STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215246	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Court Healthcare Cent.	3701 International Drive Silver Spring, MD 20906

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to store and process linens to prevent the spread of infection. This was evident for 1 out of 1 observation made in the facility's laundry room. The findings include: On 03/19/2026 at 8:47 AM, an observation of the laundry room revealed that clean laundry was stored uncovered. This included towels, placed on a rectangular table, clean tablecloths on a metal rack, an additional metal rack containing tablecloths, bed sheets, towels, and clothing, and clean linens in a basket all of which were uncovered. On 03/19/2026 at 8:47 AM, an interview with the Housekeeping Director (Staff #12) revealed that the laundry room typically had uncovered linen. On 03/19/2026 at 9:28 AM, an interview with the Director of Nursing revealed that the expectation was for linen to be covered.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that controlled substances were consistently accounted for and documented through the required dual nurse signatures during shift-to-shift narcotic counts. This was evident for 2 (Choice and Independent) out of 3 units during the facility's recertification survey.The findings include:On 03/17/2026 at 9:18 AM, following an observation of a medication pass conducted by the surveyor on the choice unit with Licensed Practical Nurse (LPN) #7, the surveyor reviewed the narcotic control book and identified a missing signature for the incoming nurse on 03/13/2026 for the 3:00 PM to 11:00 PM shift, as well as a missing signature for the outgoing nurse for the 11:00 PM to 7:00 AM shift. LPN #17 was requested to participate in a concurrent review of the narcotic book and she confirmed the date and the absence of the required signatures. On 03/17/2026 at 9:20 AM, during an interview with LPN #7, when asked for the expectation regarding signing in the narcotic book, she stated that at the beginning of each shift, narcotics are counted jointly by the outgoing and incoming nurses, and both nurses are expected to sign the narcotic book to validate that the count was completed. When asked why the signatures were missing, LPN #7 stated that the incoming nurse experienced a family emergency, and a nurse from another unit assisted with the narcotic count. LPN #7 further stated that although the count was completed and report was given, the assisting nurse failed to sign the narcotic book. LPN #7 indicated that she would follow up with LPN #17, who assisted with the count, to determine why the signature was omitted and to request completion of the documentation.On 03/18/2026 at 8:36 AM, following an observation of a medication pass conducted by the surveyor on Independence unit with LPN #21, the surveyor reviewed the narcotic binder and identified three missing signatures. These included a missing signature for the incoming nurse on 03/01/2026 for the 3:00 PM to 11:00 PM shift, a missing signature for the outgoing nurse on the same date for the 11:00 PM to 7:00 AM shift, and a missing signature for the incoming nurse on 03/04/2026 for the 11:00 PM to 7:00 AM shift. LPN #21 reviewed the narcotic binder and confirmed the missing signatures. On 03/18/2026 at 8:38 AM, during an interview, LPN #21, when she was asked about the facility's expectation for signing the narcotic book, LPN #21 stated that both the outgoing and incoming nurses are required to sign to verify that the narcotics were counted.On 03/18/2026 at 8:42 AM, LPN #7 approached the surveyor and reported that LPN #17 had subsequently signed the narcotic book while present in the facility for her shift on the night of 03/17/2026.On 03/19/2026 at 7:29 AM, during an interview with the Director of Nursing (DON), when asked for the expectation regarding signing the narcotic book, she stated that the expectation was for two nurses (the outgoing nurse and the incoming nurse) to sign the narcotic book after jointly counting and verifying that all controlled medications are accounted for. The DON further stated that the presence of two signatures serves as documentation that the narcotic count was completed. When the DON was informed of the identified missing signatures, she acknowledged the findings.

