the surveyor interviewed the Director of Rehabilitation Staff #16. During the interview Staff #16 stated that Resident #10 refused Occupational Therapy (OT) services and the last time it was offered. Staff #16 confirmed that last time Resident #10 was seen by OT was in January of 2023. Staff #16 provided the OT discharge notes from January of 2023. The recommendations were to perform passive range of motion to left digits/writ prior to splint application. It further instructed that Resident #10 should wear resting hand splint up to 2 hours/daily and to monitor for redness/irritation. The surveyor next reviewed Resident #10's orders. An order was placed on 12/15/23 that stated, left hand splint to be worn for 6-8 hours and as tolerated for contracture management. Monitor for skin breakdown.On 11/21/25 at 12:30 PM, the surveyor interviewed Resident #10. During the interview resident #10 stated that he/she had the left hand splint in the room but had not worn it for the last year or two. Resident #10 stated the splint was too ridged and not comfortable.Following the interview with Resident #10 the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concerns that Resident's 10's care plan for the left upper extremity splint was not reflective of the actual recommendations or refusal by the Resident.

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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 surveyor observation, facility staff interview, and surveyor record review it was determined that the facility failed to follow appropriate respiratory care and services. This finding was found to be evident in 1 (Resident #42) out of 1 Resident reviewed for respiratory care and services.The findings include:On tour of the long-term care (LTC) unit on 11/17/2025 at 7:45 AM the surveyor observed Resident #42 in bed with an oxygen concentrator and an oxygen emergency tank in the room. Additionally, it was observed that the oxygen humidifier bottle was dated 9/16. There was no oxygen signage posted on Resident #42's room door upon entry to the room. Resident #42 stated that he/she had not used oxygen in a while.In an interview at 8:22 AM on 11/17/2025 with the RN Unit Manager, the surveyor conveyed that Resident #42 had an oxygen concentrator and an oxygen emergency tank in the room, however there was no oxygen signage on Resident #42's room door. The RN Unit Manager observed with the surveyor the oxygen concentrator, the oxygen emergency tank, the oxygen humidifier bottle, and no oxygen signage on the door and stated that Resident #42 had a PRN (as needed) order for oxygen usage. The surveyor asked the RN Unit Manager what the expectation was for the posting of oxygen signage on Resident room doors, and the RN Unit Manager stated that the oxygen sign should be posted on Resident room doors when oxygen was in Resident rooms.The surveyor conducted a record review of Resident #42's medical record at 11:50 AM on 11/20/2025. Review of the medical record revealed that Resident #42 had a current physician order dated 10/27/2025 for oxygen via nasal cannula at 2 liters/minute as needed for shortness of breath.No additional information was provided by the facility at the time of survey exit.

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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 observations and staff interviews, it was determined that the facility failed to adhere to professional standards of practice for medication disposition. This was found to be evident in 1 out of 2 carts reviewed for medicine storage.The findings include:On 11/20/2025 at 9:28 AM, during surveyor review of a medication storage cart with LPN #11 and found the following expired medications: gabapentin 100 mg, glimepiride 2 mg, carvedilol 6.25 mg, pantoprazole 40 mg, dexamethasone 2 mg and trazodone 100 mg. The expired medications were in blister packs, lodged between the locked medication box and a drawer divider. The surveyor also found expired therapeutic nutritional supplements, Suplena and Boost, on the cart. The Director of Nursing removed the expired medications and supplements from the cart on 11/20/2025 at 9:30 AM. She stated the pharmacy recently completed a review of the carts and stated the facility would need to perform further review.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interviews, it was determined that the facility failed to ensure that a resident was served a meal according to a predetermined menu. This was evident for 1 (#10) 2 residents reviewed for food during the survey.The findings include:On 11/21/25 at 12:30 PM, the surveyor reviewed the lunch that was provided to Resident #10 along with the meal ticket. The surveyor noted there was no nectar thickened tomato juice nor pureed fresh baked roll, which were both listed on the meal ticket. The surveyor asked Resident #10 if these items had come on the lunch tray. Resident #10 stated that they didn't and that if they were available, he/she would like these items.Next the Surveyor reviewed the scheduled lunch menu. The regular menu was breaded Fried fish, stewed tomatoes, fresh baked roll, cream pie and macaroni & cheese cup.On 11/21/25 at 12:37 PM, the surveyor interviewed the Certified Dietary Manager (CDM). During the interview the CDM confirmed that he did not have nectar thick tomato juice available. He further stated that the kitchen does not puree rolls. The surveyor reviewed the concern that the resident was not provided with the meal that was preplanned, and he/she desired.

