STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215249	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Homewood	2700 North Charles Street Baltimore, MD 21218

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, it was determined that the facility failed to ensure meals were served to residents at an appealing and palatable temperature. This was evident for 1 out of 1 test tray temperature observation. This practice has the potential to affect all residents who eat the food prepared by the facility.The findings include:Resident interviews revealed ongoing concerns regarding the quality, taste temperature, variety, and portions of meals served by the facility.On 6/23/2026 at 8:54 AM, Resident #104 stated that the food tasted awful, lacked variety, and was served cold.On 6/23/2026 at 9:14 AM, Resident #8 stated that food did not taste good.On 6/23/2026 at 9:27 AM, Resident #14 stated that the food was room temperature.On 6/23/2026 at 9:32 AM, Resident #39 stated that meals lacked variety and were usually cold.On 6/23/2026 at 9:43 AM, Resident #138 complained that meal portions were inadequate.On 6/23/2026 at 10:33 AM, Resident #38 stated that the food was rarely served hot.On 6/24/2026 at 7:53 AM, Resident #17 stated that the food tasted terrible.On 06/26/2026 7:56 AM, the surveyor conducted a breakfast tray line observation and requested that Dietary Aide (Staff #24) place a test tray on the last insulated meal cart designated for Unit 1. In the absence of the Dietary Manager (Staff #8), the Nursing Home Administrator (NHA) accompanied the surveyor during the observation.At 8:18 AM, the insulated meal cart was loaded with breakfast trays and departed the kitchen at 8:25 AM. The cart arrived on Unit 1 at 8:27 AM.At 8:33 AM, after the last tray was served in Unit 1, the NHA begun to obtain the following temperatures from the test tray using the facility's food thermometer :- Breakfast Burrito: 80 F- Cream of wheat: 100 F- Coffee: 110 F- Juice: 30 FThe surveyor immediately informed the NHA that the temperatures of the hot food items and coffee were significantly below the facility's recommended serving temperatures. The NHA stated that he was unsure of the required food temperature standards and indicated that he would provide the surveyor with a copy of the facility's policy.On 6/26/26 at 11:55 AM, a review of the facility's Food Temperature Control policy, revealed the following recommended serving temperatures:Meat protein 155-160 FStarch 160-170 FVegetable 160-170 FHot liquid 130-160 FCold Foods below 40 FThe breakfast burrito, cream of wheat, and coffee were served below the facility's recommended temperature ranges.On 6/30/2026 at 9:03 AM, the Dietary Manager (Staff #8) was notified of the findings.

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

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

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F 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 observation and interview, it was determined that the facility failed to ensure food items were properly labeled and stored to maintain their integrity and prevent the use of outdated food. This was evident during the initial tour of the kitchen, and this finding had the potential to affect all residents who received food prepared by the facility. The findings include: On, 6/23/2026 at 7:53 AM, during the initial tour of the kitchen with the Dietary Manager (Staff #8), the surveyor observed more than 20 plastic souffle cups containing salad dressing labeled with a preparation date of 6/9/2026. The surveyor also observed a clear container of leftover egg salad covered with a plastic wrap and labeled 6/13/2026. During the same tour, the surveyor observed two dry storage bins containing flour and sugar that were not labeled. On 6/26/2026 at 7:56 AM, Dietary Aide (Staff #22) stated that leftover food items should be labeled, refrigerated, and discarded after 3 days. On 6/26/2026 at 8:33 AM, the Nursing Home Administrator (NHA) was notified of the findings. On 6/29/2026 at 1:41 PM, a review of the facility's Storage and Use of Leftover Foods, dated February 2001 revealed that all refrigerated leftover foods must be used within 48 hours. On 6/30/2026 at 9:03 AM, Staff #8 was informed of the observations and confirmed that leftover food items were expected to be labeled, refrigerated, and discarded after 3 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, it was determined that the facility failed to promote and maintain residents' dignity by serving meals on paper trays with disposable plastic utensils for an extended period without a documented clinical or regulatory justification. This was evident for 2 (Residents #39 and #9) of 3 residents reviewed for dignity during the recertification and complaint survey. The findings include: Contact Precautions and Enhanced Barrier Precautions (EBP) are both infection-control strategies used to prevent the spread of multidrug-resistant organisms (MDRO). The key difference is that EBP targets high- risk residents without isolating them, while Contact Precautions require strict room isolation for contagious infections. On 6/23/2026 at 9:32 AM, Resident #39 stated during an interview that meals were routinely served on paper trays with plastic utensils. The resident expressed dissatisfaction with the practice. On 6/23/2026 at 9:59 AM, Resident #9 was also expressed concern regarding the continued use of paper trays and plastic utensils for meals. On 6/26/2026 at 8:27 AM, the Nursing Home Administrator (NHA) was notified of the residents' concerns and stated that paper trays and plastic utensils were being used on Unit 1 for residents on Contact Precautions, however, Residents #39 and #9 were only on EBP. On 6/29/2026 at 9:09 AM, during a follow-up interview, Resident #39 continued to express dissatisfaction, stating that using paper plates and plastic utensils was a dignity issue and that residents had not been informed why these items continued to be used. On 6/29/2026 at 9:17 AM, Registered Nurse (RN) #19 stated that residents on Unit 1 were using paper products because many residents were on Enhanced Barrier Precaution (EBP) and Contact Precautions for infection prevention purposes. On 6/29/2026 at 11:39 AM, during a telephone interview, the Infection Prevention and Control (IPC) Nurse (Staff #28) stated that after Resident #85 tested positive on 4/29/2026 for New Delhi [NAME]-beta-lactamase (NDM) Citrobacter freundii and NDM Klebsiella Pneumoniae, the facility began using paper trays and plastic utensils around the first or second week of May 2026 to reduce the risk of transmission. The IPC Nurse stated that the intervention had no established stop date. On 6/30/2026 at 9:03 AM, the Dietary Manager (Staff #8) stated that paper trays had been used on Unit 1 for more than one month. She stated she had repeatedly asked management why disposable products continued to be used and was informed the facility expected additional guidance on 6/30/2026.On 6/30/2026 at 9:51 AM, the Regional Clinical Nurse stated that representatives from the Maryland Department of Health (MDH) visited the facility during the first or second week of May 2026 and provided education regarding the organism and infection prevention practices. She stated that the facility understood from the verbal guidance that paper trays and plastic utensils should be used to prevent items from residents' room from being returned to the kitchen. She further stated that the duration of the intervention was not discussed and that the facility was awaiting Resident #85's laboratory results from the Maryland Public Health Laboratory by the end of June. When asked whether residents and/or their representatives had been notified regarding the reason for the ongoing use of disposable meal service, she stated they had been notified but was unable to provide documentation to support that notification.On 6/30/2026 at 1:29 PM, review of Resident #85's medical record revealed the resident had been transferred to the hospital on 6/26/2026 at 12:30 PM.On 6/30/2026 at 1:59 PM, the Regional Clinical Nurse provided the surveyor with a copy of the official MDH memorandum dated April 30, 2026 that had been distributed to healthcare providers, including skilled nursing facilities, hospitals, laboratories, dialysis centers, and other healthcare organizations regarding the outbreak of NDM Klebsiella Pneumoniae. Review of the memorandum revealed recommendations for infection prevention, surveillance, and clinical management; however, it did not identify or recommend the routine use of disposable meal trays, dishes or utensils as an infection prevention measure. The Regional Clinical Nurse further stated that, despite Resident #85 no longer resided in the facility, the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility continued to serve meals on disposable paper trays with plastic utensils while the IPC Nurse sought additional guidance from the MDH Epidemiologist.On 6/30/2026 at 5:33PM, the surveyor received written clarification from the Maryland Department of Health stating: As for the recommendations provided to the facility, one of our IPC specialists sent the email below to the facility administrator yesterday afternoon. We are not sure where the recommendation for paper plates and utensils originated. Thank you for reaching out. Neither the Centers for Disease Control (CDC) nor MDH requires the use of disposable dining trays or plastic utensils for residents on Transmission-Based Precautions including hvKP NDM Klebsiella pneumoniae. Reusable trays, dishes, and metal utensils are appropriate, provided they are cleaned and sanitized in a commercial dishwasher using standard hot water and detergent. No special handling of these items is required. Please remind staff to perform hand hygiene after handling a resident's meal tray and before providing care to another resident or handling clean equipment. On 7/1/2026 at 10:56 AM, the surveyor shared the written clarification to the facility's NHA.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility staff failed to protect the privacy of a resident's clinical information. This was evident for 1 (Resident #86) out of 45 residents that were in the survey sample.The findings include:During an environmental tour of the facility on 6/29/26 at 8:37 AM an unlocked medication cart with an open laptop was observed outside room [ROOM NUMBER]. Closer inspection revealed that Resident #86's medications and some personal information were onscreen and visible. This surveyor then stood two feet away from the medication cart to continue the observation.Licensed Practical Nurse (LPN) #5 came out of the room at 8:38 AM, went to the cart and opened the controlled substance logbook. He searched through the logbook and called back to the resident to let the resident know he was searching for information regarding whether the resident was administered a particular medication or not. LPN #5 came out of the room again, went to the cart, looked at the computer screen, closed the window on the computer screen, and then locked the cart. Another nurse approached the cart; LPN #5 informed her of the medication issue. They went into the room and talked to the resident. When LPN #5 came out of the room again at 8:43 AM this surveyor interviewed him. This surveyor shared the above observations and asked if what he did was appropriate. LPN #5 acknowledged the observations, did not deny leaving the screen visible, and stated he would correct his actions.The findings were shared with the Administrator on 6/30/26 at 9:30 AM.