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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, it was determined that the facility failed to ensure that food items were stored in a manner that maintained the integrity of the specific items. This was evident for 1 (initial observation) of 2 of the kitchen areas upon facility entry. The findings include: On 03/16/2026 at 8:05 AM, an observation of the kitchen revealed a tray of freshly cooked chicken in the refrigerator that was uncovered. On 03/16/2026 at 8:07 AM, an observation of the kitchen's dry storage revealed a packet of crackers that was unlabeled. On 03/16/2026 at 8:10 AM, an observation of the kitchen's freezer revealed unlabeled shrimp, cinnamon sticks, and chicken. On 03/17/2026 at 12:24 PM, an interview with the Dining Services Director (Staff #3) revealed that the expectation was that the food items should have been labeled and not left uncovered. On 03/18/2026 at 9:05 AM, the concerns were addressed with the Director of Nursing and she indicated that she understood.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documents and interviews, it was determined that the facility failed to: 1) conduct quality assurance meetings on a quarterly basis, and 2) ensure the presence of required quality assurance committee members in meetings. This was evident during the quality assurance and performance improvement task conducted as part of the recertification survey process. The findings include:QAPI (Quality Assurance and Performance Improvement) is a data-driven, proactive approach to healthcare management, mandated by CMS for nursing homes and home health agencies, merging Quality Assurance (QA) with Performance Improvement (PI) to improve patient care, safety, and quality of life.On 03/19/2026 at 10:04 AM, the surveyor requested QAPI attendance sheets for the past 12 months.On 03/19/2026 at 12:00 PM, an interview with the Facility's QAPI coordinator, Staff #1, was conducted. She reported that the facility's QAPI binder was missing and that she could not find attendance sheets for April 2025, May 2025 and October 2025. When asked when quarterly QAPI meetings were held, she stated April 2025, July 2025, October 2025 and January 2026. On 03/19/2026 at 12:28 PM, Staff #1 further reported that she had looked for quarterly meeting minutes and confirmed that there was no evidence that a QAPI meeting was held in April 2025. On 03/19/2026 at 1:32 PM, the surveyor and Staff #1 reviewed the attendance sheets and meeting minutes for the past 12 months. The review of attendance revealed the following: No infection preventionist was present for 7 months (April, May, June, July, October, November and December).No Administrator or Board Member was present for 2 months (April and July). No Medical Director was present for 2 months (April and August). No Dietitian was present for 8 months (April, May, June, July, August, September, October, and December).No Geriatric Nursing Assistant (GNA) was present for 7 months (April, May, June, July, August, September and October).On 03/19/2026 at 1:53 PM, a follow up interview with Staff #1 was conducted. She acknowledged that not all members of the quality assurance committee attended the meetings as required and that the facility had been encouraging staff members to participate to fulfill both federal and state attendance requirements. On 03/19/2026 at 2:23 PM, the Facility Administrator was notified of the QAPI concerns.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record review and staff interviews, it was determined that the facility failed to ensure staff received ongoing Quality Assurance and Performance Improvement (QAPI) training. This deficient practice was identified in 5 of 5 employee files reviewed during the facility's recertification survey.The findings include:On 03/19/2026 at 7:44 AM, a review of employee records for Registered Nurse (RN) #16, Licensed Practical Nurse (LPN) #17, and Geriatric Nursing Assistants (GNAs) #18, #19, and #20 revealed no evidence of ongoing QAPI training following initial hire. Hire dates for the GNAs ranged from 2003 through 2025, indicating employment without documented continuation of QAPI education.On 03/19/2026 at 11:17 AM, during an interview, the Human Resources (HR) Director, when asked who was responsible for ensuring staff members maintained required training, she stated that she was responsible. When asked to provide documentation of QAPI training for the identified employees, she stated she would locate and provide the records.On 03/19/2026 at 12:49 PM, the HR Director reported that she was unable to locate documentation of QAPI training but would continue searching for any relevant records. On 03/19/2026 at 1:50 PM, upon follow-up, the HR Director confirmed that she was still unable to produce the requested documentation. On 03/20/2026 at 7:10 AM, during a follow-up interview, the Director of Nursing (DON) stated that the identified staff members had not received QAPI training and confirmed that no documentation was available to support that such training had been conducted. When she was informed that this was a concern, the DON acknowledged it.On 03/20/2026 at 7:18 AM, in an interview with the Nursing Home Administrator (NHA), when he was asked for the expectation regarding QAPI training for staff members, he stated that staff are expected to receive QAPI training; however, he did not have access to training records. Upon being informed of the identified concerns regarding the lack of QAPI training for the selected staff members, the NHA acknowledged the issue.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that that the facility failed to refer a resident for a PASARR evaluation review after a new mental health diagnosis.This was evident for one (Resident # 4) out of five residents reviewed for unnecessary medications.The findings include:A review of Resident # 4's medical record on 3/17/26 revealed Resident # 4 was admitted to the facility on [DATE] with diagnoses that include: dementia, generalized anxiety disorder and major depressive disorder. An admission PASARR (preadmission screening and resident review) level I screen dated 7/14/21documented Resident # 4 as not having any mental health or intellectual disability or related conditions.Further review of Resident # 4's medical record revealed that Resident # 4was diagnosed with bipolar disorder on 1/9/26. There was no evidence in Resident # 4's medical record that a new PASARR screening was completed after the addition of this mental health diagnosis.In an interview with Staff # 2 (social service coordinator) on 3/18/26 at 9:46 AM, Staff #2 stated, .If I get notified of a new diagnosis or medication, I reapply for a new PASARR review for the resident. It can take several days to get a reply. I was not aware that Resident # 4 was given a new psychiatric diagnosis of bipolar disorder. I did not put Resident #4 in for a new PASARR evaluation because I did not know about his/her new diagnosis.