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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 interview, it was determined that the facility failed to perform hand hygiene between resident encounters. This was evident for 1 (Resident #72) out of 6 medication passes observed during the recertification survey.The findings include:During a med pass on 11/20/2025 at 8:32AM, the surveyor observed LPN #19 exit Resident #72's room and begin preparing medications for another resident without performing hand hygiene. When asked the facility policy for performing hand hygiene between residents LPN #19 stated, I am supposed to perform hand hygiene after each resident encounter. A bottle of hand sanitizer sat on the medication cart. The Director of Nursing acknowledged the concern of the missed opportunity for hand hygiene during an interview on 11/20/2025 at 9:30 AM.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, staff interviews and record reviews, it was determined that the facility failed to ensure that a Resident's environment was free from accident hazards related to the compatibility of a Resident's mattress and bed frame. This finding was found to be evident in 1 (Resident #12) out of 1 Resident reviewed for accident hazards and Resident beds.The findings include:On the initial tour of the nursing facility on 11/17/2025 at 7:45 AM the surveyor observed Resident #12 in bed in the Resident room in no distress. The surveyor observed that Resident #12 had a gap between the end of the mattress and the footboard of the bed frame. Additionally, the surveyor observed that there was a long blue pillow in the gap between the end of the mattress and the footboard of the bed.In an interview with the Director of Nursing (DON) on 11/17/2025 at 1:09 PM the surveyor conveyed that Resident #12 had a pillow between the end of the mattress and the footboard of Resident's bed and that this was a concern for Resident's safety. The DON acknowledged the surveyor and Resident #12's bed, mattress and the pillow were observed by the DON. Review of Resident #12's medical record on 11/18/2025 at 9:22 AM revealed that Resident was at risk for falls and had recent falls. Additionally, Resident's weight was 137 lbs. and height was 70 (5 feet 8 inches).On 11/18/2025 at 1:30 PM the surveyor observed a plastic foam cushion that was between the end of the mattress and the footboard for Resident #12's bed. The cushion filled the gap between the footboard and the end of the mattress, but the cushion was not secure and did not stay in place on the bed frame. The surveyor interviewed the Maintenance Assistant at 8:20 AM on 11/21/2025 and conveyed that Resident #12 had a mattress on the bed that did not fit the bed frame properly and the cushion was not secure and did not stay in place between the mattress and the footboard. The Maintenance Assistant observed Resident #12's bed and the cushion that was between the end of the mattress and the footboard of the bed. The Maintenance Assistance acknowledged the surveyor and stated that he was told by Nursing to change the bed for Resident #12. At 11:15 AM on 11/21/2025 the surveyor observed that Resident #12 had a new bed. The mattress and the bed frame were observed as compatible, and the mattress fit the bed frame properly. There was no cushion and no gap between the foot board and the end of the mattress.No additional information was provided by the facility by the time of survey exit.

