

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Nursing Home Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 East Belvedere Avenue Baltimore, MD 21239	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interviews with facility staff, it was determined that the facility failed to ensure that residents' personal hygiene needs were adequately met, timely assistance was provided for incontinence care, and assistance with meals was provided. This was evident for 5 (Resident #5, #9, #49, #39, and #1) of 7 residents reviewed for Activities of Daily Living (ADLs) during the recertification/complaint survey. The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, toileting, and mobility. 1) On 04/27/2026 at 8:25 AM, during an observation of Resident #5, brown substances were noted present under the fingernails of the right hand. Resident #5 stated a need for the nails to be cleaned and trimmed. On 04/27/2026 at 11:41 AM, Staff #6 (Unit Manager Registered Nurse RN) verified Resident #5 had a brown substance under the fingernails of the right hand and stated she would inform the other Unit Manager. On 04/28/2026 at approximately 2:00 PM, a review of Resident #5's care plan titled ADL self-care performance deficit related to stroke as evidenced by requiring total assistance from nursing staff for ADL care was originally created on 06/26/2018 and last revised on 04/07/2025. 2) On 04/27/2026 at 9:32 AM, an observation revealed that the fingernails on Resident #9's right hand were soiled with a dark brown/black substance. On 04/27/2026 at 11:39 AM, Staff #6 (Unit Manager Registered Nurse) verified Resident #9's nails with dark brown/black substances and stated she would have staff soak his/her nails later. On 04/28/2026 at approx. 2:30 PM, a review of Resident #9's care plan noted a self-care deficit (impaired balance, inability to complete daily tasks independently) related to CVA and generalized weakness. Created: 01/10/2022. Revised: 05/29/2024. 3) On 04/27/2026 at 11:17 AM, during an observation of Resident #49, noted fingernails were noted to be long and untrimmed. On 04/27/2026 at 11:34 AM, during an interview, Staff #6 (Unit Manager Registered Nurse) shared that residents' care of fingernails is completed as needed, and on shower days, the facility does clip and file residents' nails. Staff #6 verified Resident #49's nails were long and needed to be trimmed. On 04/27/2026 at approximately 11:40 AM, in review of Resident #49's care plan for Activity of Daily Living (ADL), Resident #49's noted self-care performance deficit related to activity intolerance, impaired balance, and cognitive impairment as evidenced by his dependency on staff for all needs. Created on: 08/14/2020 Revision on 07/14/2025. On 04/29/2026 at 10:56 AM, during an interview, the Assistant Director of Nursing (ADON) stated that Activities of Daily Living (ADL) care included nail care and that staff are expected to trim and clean long fingernails or those with brown/black substances underneath. This concern regarding nail care was shared with the ADON at that time. 4) On 04/27/2026 at 9:20 AM, during an observation, an odor was noted in the hallway near Resident #39's room. A brown substance was observed on Resident #39's bed, wheelchair, and call light. Unknown staff members continued to walk past the room. On 04/27/2026 at 10:06 AM, during a second observation, the brown substance remained present on Resident #39's bed, wheelchair, and (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215241	If continuation sheet Page 1 of 21

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light. On 04/27/2026 at 10:07 AM, during an interview with Staff #4, Licensed Practical Nurse (LPN) confirmed that she informed the assigned Geriatric Nursing Assistant (GNA) that it smelled down there, after which the GNA went on break. Staff #4, LPN, then knocked on Resident #39's bathroom door and asked if the resident was okay. The LPN stated Resident #39 requested assistance with a brief and clothing change. However, Staff #4's assistance was provided about 47 minutes after Resident #39's incontinent episode and only following the surveyor's intervention in notifying Staff #4. On 04/27/2026 at 2:48 PM, a review of Resident #39's care plan of self-care deficit related to dementia and glaucoma (impaired vision, difficulty walking). The initial plan, dated November 29, 2022, and revised on November 30, 2022, specifies that one staff member is required to assist the resident with dressing (per the 11/29/2022 plan), as well as toileting and transfers (both revised on 10/02/2024). On 04/29/2026 at 10:56 AM, during an interview, the Assistant Director of Nursing (ADON) discussed ADL care. The ADON stated that if a nurse reported an odor of incontinence, indicating a resident might need assistance, they would expect a staff member to assist the resident. The ADON also noted that she has observed that Resident #39 has now started to require more assistance. At this time the concern was shared with ADON.5) On 04/30/2026 at 8:37 AM, during an observation of Resident #1 lying in bed with a breakfast tray in front of him/her, there was no staff present. On 04/29/2026 at 3:00 pm, review of Resident #1's