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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 ensure a resident's psychotropic drug regimen was free from unnecessary medications by failing to timely act upon a pharmacist's recommendation to evaluate, add a duration, or implement a stop date for an active as needed (PRN) anxiolytic medication. This was evident for 1 (Resident #18) of 5 Resident records reviewed for unnecessary medication during the recertification survey process.The Findings Included:A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.On 06/25/2026 at 10:15 AM, a review of the Resident#18's clinical records revealed that on 04/08/2026 a monthly pharmacy review of the resident's medication was conducted and the Pharmacist's recommendation showed that: Resident #18 had an order of hydroxyzine 50mg PO Q12 hours PRN anxiety. Re-evaluate the continued use of Hydroxyzine PRN, perhaps consider adding a duration of therapy or a stop date.Another pharmacy review conducted on 06/01/2026 by the pharmacist indicated for the second time that Resident#18 had an order of hydroxyzine 50mg PO Q12 hours PRN anxiety. Re-evaluate the intent for duration of therapy consider duration or stop date. Documentation showed that the resident's provider did not review or sign off on either recommendation until 06/24/2026 (a delay of 77 days), at which point they marked Agreed and added a comment to refer to psych.On 06/25/2026 at approximately 10:25 AM, a review of the Medication Administration Record (MAR) confirmed the resident continued to hold an active order for Hydroxyzine Pamoate 50 MG Capsule (1 capsule PO Q12H PRN for Anxiety) from its start date of 04/07/2026. The MAR revealed that the resident received a single dose of hydroxyzine for anxiety on the following dates: 04/26/2026, 05/04/2026, 05/08/2026 and 06/04/2026. The order for the above-mentioned medication was finally discontinued on 06/24/2026. However, a new order was placed on 06/24/2026 for hydroxyzine Pamoate Oral Capsule 50 MG (Hydroxyzine Pamoate) Give 1 capsule by mouth every 12 hours as needed for Anxiety for 2 Months.A review of the order details in the resident's chart revealed that Hydroxyzine Pamoate was classified as an antianxiety agent.On 06/25/2025 at 3:20 PM, in an interview with the Director of Nursing (DON), the DON was asked about how the facility prescribe psychotropic medication duration and he explain that the duration differed based on the resident's needs and healthcare provider's order. He was asked specifically about Resident #18's Hydroxyzine order and he explained that because hydroxyzine was not classified as a psychotropic medication the doctors would typically use a longer duration when order. The surveyor communicated to the DON that medication was being used for anxiety and documentation from the healthcare practitioner about the duration rationale was needed if being used to treat anxiety. The DON verbalized understanding stated that he was not sure if the doctor documented the rationale for the extended duration.On 6/26/2026 at 8:56 AM, in an interview with Registered Nurse (RN)#25, She was asked what she expected to see for resident who were receiving PRN psychotropic medications and she explained that she expected to see a psychiatric evaluation, a numerical tool used to document behavioral monitoring of symptom every shift, documentation about the medication effectiveness after administration. She was asked if there was a duration for PRN psychotropic medications and she stated that the duration varies based on physician order.On 06/26/2026 at 9:03 AM, in an interview with RN#7, she was also asked about the process for obtaining and monitoring PRN psychotropic medications. She explained that the PRN psychotropic medications were usually prescribed for symptoms such as agitation/anxiety, the nurse would ensure that the right medication was prescribed to treat the resident's symptom, they also monitor for the effectiveness of the medication. The behavioral monitoring tool is connected to the psych order and are completed each shift. She was asked if there a duration for the psychotropic medication and she replied Yes, the duration varied based on the resident and the psychiatric (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. The psychiatric provider re-evaluate the medication and the resident need and may adjust the orders if needed. RN#7 was asked to clarify if the resident was seen by psych and she reported that the only psych notes in the resident's record were from January 2026 (confirming the surveyor finding).On 06/26/2026 approximately 10:00 AM, in an interview with the DON, he was asked to explain the monthly pharmacy review process, and he reported that when the pharmacy review was completed the facility would receive a copy of the review and if there were no recommendations the nurses notify the physician and document. If pharmacy recommendations were made the nurse practitioner (NP) should review the recommendation within 7 days.The DON was notified that the pharmacy review completed on 04/08/2026 indicated that Resident #18's hydroxyzine needed a duration or stop date; However, the duration date was not added until 06/24/2026 and not within the 7-day period as he stated.06/26/2026 3:20 PM, in an interview with the DON and Regional clinical nurse, they were notified of findings related to pharmacy review. The DON stated that he spoke with the physician when the finding was brought to his attention. The regional clinical nurse stated that they will ensure that a psychiatric consult would be obtained, and she informed the DON to ensure that the doctor placed a note in the resident's chart to address the PRN hydroxyzine duration.