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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 observations, record reviews, and interviews it was determined that the facility failed to develop and/or update residents care plan. This was for 2 (Resident #1 and #49) out of 3 residents reviewed for care plan during the recertification survey. The findings include: A care plan is a simple written plan that explains how to take care of a resident's health and daily needs. It lists what the resident needs help with, what their goals are, and what caregivers should do to help them. It makes sure everyone helping the resident knows the same plan so the care stays organized and consistent. 1). On 03/16/2026 at 8:57 AM, an observation of Resident #1 revealed that the resident was receiving oxygen therapy. On 03/17/2026 at 8:55 AM, record review revealed that Resident #1's MDS (Minimum Data Set) the resident was on oxygen therapy. At the same time, further review of the comprehensive care plan revealed no goals, or interventions addressing oxygen therapy, including administrations, monitoring or safety precautions. On 03/18/2026 at 8:57 AM, an interview with the Director of Nursing revealed that the expectation was that residents receiving oxygen therapy had this addressed in the comprehensive care plan. On 03/18/2026 at 9:00 AM, the concern was addressed with the Director of Nursing, and she indicated that she understood. 2). On 03/17/2026 at 11:17 AM, a review of Resident #49's medical records was conducted. The review revealed that the resident was re-admitted into the facility on 1/11/2026. The review of the hospital discharge summary indicated that Resident #49 had a new diagnosis of respiratory insufficiency which required the resident to be on 3L of Oxygen. Further review of the records revealed a nurses note entered on 1/11/2026, that stated Resident #49 returned to the facility with a wound to the sacrum. Additionally, there was a new order for Oxygen at 3L via nasal cannula continuously every shift. On 03/17/2026 at 12:59 PM, a review of Resident #49 care plan was conducted. The care plan failed to indicate that the resident had a new wound to the sacrum and that the resident was on supplemental oxygen therapy. On 03/17/2026 at 1:15 PM, a review of Resident #49's Treatment Administration Records (TAR) for January, indicated that the resident received 3L of oxygen every shift. On 03/19/2026 at 10:31 AM, an interview with the Director of Nursing (DON) was conducted. When asked who was responsible for revising the care plan after a resident is admitted /re-admitted into the facility, the DON stated that the admitting nurse is supposed to revise the care plan. If the revisions are not done, then the nurse supervisor can also update the care plan. DON further stated that for Resident #49, respiratory monitoring should have been added to the care plan before the end of shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2026 at 11:36 AM, the surveyor notified the DON and Facility Administrator of the care plan revision concerns.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews it was determined that the facility failed to maintain professional standards of practice related to: 1) oxygen orders and 2) providing sufficient documentation to support a new mental health diagnosis. This was evident for 2 (Resident #1 and #4) out of 6 residents reviewed for respiratory orders and unnecessary medications during the recertification survey. The findings include: 1). On 03/16/2026 at 8:57 AM, an observation of Resident #1 revealed that the resident was receiving oxygen therapy. On 03/16/2026 at 9:55 AM, record review failed to reveal an active order for oxygen. On 03/18/2026 at 8:57 AM, an interview with the Director of Nursing revealed that the expectation was that if a resident was on oxygen, there should be an order to reflect it. 2) The DSM-5 (Diagnostic and Statistical [NAME] of Mental Disorders, Fifth Edition) is the standard of care for diagnosing and treating patients with mental health conditions. The DSM- 5 Bipolar Disorder Adult Guidelines 2019-20 set the criteria for the diagnoses of bipolar disorders. For a diagnosis of Bipolar I disorder, it is necessary to meet the following criteria for a manic episode. A manic episode is defined as a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes. During the period of mood disturbance and increased energy or activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: (1) Inflated self-esteem or grandiosity , (2)Decreased need for sleep (e.g., feels rested after only 3 hours of sleep), (3) More talkative than usual or pressure to keep talking , (4) Flight of ideas or subjective experience that thoughts are racing, (5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless, non-goal-directed activity), (6) Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). The DSM-5 documents the criteria for the diagnosis of Bipolar II disorder. For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the criteria for a current or past major depressive episode. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day. During the period of mood disturbance and increased energy and activity, 3 (or more) of the above symptoms (4 if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree. On 3/17/26 at 10:34 AM, a review of Resident # 4's medical record revealed that Resident # 4 was diagnosed with moderate dementia with other behavioral disturbances on 8/1/25. The review also revealed that Resident # 4 was diagnosed with bipolar disorder, unspecified on 1/9/26. A review of Resident # 4's Minimum Data Set (MDS) assessment dated [DATE] revealed no documented evidence (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of bipolar behaviors in Section D Mood, Section E Behaviors or Section I Active Diagnoses. During an interview on 3/18/26 at 10:48 AM, Nurse Practitioner (NP) # 10 stated that Resident # 4 does have visual and auditory hallucinations and he/she does have behaviors that fall within the DSM diagnosis criteria for bipolar, saying, He/she gets hyper and has exit seeking behavior. He/she has insomnia. Yes, I know bipolar is typically diagnosed in younger adults and Resident # 4 was [AGE] years old when diagnosed. He/she is on Seroquel for dementia with neuropsych behaviors. A review of Resident # 4's medical record on 3/18/26 at 11:30 AM failed to provide documentation of Resident # 4 exhibiting behaviors such as grandiosity, hallucinations, distractibility, pressured speech, flight of ideas, excessive involvement in harmful activities in the timeframe between the 11/10/25 MDS assessment and the 1/9/26 diagnosis of bipolar disorder. During an interview on 3/18/26 at 11:52 AM, Physician # 9 stated, [Resident # 4] does not have a diagnosis of bipolar. While it may have been coded in his/her medical record, he/she does not meet the criteria for that diagnosis. During an interview with caregivers, Licensed Practical Nurse (LPN) #11 stated that Resident # 4 cannot even hold a conversation anymore. Staff # 11 stated that Resident # 4's medications had to be decreased because he/she has been lethargic and less interactive the past few months. Further review of Resident # 4's medical record on 3/19/26 at 1:35 PM revealed none of the psychiatric provider's (Staff # 27) notes, with the most recent note dated 3/16/26, documented a diagnosis of bipolar disorder or behaviors that meet the diagnostic criteria. The facility failed to have documented evidence of Resident # 4 exhibiting behaviors that meet the diagnostic criteria to warrant the diagnosis of bipolar disorder.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interview, it was determined that the facility failed to maintain good grooming and personal care services for Resident # 6. This was evident for one (Resident # 6) out of one resident reviewed for Activities of Daily Living (ADLs).The findings include: During screening on 3/16/26 (Monday) at 9:08 AM, Resident # 6 was observed to have greasy hair. When interviewed about ADLs, Resident # 6 stated, .I only remember getting showered one time when I got my hair washed.During an observation on 3/19/26 at 9:13 AM, Resident #6 was in bed in a hospital gown and his/her hair appeared greasy. Resident #6 stated, I think I had a bath yesterday . I am not sure when my hair was washed last. During an interview on 3/19/26 at 9:49 AM, Staff # 11 (LPN) stated, We [staff] document showers/baths in the Task Tab in the [medical record system]. We don't use a shower book in this facility.A review of Resident # 6's medical record on 3/19/26 (Thursday) at 11:14 AM revealed Resident # 6 was admitted on [DATE]. Further review of Resident #6's medical record revealed that Resident # 6 was scheduled for baths on Wednesdays and Saturdays. There was evidence in the GNA's (geriatric nursing