care plan, created 03/30/2025 and revised 01/13/2026, indicated imbalanced nutrition related to diabetes, hypertension, hyperlipidemia, and recent weight loss. An intervention for 1:1 meal assistance was created/revised on 11/25/2025. On 04/30/2026 at 8:46 AM, Staff #20 (Regional Clinical Nurse) was interviewed. She stated a speech therapist determines if feeding assistance is needed, which would then be documented in a care plan and noted on the Kardex and assignment sheet. She clarified that 1:1 meal assistance requires a staff member to be present and are to assist with the meal. She confirmed no staff was assisting Resident #1 with the required 1:1 meal assistance. The concern was shared at this time. On 05/01/2026 at approximately 1:30 PM, the concerns were shared with the Administrator and Regional Clinical Services Manager.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, it was determined that the facility failed to provide necessary respiratory care that consistent with professional standards of practice. This was evident for 4 Residents (Resident #7, #49, #88 and #89) of 4 residents reviewed for respiratory care during the recertification survey. The findings include: A nebulizer mask is a medical device used to deliver medication directly into the lungs in the form of a fine mist. A nasal cannula is a lightweight, flexible plastic tube with two small prongs placed just inside the nostrils to deliver supplemental oxygen. 1) On 4/27/2026 at 8:31 AM, the surveyor observed a nebulizer mask resting on top of Resident #88's soiled breakfast tray, creating a potential for contamination of respiratory equipment. An unused portable oxygen cylinder was also observed beside the nightstand. Registered Nurse (RN) #10 was immediately notified. On 4/29/2026 at 7:27 AM, a review of Resident #88's medical record revealed: -No physician order oxygen for therapy; and -An active order for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 milliliters (ml) inhale orally every 6 hours for shortness of breath for 7 days, with an end date of 5/1/26. (liquid medications used to relax and open airways to improve breathing). On 4/29/2026 at 9:40 AM, the portable oxygen cylinder remained in Resident #88's room. RN #14, confirmed that Resident #88 was not receiving oxygen therapy and was unsure why the oxygen tank was stored in the room. On 4/29/2026 at 11:00 AM, the Assistant Director of Nursing (ADON) confirmed there was no oxygen order and stated oxygen tanks should be stored in the designated oxygen storage area when not in use. On 5/01/2026 at 10:19 AM, review of the facility policies confirmed: -Medical gas safety and storage requires equipment to be returned to its proper storage location when not in use; and-Handheld nebulizer equipment is to be stored in a clean plastic bag and maintained ready for use. 2) On 4/27/2026 at 9:03 AM, the surveyor observed Resident #89's oxygen tubing and humidifier bottle were not labeled, increasing the risk for improper use and infection control concerns. RN #10 was notified at that time. On 4/28/2026 at 11:36 AM, medical record review revealed active physician orders to: -Change the humidifier bottle every night shift on Mondays; and-Change oxygen tubing weekly on (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	night shift on Mondays. On 4/29/2026 at 8:57 AM, Licensed Practical Nurse (LPN) #24 stated that staff are expected to change and label oxygen tubing weekly and replace the humidifier bottle as ordered. LPN #24 further stated that respiratory equipment should be stored in a clean clear bag when not in use. On 4/29/2026 at 9:20 AM, Resident #89's nasal cannula was observed hanging uncovered on the side of the bed, exposing the equipment to environmental contamination. RN #14 was notified. On 4/29/2026 at 11:06 AM, the ADON was notified of the above concerns. 3) On 04/27/2026 at 09:54 AM, during the initial tour of Resident #7's room the surveyor observed resident on oxygen via a nasal cannula, upon closer inspection it showed that the resident was on 1.5 liters of oxygen. On 04/27/2026 at 09:56 AM, in an interview with Registered Nurse (RN) #14, she was asked how many liters of oxygen the resident was ordered and she reported 2 liters after confirming with the resident's medical record. The surveyor asked her to take a look at the resident's current oxygen administration, and she confirmed that the resident was on 1.5 liters. She reported that she would increase the dose as ordered. The nurse was notified that the mentioned finding was a concern. On 04/27/2026 at approximately 10:15 AM, the nurse was observed removing an oxygen concentrator from the resident's room. She reported that the oxygen concentrator machine was broken and was just replaced. On 04/29/2026 at approximately 11:10 AM, the surveyor reviewed Resident #7's medical orders which confirmed that resident had an order for oxygen via Nasal Cannula at 2 Liters Per minute every shift. Start Date 04/08/2026. On 04/29/2026 at approximately 11:03 AM the Assistant Director of Nursing was notified of the concerns found. 