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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 the facility failed to 1) ensure that the resident's call system was functioning properly and 2) failed to have a call light device accessible for a Resident to call for staff assistance. This was found to be evident for 1 (Resident #25) for call light function and 1 (Resident #42) out of 8 Residents reviewed for Resident call system accessibility. The findings include:1) On 11/17/25 at 10:24 AM, the surveyor asked Resident #25 to push his/her call button. On 11/17/25 at 10:25 AM, the surveyor observed Unit Manger #6 walk into Resident #25's room. On 11/17/25 at 10:25 AM, the surveyor asked UM #6 if Resident #25's call button was on. UM #6 stated that she had heard the call light on at the nurse's station but was not sure who's call light it was. She stated that no light was on in the hallway above Resident #25's room. The surveyor asked UM #6 to push the call button to see if the light would come on. UM #6 then pushed the call button. Again, no light came on in the hallway above Resident 25's room. Resident #25 stated that the call light doesn't work. On 11/1725 at 10:30 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) in the nurses' station. Both staff were at the call light monitor, which had a black screen display. The DON stated that the call light monitor would normally give the location of a call light request, however the system was being rebooted. The surveyor reviewed the concern that the call light was not lit up above Resident #25 hallway door and that the staff were unaware of which Resident was requesting help. 2) On tour of the long-term care (LTC) unit on 11/17/2025 at 7:45 AM the surveyor observed Resident #42 in bed in his/her room. Resident #42 was alert and oriented, in no distress. The call light device was observed lying on the floor next to Resident #42's bed. Resident #42 was unable to call for staff assistance because the call light device was on the floor next to Resident's bed, and Resident #42 was unable to reach the call light device. In an interview at 8:22 AM on 11/17/2025 with the RN Unit Manager, the surveyor conveyed that Resident #42 was unable to reach the call light device as the device was lying on the floor next to Resident's bed. The RN Unit Manager observed with the surveyor Resident #42's call light device lying on the floor in Resident's room next to the bed and acknowledged the surveyor. The surveyor asked the RN Unit Manager what the expectation was for Resident accessibility of call light devices, and the RN Unit Manager stated that the call light devices should be in reach for Residents to call for staff assistance. No additional information was provided by the facility at the time of survey exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interviews and record reviews it was determined that the facility failed to provide a safe, functional, sanitary and comfortable environment for a Resident and staff. This finding was found to be evident for 2 (Resident #24 & #33) out of 33 Residents reviewed for a safe, functional, sanitary and comfortable environment and in the laundry and parking lot area. The findings include: 1. The surveyor conducted an initial tour of the facility on 11/17/2025 at 7:45 AM. The surveyor observed Resident #24's room. The toilet in Resident #24's bathroom was observed as inoperable, specifically the toilet was not attached to the sewer hole/line, and the toilet was resting next to the sewer hole/line with a cloth stuck in the hole in the floor. Resident #24 was sitting in a wheelchair in the room and stated that the toilet had been broken since last week and maintenance was working on it. In an interview with the Director of Nursing (DON) and the RN Unit Manager at 9:45 AM on 11/17/2025 the surveyor conveyed that Resident #24 had a toilet in the bathroom that was inoperable. They acknowledged the surveyor and stated that maintenance was aware and were working on fixing the toilet. In an interview with the Licensed Nursing Home Administrator (LNHA) on 11/19/2025 at 7:15 AM the surveyor conveyed that the inoperable toilet was a concern as the bathroom toilet did not provide a safe, functional and sanitary environment for the Resident and staff that provided assistance to Resident #24. The nursing staff did not have an operable toilet in Resident room to dispose of urine and solid waste. The LNHA acknowledged the surveyor and stated that the Resident was incontinent, and that the toilet had been out of operation since last Wednesday (11/12/2025). The LNHA stated that the toilet was leaking from the base, and maintenance was unable to remove the pipe. The LNHA further stated that 2 outside vendors were contacted regarding the inoperable toilet and repair of the pipe. Additionally, the LNHA stated that Resident #24 was offered but refused to be transferred to another room temporarily. The surveyor conducted a review of Resident #24's medical record on 11/19/2025 at 8:30 AM. Review of the medical record revealed that Resident #24 was continent of bladder and bowel but experienced occasional bladder and bowel incontinence. Additionally, Resident #24 used a urinal at bedside. The LNHA on 11/19/2025 at 12:15 PM provided the surveyor with a timeline of the repair of Resident #24's toilet. The pipe was repaired, and the toilet was replaced, and the toilet was operable status as of 11/20/2025. 