assistant) task documentation that on 3/18/26 at 10:27 PM Resident # 6 was given a bath in which he/she required partial/moderate assistance. However, there was no documentation of any showers or baths prior to 3/18/26 in the EMR (electronic medical record).During an interview with Resident # 6 on 3/19/26 at 12:18 PM, Resident # 6 stated, My preference would be a bed bath. I was given a bed bath last night. But to get my hair washed, I have to go to the shower room every once in a while. I don't remember the last time that I had my hair washed.The facility was unable to provide evidence of more than one bath since Resident # 6's admission on [DATE] and there was no evidence of his/her hair being washed.During an interview with the DON and Staff # 13 (Senior Director of Nursing Services) on 3/19/26 at 2:22 PM, Staff # 13 stated, I had not trained [the DON] on adding the bathing tasks to (the medical record system]. I added the task for Resident # 6 when I got her on Tuesday [3/17/26]. The DON stated that the expectation would be that the GNA (geriatric nursing assistant) would document the care given in the Task tab of [the medical record system].

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interviews, observations and record reviews, it was determined that the facility failed to: 1) provide appropriate treatment to maintain an individual's limited range of motion, and 2) evaluate a resident for therapy services to prevent further decline in the range of motion. This was evident for 1 (Resident #19) out of 6 residents reviewed for position and mobility during the recertification survey. The findings include:On 03/16/2026 at 8:40 AM, an interview with Resident #19 was conducted. The resident reported that they had a stroke during their stay at the facility and that they wore a splint on their right hand, but the therapy services took it away.During the interview, the surveyor observed that Resident #19 had a contracture on the right hand. When asked if they were receiving any therapy services, the resident stated that they had not had therapy services for a long time. On 03/17/2026 at 9:04 AM, a review of Resident #19's medical records was conducted. The care plan indicated that the resident had musculoskeletal condition, hemiparesis and contracture on the right upper and lower extremity. An intervention was entered for Resident #19 to wear a right elbow and right-hand splint per doctor's order.On 03/17/2026 at 11:04 AM, another observation was conducted. Resident #19 was observed not wearing a splint on the right hand. Surveyor requested therapy notes for Resident #19.On 03/17/2026 at 11:15 AM, a review of the therapy notes provided by facility revealed that Resident #19 was last evaluated for therapy services in January 2024. The therapy notes provided had a sentence that stated the resident had refused to wear a splint. On 03/18/2026 at 9:14 AM, an interview with Staff #25, Directory of Therapy Services, was conducted. When asked how often residents are supposed to be evaluated for therapy services, Staff #25 stated that it's the facility's expectation that residents are evaluated quarterly. Staff #25 further stated that she was not aware of any restorative services that the resident was receiving at the facility. After another review of the therapy notes, Staff #25 confirmed that there were no records that indicated Resident #19 was re-evaluated for therapy services in 2025. On 03/19/2026 at 10:36 AM, an interview with the Director of Nursing (DON) was conducted. She stated that if a resident refused an intervention, the facility staff is supposed to educate the resident on the benefits of care and was expected to try again later. If the resident continued to refuse and there was a pattern, then the refusal is supposed to be documented, provider and resident representative notified, and the care plan should be updated to reflect the refusals.The surveyor asked the DON to provide documentation to indicate a pattern of splint refusals for Resident #19.On 03/19/2026 at 10:55 AM, the DON confirmed that there were no documented refusals beside the one-time documentation in January 2024. She also stated the care plan had not been updated to indicate the resident had a pattern of refusing to wear the splint.On 03/20/2026 at 8:09 AM, the Facility Administrator and the DON were notified of the splint concerns and failure to re-evaluate a resident for therapy services.