4) On 04/27/2026 at 11:15 AM, during an observation of Resident #49, it was noted that the oxygen tubing was on the floor while Resident #49 was lying in bed. The oxygen concentrator was on, set at 3 liters per minute. On 04/27/2026 at 11:26 AM, Resident #49 was observed accompanied by Staff #4, Licensed Practical Nurse (LPN). Resident #49's oxygen concentrator was on and set to 3 liters per minute, but oxygen was not being delivered because the tubing was lying on the floor. Staff #4 acknowledged the oxygen tubing on the floor and the oxygen setting, stating she would retrieve new oxygen tubing. On 04/28/2026 at 10:38 AM, a review of Resident #49's medical record revealed a physician order from 11/20/2020 for oxygen at 2 liters per minute continuously every shift. On 04/28/2026 at 10:42 AM, a continued review of Resident #49's medical record revealed a care plan (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(created 04/29/2025, revised 04/17/2026) for impaired gas exchange (shortness of breath/hypoxia) with an intervention for continuous oxygen at 2 liters via nasal cannula. On 04/29/2026 at 10:59 AM, during an interview with the Assistant Director of Nursing (ADON), the following protocol was discussed: the oxygen concentrator's liter setting must align with the physician's order. If the oxygen tubing is found on the floor, it should be immediately discarded and replaced with new tubing. The expectation is that the resident would consistently receive oxygen as ordered. The concern was shared with the ADON at this time.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on record reviews, observations and interviews, it was determined that the facility failed to ensure that pain management was provided to each resident in a way that was consistent with the professional standards of practice, residents goals and preferences. This was evident for 8 Residents (#80, #7, #97, #2, #4, #10, #127, #12) of 8 Residents reviewed for pain management during the recertification/complaint survey. The finding include: Non-pharmalogical interventions are identified as an alternative method of treatment for a medical concern without the use of medication. This could include physical, psychological, and lifestyle interventions designed to reduce pain and improve quality of life. The CDC's 2022 Clinical Practice Guideline for Prescribing Opioids emphasizes non-pharmacological, non-opioid therapies as the first line of treatment for subacute and chronic pain. The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents. Oxycodone is a strong painkiller from a group of medicines called opiates, or narcotics used to treat moderate to severe pain. 1) On 4/27/2026 at 08:28 AM during the screening process of the annual survey, Resident #4 stated that she/he received pain medication for the pain in his/her legs, ankles, and sacral area, but it still hurts. During record review on 4/29/2026 at 1:18 PM, it was noted that resident had the following pain medications ordered: -Oxycodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain written on 11/18/2025 -Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Pain *Use caution w/ APAP total daily dose greater than 3,000mg* written on 11/17/2025 Further record review on 4/29/2026 at 1:38 PM of the resident's care plan created on 3/28/2025, revealed that resident had actual pain related to wound on sacrum as evidenced by need for pain management, with intervention to implement non-pharmacological approaches every shift. On 04/29/2026 at 10:43 AM, the Assistant Director of Nursing (ADON) was interviewed regarding the pain management process. The ADON stated that pain assessments are completed every shift and documented on the Treatment Administration Record (TAR), but nonpharmacological methods are not documented, because they are in the care plan. The surveyor asked how the staff would know what nonpharmacological interventions were used prior to the administration of pain medications. The ADON stated that the nurse would write it in a progress note. In addition, the surveyor informed ADON that the pain medications ordered did not indicate which to use for mild, moderate, or sever pain, to which the ADON agreed. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/2026 at 07:40 AM, the Regional Clinical Services Manager stated that after further review of the pain management guidelines, he agreed that nonpharmacological measures used for pain management should be documented on the TAR or written in the progress notes. He also stated that the facility would initiate an Inservice to the staff regarding pain management. 