2. On 11/17/25 at 11:41 AM, the surveyor conducted an interview with Resident # #33 in his/ her room. During the interview the surveyor observed an electrical outlet in the wall that did not have an outlet cover it. On closer observation a silver object was noted in the lower right prong of the outlet. On 11/21/25 9:03 AM, the surveyor conducted an interview with maintenance assistant #9. During the interview Staff #9 stated he was not sure why the outlet was like that and would fix the concern. 3. During an observation of the laundry area on 11/18/2025 at 11:31 AM with the Director of Housekeeping, the surveyor identified a concern for bulging, stained ceiling tile over a washing (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine as well as other stained and broken tiles in the surrounding area. The Director of Housekeeping stated the roof used to leak. The Maintenance Assistant stated the tile was dry but damaged from an old leak and he would fix it right away. On 11/18/2025 at 11:45 AM, the Nursing Home Administrator (NHA) was shown the ceiling tile concern. The Administrator stated it would be fixed and acknowledged that it was a concern. 4. On 11/21/2025 at 12:40 PM, the surveyors observed a large pothole in the parking lot measuring 70 inches long, 38 inches wide, and 2 inches deep. The NHA acknowledged the concern on 11/21/2025 at 1:16 PM, and stated he would look into having it repaired.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations and facility staff interviews, it was determined that the facility failed to ensure all corridors had firmly installed handrails on each side.The findings include:On 11/20/25 at 11:29 AM, the surveyor observed a resident in a wheelchair grasping with both hands the hall handrail adjacent to the kitchen hallway. Next the surveyor observed Human Resource Director Staff #17 assist the Resident off the handrail and wheeled him/her to the requested destination. The surveyor observed that there were no hallway handrails in the hallway of the front entrance nor back past the dining area towards the Atlantic units. The resident was observed between these two areas.On 11/21/25 at 7:20 AM, the surveyor reviewed the observations with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA agreed that there were no handrails in the front lobby or hallway leading to the dining room areas and agreed that residents use these areas.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, staff interviews and record review it was determined that the facility failed to display the current posted nurse staffing information in a timely manner. This finding was found to be evident in review of sufficient and competent nurse staffing.The findings include:Nursing facilities are required to post daily nurse staffing information, including the facility name, current date, Resident census, and the total number and actual hours worked per shift for licensed and unlicensed nursing staff responsible for Resident care. This includes Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nurse Aides (CNA), Geriatric Nurse Aides (GNA) and Certified Medication Aides (CMA). The information should be easily accessible and clearly displayed for Residents and visitors. Facilities should also retain nurse staffing data for review by the surveyors for a minimum of 18 months.On the initial tour of the facility when the survey team entered the facility at 7:00 AM on 11/17/2025 it was observed that the posted nurse staffing information sheet was not the current date. The date was 11/14/2025 on the daily staff posting sheet that was displayed on the receptionist desk in the facility lobby.The surveyor interviewed the Director of Nursing (DON) at 12:45 PM on 11/20/22025 and asked what the expectation was for posted nurse staffing information. The DON stated that it was the responsibility of the Nursing Supervisor to post the nurse staffing sheet daily, including the weekend. The DON was made aware that when the surveyors entered the facility at 7:00 AM on Monday 11/17/2025, the posted nurse staffing information sheet was dated 11/14/2025 which was displayed on the receptionist desk in the facility lobby. The DON acknowledged the surveyor and stated that the current nurse staffing sheet should have been posted by the Nursing Supervisor. No additional information was provided by the facility at the time of survey exit.