2) On 04/27/2026 at 8:46 AM, during an interview, Resident #10 reported that their current pain medication was inadequate for managing their pain. On 04/28/2026 at 1:33 PM, a review of Resident #10's medical record revealed a 04/17/2026 physician order for Tramadol HCl 50 mg: 1 tablet by mouth every 12 hours as needed for pain scale 4-10 AND every 12 hours for pain. A 02/06/2026 order was for Acetaminophen Extra Strength 500 mg: 2 tablets by mouth every 6 hours as needed for pain scale 1-3. On 04/28/2026 at 1:50 PM, continued review of Resident #10's medical record revealed a care plan (created 08/09/2025, revised 11/20/2025) for Risk for pain related to diabetes. The interventions section (created 08/14/2025, revised 11/20/2025) included implementing nonpharmacological approaches like relaxation, guided imagery, music, distraction, and massage before, after, and, if possible, during painful activities or before pain occurs. On 04/28/2026 at 1:54 PM, a review of Resident #10's medication administration records (February-April 2026) showed multiple instances where Tramadol was given for pain with no documentation of non-pharmacological interventions before the administration of Tramadol for pain: 7 times in February, 5 in March, and 4 in April. On 04/29/2026 at 10:43 AM, the Assistant Director of Nursing (ADON) was interviewed regarding the pain management process. ADON stated that pain assessments are completed every shift and documented on the treatment administration record. For new-onset pain, a pain evaluation (including non-pharmacological interventions) should be documented in a progress note or the pain assessment/evaluation. If a resident requests pain medication, the nurse may not do non-pharmaceutical interventions; they are typically done for new-onset expressed pain. On 04/30/2026 at 7:40 AM, the Regional Clinical Services Manager (Staff # 19) agreed that nonpharmacological pain management should be documented on the treatment administration record (TAR) or in a progress note. Staff #19 confirmed an Inservice for nurses starts today to ensure documentation of nonpharmacological methods. On 05/01/2026 at approximately 1:30 PM, the concern was shared with the Regional Clinical Services Manager and the Administrator. 3) On 04/27/2026 at 09:18 AM, in an interview with Resident #80, the resident reported that he/she was experiencing pain management issues for 4 days. The resident explained that the nurse last night did not know how much pain medication he/she should have or the name of the medication. Resident #80 expressed that the pain sometimes prevents him/her from participating fully in physical therapy and expressed concern that he/she will be able to meet the goals of physical therapy before discharge date . The resident stated that the pain level is 10/10 and medication only takes the pain (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled and as needed) to treat the resident's pain; however, there was no documented evidence to support that the facility took additional measures to offer other non-pharmacological interventions to treat the resident's pain. On 05/01/2026 at approximately 12:30 PM, in an interview with the ADON, she was notified that the facility failed to have documentation to support non-pharmacological interventions were in place to manage resident pain as needed. 7) On 4/29/2026 at 12:41 PM, a review of the active physician orders revealed that Resident # 2 was prescribed: Oxycodone Hydrochloride (HCl) 10 milligrams (mg) orally every 4 hours as needed for pain rated 4-6; and Oxycodone HCl 15 mg (administered as three 5mg tablets) orally every 4 hours as needed for pain rated 7-10. A review of the Medication Administration Record (MAR) for April 2026 indicated that Resident #2 received: Oxycodone 10 mg a total of 32 times; and Oxycodone 15 mg a total of 9 times. Resident #2's care plan created on 3/12/26 indicated Implement nonpharmacological approaches imagery, relaxation and deep breathing techniques. However, there was no evidence that these non-pharmacological interventions were implemented or documented. 8) A review of Resident #127's clinical record revealed that the resident was prescribed Morphine Sulfate (concentrate) solution 20mg/ml to be administered 5 mg by mouth every 4 hours as needed for pain, Acetaminophen Rectal Suppository 650 mg to be administered every 6 hours as needed, and Acetaminophen 325 mg to be administered as two tablets for 650 mg every 6 hours as needed for pain. Further review revealed the absence of non-pharmacological measures being attempted prior to the use of medications to relieve pain. The survey team brought the issue of not finding non-pharmacological measures in residents' clinical records to the attention of Staff #19 on 4/29/26. Staff #19 stated that the facility nursing staff used non-pharmacological measures, but they are noted in the resident care plans but not documented on either the Medication Administration Record or the Treatment Administration Record. A member of the state survey team interviewed Staff #19 on 4/30/26 at 7:40 AM. He stated that he reviewed information concerning pain management last evening. He agreed that nonpharmacological measures should have been implemented for pain management and should have been documented on the Treatment Administration Record. 9) A review of Resident #12's clinical record revealed that the resident was prescribed Acetaminophen 325 mg to be administered as two tablets for 650 mg every 6 hours as needed for pain. Further review revealed the absence of non-pharmacological measures being attempted prior to the use of medications to relieve pain. (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Good Samaritan Nursing Home Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 East Belvedere Avenue Baltimore, MD 21239	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The survey team brought the issue of not finding non-pharmacological measures in residents' clinical records to the attention of Staff #19 on 4/29/26. Staff #19 stated that the facility nursing staff used non-pharmacological measures, but they are noted in the resident care plans but not documented on either the Medication Administration Record or the Treatment Administration Record. A member of the state survey team interviewed Staff #19 on 4/30/26 at 7:40 AM. He stated that he reviewed information concerning pain management last evening. He agreed that nonpharmacological measures should have been implemented for pain management and should have been documented on the Treatment Administration Record.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews with facility staff, it was determined the facility failed to provide an environment that promotes resident respect and dignity. This was evident for 2 (Resident #9 and #39) of 2 residents reviewed for dignity during the recertification/complaint survey. The findings include: 1) On 04/27/2026 at 9:32 AM, an observation of Resident #9 lying in bed showed the linen on the bed had multiple areas of yellow dried substance and an odor of urine. On 04/27/2026 at 2:07 PM, an observation/interview was conducted with Staff #8 and Staff #9, both Geriatric Nursing Assistants (GNAs). The staff stated that resident linens are changed every other day or when they are soiled. However, GNA #8 verified that Resident #9's fitted sheet, top sheet, and white blanket had multiple dried yellow areas. GNA #9 confirmed both the presence of an odor of urine and the dried, yellow-stained condition of Resident #9's linens. 2) On 04/27/2026 at 9:20 AM, during an observation, an odor was noted in the hallway near Resident #39's room. A brown substance was observed on Resident #39's bed, wheelchair, and call light. Unknown staff members continued to walk past the room. On 04/27/2026 at 10:06 AM, during a second observation, the brown substance remained present on Resident #39's bed, wheelchair, and call light. On 04/27/2026 at 10:07 AM, during an interview, Staff #4, Licensed Practical Nurse (LPN), confirmed that the brown substance was bowel and was considered a dignity issue. On 04/29/2026 at 10:56 AM, during an interview, the Assistant Director of Nursing (ADON) stated that staff are expected to change residents' linen daily and as needed. The ADON agreed that soiled linen constitutes a dignity issue for residents. The concern was shared with the ADON at this time.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on interviews and record review, it was determined that the facility failed to assess the resident's right to self-administer medication. This was evident for 1 resident (#111) of 1 resident reviewed for medication self-administration during the recertification/complaint survey. Findings Included: On 04/30/2026 at 2:20 PM, in an interview with Resident #111, the resident explained that he/she kept medication (inhaler) at the bedside because he/she alleged that the staff failed to administer medication in a timely manner. The resident explained he/she had a respiratory illness and as a result the resident required his/her respiratory medication timely. The resident reported that he/she has received a lot of opposition from the nurses for keeping the inhaler at the bedside. The resident reported that he/she has capacity to administer their own medication and as a result should be allowed that right to keep medication for safety and comfort reasons. On 05/01/2026 at approximately 8:00 AM, a review of a progress note written on 04/25/2026 at 05:55 AM, revealed: Resident complain of shortness of breath and was given a nebulizer treatment. The resident requested the inhaler, and the nurse went into the medication room to check for the resident medicine, medication was not available. Resident used their own inhaler at bedside and shortness of breath has decreased. On 05/01/2026 at 10:31 AM, a review of Resident #111's medical record was completed and revealed that there was no physician's orders for self-administration, no care plan and/or progress notes to support that the resident was appropriately assessed for self-administration of medication. However, resident reported that medication was kept at the bedside at all times. On 05/01/2026 at 11:02 AM, during an interview with the Assistant Director of Nursing (ADON), the ADON was questioned about residents who self-administered medication. She explained that the facility had no residents who self-administered medication within the last month. When asked to describe the process for assessing a resident's ability to self-medicate, she explain that the resident's cognitive ability to self-administer their own medication would be assessed and if a medication assessment was completed it would be documented in the nursing note. The ADON confirmed that keeping medication at the bedside was not permitted unless the resident was assessed as capable, and that the Medication Administration Record (MAR) would identify the medication as self-administration. The ADON was subsequently notified that the facility failed to properly assess residents for self-administration ability to ensure that the resident was able to safely administer his/her own medication as desired.		

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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, record reviews, and interviews, it was determined that the facility failed to ensure that call bells were consistently maintained within residents' reach. This was evident for 2 (Residents #61 and #78) of 133 residents observed during the recertification survey. The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 4/27/2026 at 9:00 AM, Resident #61 was observed seated in a wheelchair and requested assistance to turn on the room light. At that time, the call bell was observed on the floor across the room, inaccessible to the resident. Registered Nurse (RN) #10 was immediately notified of the observation. On 4/29/2026 at 11:57 AM, a review of the medical record revealed that Resident #61 utilized a wheelchair for mobility and required supervision and staff assistance with ADLs. The resident's care plan indicated a self-care deficit as evidenced by functional decline, indicating a need for accessible assistance. 2) On 4/27/2026 at 9:31 AM, Resident #78's call bell was observed on the floor and not within reach. The surveyor notified RN #11 at the time of the observation. On 4/29/2026 at 8:57 AM, during an interview with Licensed Practical Nurse (LPN) #24, he/she stated that staff are expected to ensure that call bells are placed within residents' reach at all times. On 4/29/2026 at 12:12 PM, a review of medical record revealed that Resident #78 required the use of a walker for mobility and was dependent on staff for ADLs. The resident's care plan also identified a self-care deficit, indicating the need for assistance. On 4/30/2026 at 11:33 AM, the Assistant Director of Nursing (ADON) was informed of the above findings and acknowledged the concerns.		

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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 record review, complaint # 2991568 and interviews, it was determined the facility staff failed to report alleged violations related to neglect and/or abuse, including injuries of unknown source with major injuries to the Office of Healthcare Quality as required. This was evident for 1 (Resident #97) of 39 residents records reviewed during the recertification survey process. The findings include: On 04/27/2026 at approximately 11am, a review of complaint #2991568 alleged that Resident #97 was being accused of verbally threatening his/her roommate, with no proof of the alleged abuse. On 04/27/2026 at 2:43 PM, in an interview with Resident #97, the resident reported that he/she was accused of threatening to kill his/her roommate (Resident #166). Resident #97 stated that the staff alleged that Resident #166 reported the alleged threat to the staff and they called the police on him/her; however, Resident #97 denied threatening the roommate (Resident #166). On 4/30/2026 at 11:45 AM, a review of Resident #97's care plan created on 03/24/2026 revealed that Resident #97 had a diagnosis of Mood disturbance related to Depression as evidenced by fluctuations in mood. On 04/30/2026 at 11:54 AM, a review of a change in condition evaluations completed on 04/21/2026 at 11:43 PM revealed that Resident #97 became verbally aggressive toward his/her roommate after accusing the roommate of eating his/her food. It was alleged that Resident #97 stated, I will kill you, in the presence of a staff. The police were called to evaluate the situation. On 04/30/2026 at 12:13 PM, in an interview with Assistant Director of Nursing (ADON) and the Regional Clinical Services Manager, they were asked if the above-mentioned incident was submitted to the Office of Health Care Quality (OHCQ) and the ADON stated no. They were asked what the expectation of the facility was, if a resident threatens to kill another resident. They acknowledged that the facility should have reported the incident to OHCQ.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of facility investigative materials, medical records, and staff interviews, it was determined that the facility failed to thoroughly investigate an injury of unknown origin. This was evident for one (Resident #161) of three residents reviewed during this recertification/complaint survey. The findings include: On 4/30/26 at 7:53 AM, the surveyor reviewed a self-reported incident #340529. The review revealed that on 5/01/25 at approximately 1:00 AM, Resident #161 was found with their head hanging off the side of the bed while their lower body remained on the mattress. The resident sustained a skin tear on the right lateral leg, which required transfer to the hospital and seven superficial Prolene sutures. The facility's internal investigation concluded that because the fall was unwitnessed, the cause could not be determined. Further review of Resident #161's medical record revealed that the resident's most recent Brief Interview for Mental Status (BIMS), dated 4/18/25, resulted in a score of 13 out of 15, indicating intact cognitive function. Despite the resident's intact cognitive status, the facility's investigative packet contained no written statement from Resident #161 regarding the cause of the injury. During an interview on 4/30/26, the Regional Clinical Services Manager (Staff #19) provided a statement from Licensed Practical Nurse (LPN) #23, who performed the initial assessment. LPN #23 claimed the resident did not know what happened because they were asleep. Review of the hospital visit notes dated 5/01/25 revealed a different account. The resident told hospital staff they were standing on the side of the bed when an aide came in to help, and noted they had been sleeping prior to calling for staff assistance. On 5/01/26, these concerns were presented to the Assistant Director of Nursing, the Regional Clinical Services Manager, and the Nursing Home Administrator. The facility leadership validated these findings.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that the facility failed to develop and implement a comprehensive care plan addressing the use of a nebulizer and an arm sling. This was evident for 1 (Resident #88) of 36 residents reviewed for care planning during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each Resident. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. The care plan consists of focus, goal and interventions. A nebulizer is a medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or face mask. On 4/27/2026 at 8:31 AM, the surveyor observed a nebulizer mask resting on top of Resident #88's soiled breakfast tray. Resident #88 was seated in a wheelchair with a sling applied to the left arm and reported discomfort. Registered Nurse (RN) #10 was immediately notified of the observation. On 4/29/2026 at 7:27 AM, a review of Resident #88's medical record indicated the following physician orders: Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 milliliters (ml) inhale orally every 6 hours for shortness of breath for 7 days, with an end date of 5/1/26. (liquid medications used to relax and open airways to improve breathing). Left arm in sling at all times except for hygiene every shift. A change in condition note dated 4/24/26 confirmed that Resident #88 experienced shortness of breath (SOB) and was initiated on breathing treatments. Further review indicated the resident was admitted on [DATE] with a closed fracture of multiple ribs, requiring the use of a sling to the left arm. Despite these identified needs and physician orders, there was no evidence in the medical record that a care plan was developed or implemented to address SOB and the use of a nebulizer treatments, and the use and management of the left arm sling. On 4/29/2026 at 11:00 AM, during an interview with the Assistant Director of Nursing (ADON), she confirmed that care plans are initiated upon admission by supervisors or Unit Managers and subsequently reviewed and completed by the Interdisciplinary Team (IDT). The ADON further stated that care plans are updated with new physician orders, falls, and changes in condition, as well as during routine quarterly reviews. The ADON confirmed that there was no care plan addressing the resident's SOB or the use of nebulizer treatments. On 4/30/2026 at 1:38 PM, the ADON also confirmed that there was no care plan in place addressing the use of sling.		

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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 record review and interviews, it was determined that the facility failed to revise the comprehensive care plan to reflect the resident's current treatment needs. This was true for 1 (Resident #97) of 36 residents reviewed for care planning during the recertification survey. Findings Included: On 4/29/2026 at 11:00 AM, during an interview with the Assistant Director of Nursing (ADON), she confirmed that care plans are initiated upon admission by supervisors or Unit Managers and subsequently reviewed and completed by the Interdisciplinary Team (IDT). The ADON further stated that care plans are updated with new physician orders and changes in condition, as well as during routine quarterly reviews. On 04/30/2026 at 11:54 AM, a review of Resident #97's progress report written on 04/22/2026 at 07:01 AM revealed that the resident who was alert and oriented was observed by staff ambulating/standing by the nursing station in his/her underwear only. On 04/30/2026 at 11:54 AM, a review of a change in condition evaluation form completed on 04/21/2026 at 11:43 PM revealed that Resident #97 became verbally aggressive toward his/her roommate after accusing him/hers of eating his/her food. Resident stated, I will kill you, in the presence of a staff. The police were called to evaluate the situation. On 4/30/2026 at 12:22 PM, in an interview with the Nursing Home Administrator (NHA), she was informed that Resident #97 had multiple behavioral issues such as non-compliance with treatment orders, verbal altercation with two different roommates and inappropriately dressed at the nursing station; however, the facility failed to revised the care plan to reflect that the resident had the above mentioned behavioral issues, the NHA acknowledged the findings. On 05/01/2026 at approximately 12:30 PM, the ADON was notified of the above-mentioned findings and it was acknowledged and no additional documentation was provided at that time.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a complaint investigation, medical record reviews, and staff interviews, it was determined that the facility failed to ensure a resident received psychotropic medication as recommended by psychiatric consultants. This deficiency affected one resident (Resident #162) out of five reviewed for behavioral health during the recertification/complaint survey. The findings include: On 4/29/26 at 8:59 AM, the surveyor reviewed a complaint alleging that Resident #162 did not receive appropriate treatment for mental health issues during their stay at the facility. Further review of medical records for Resident #162 revealed that the resident was admitted to the facility on [DATE]. An initial psychological evaluation on 4/22/25 recommended Depakote 125 mg twice daily for mood and behavioral disturbances. Subsequent psychiatric consultations on 4/23/25 and 4/29/25 confirmed the ongoing need for this treatment. On 4/29/26 at 11:30 AM, a review of Resident #162's medication orders revealed that on 4/25/25, Depakote 125 mg was started three times daily rather than the recommended twice daily. The Medication Administration Record (MAR) for April 2025 showed the resident received this incorrect dose seven times between 4/26/25 and 4/28/25. On 4/28/25, an order for Depakote 125 mg twice daily was briefly entered and then immediately discontinued. As a result, the medication was never restarted, leaving the resident without the recommended treatment. During an interview on 4/29/26, the Assistant Director of Nursing (ADON) reviewed the records with the surveyor. The ADON confirmed that the resident received the incorrect dosage from 4/26/25 to 4/28/25 and validated that the correct order was discontinued without an accompanying clinical assessment or justification.		

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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 observations of the facility's kitchen and food services, it was determined that the facility failed to maintain sanitary food service operations. This deficiency was identified during multiple observations of kitchen and food service areas throughout the recertification/complaint survey. The findings include: During the initial tour of the kitchen on 4/27/26 at 7:50 AM, the surveyor noted a beverage cart containing apple juice, cups of milk, and cups of water that did not have dates marked on their lids. When asked how staff or residents would know when these beverages were prepared, Dietary Manager #25 stated, Everything in this kitchen is supposed to have a date. She then instructed a dietary aide to label the lids. On 4/28/26 at 7:28 AM, the surveyor inspected the nourishment rooms on the first floor. Accompanied by Geriatric Nursing Aide (GNA) #26, the surveyor found a paper bag containing food labeled with Resident #76's name in the refrigerator; however, it lacked a storage date. Additionally, the refrigerator contained an undated plate of cornbread and an unmarked dragon fruit. The interior of the refrigerator also exhibited dust and dark stains. GNA #26 validated these findings. During a follow-up tour of the kitchen on 4/30/26 at 11:50 AM, it was noted that Kitchen Aide #27 was not wearing a beard cover while handling food for service. Dietary Manager #25 confirmed that staff are required to wear hairnets and beard always covers while in the kitchen. In an interview with the Nursing Home Administrator (NHA) on 4/30/26 at 1:42 PM, the surveyor shared the aforementioned concerns. The NHA validated the findings.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, it was determined that the facility failed to ensure that staff COVID-19 vaccination status was consistently monitored and documented. This was evident for 2 Geriatric Nurse Assistants (GNA) #18 and #9 of 5 randomly selected staff members reviewed during the recertification survey. The findings include: A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease. On 5/01/2026 7:26 AM, a review of the employee health records for GNA #18 and #9 revealed no documented evidence of COVID-19 vaccination status. On 5/01/2026 at 8:04 AM, in an interview with the Assistant Director of Nursing (ADON), she stated that the facility offers COVID-19 vaccinations to all staff during on-site clinics; however, she acknowledged that vaccination status had not been consistently documented. On 5/01/2026 at 9:06 AM, the ADON provided an email correspondence with a community pharmacy indicating that 3 employees had expressed interest in receiving the COVID-19 vaccine during a 2024 clinic. No documentation was provided to confirm whether these vaccinations were administered or recorded in the employees' health records.		