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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 clinical record review and staff interview it was determined that the facility staff failed to ensure a resident's annual Minimum Data Set (MDS) was accurate. This was evident for 2 (Resident #10 and Resident #17) out of 30 residents reviewed for MDS assessment during the annual survey. The findings include:A colostomy is a surgical procedure which involves creating a hole in the abdominal wall called a stoma, through which a portion of the colon is brought to the surface and attached to a pouch outside the body to collect stool (colostomy bag). The Minimum Data Set (MDS) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned for based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 6/23/2026 at 8:25 AM, during the screening process of the survey, the surveyor observed that Resident #17 had a colostomy with a pouch on the lower area of his/her abdomen. The Resident stated that the procedure was done in the hospital. A review of Resident #17's medical record on 6/24/2026 at 1:00 PM, revealed a hospital Discharge summary dated [DATE] documented the following: [AGE] year-old admitted for acute kidney injury, Chronic kidney disease, heart failure, malignant neoplasm of rectum, asthma, chronic obstructive pulmonary disease, history of Lynch Syndrome status post colectomy/colostomy. On 6/24/2026 at 1:09 PM, a review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated in Section H (Bladder and Bowel Appliances) were coded as No ostomy present. Further review of the clinical record revealed there was no current comprehensive care plan addressing colostomy care, and there were no active physician orders instructing nursing staff on how to manage the residents' colostomy and perform stoma care. During an interview on 6/26/2026 at 3:00 PM, the MDS Coordinator (Staff # 20) acknowledged that the colostomy was missed during the assessment process and was not captured on the MDS, leading to the omission of colostomy care in the resident's care plan. The MDS coordinator agreed that this was a concern and stated that the MDS would be corrected. On 06/26/2026 3:15 PM, the surveyor shared the findings with the DON and the Regional Clinical Nurse, who stated that the MDS Coordinator had shared the concern, They agreed that the MDS should have captured the colostomy either from the hospital discharge summary, or from the resident's physical assessment. 2) A review of Resident #10's clinical record on 6/26/26 at 2:00 PM revealed the resident was prescribed insulin and was being administered daily injections. A review of the resident's annual MDS, completed on 6/17/26, section N Medications on 6/26/26 at 2:10 PM revealed that the facility staff noted that the resident did not receive any injections and was not on insulin. This surveyor interviewed the MDS coordinator (Staff #20) on 6/26/26 at 2:30 PM. This surveyor shared the above findings with her. This surveyor informed her that insulin was not listed in the medication section. She replied Oh, it wasn't? I'll have to take a look. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #20 returned to the conference room on 6/29/26 at 3:00 PM and told the survey team that insulin was not listed in the MDS but should have been under Section N. Administrator was informed of the findings on 6/30/26 at 9:30 PM.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that the facility failed ensure physician orders were obtained and implemented in accordance with their assessed needs and individualized care plans by: 1) failing to obtain and implement physician orders for turning and repositioning dependent residents; and 2) failing to obtain a physician order that included the clinical indication for a resident's chronic urinary catheter. This was evident for 2 (Resident #1 and #6) of 3 residents reviewed for positioning and mobility, and for 1 (Resident #1) of 3 residents reviewed for urinary catheter management during the annual and complaint survey.The findings include:1a) According to the Mayo Clinic, a contracture is a condition where muscles, tendons ligaments, or skin tighten, restricting the normal movement of the affected body part. This can lead to a joint being stuck in a bent or flexed position.The MDS (Minimum Data Set) assessment is a standardized tool used to evaluate the residents' functional, physical, and psychosocial status and to guide individualized care planning.On 6/26/2026 at 11:07 AM, a review of the Resident #1's medical record revealed diagnoses that included:Contracture of the right and left hips;Contractures of the right and left knees;Contractures of the right and left elbows; andContractures of the right and left wristsReview of the MDS assessment with an Assessment Reference Date (ARD) of 5/11/2025 revealed impairment in range in motion of both upper and lower extremities.Review of the comprehensive care plan, initiated 1/14/2025, included the intervention, Assist resident to turn/reposition at least every 2 hours. However, review of the physician orders revealed no corresponding order directing staff to turn and reposition the resident every two hours.On 6/29/2026 at 9:15 AM, Geriatric Nurse Assistant (GNA) #15, stated that the GNAs and Nurses were responsible for turning and repositioning residents. GNA #15 explained that documentation of this task should be completed on the GNA Task Care Record; however, the record was not available for staff to document completion of the intervention.On 6/29/2026 at 12:28 PM, The Regional Clinical Nurse provided Treatment Administration Records (TAR) for January through March which reflected nurses' documentation of turning and repositioning. She acknowledged that beginning in April 2026, the facility failed to enter the corresponding physician order, resulting in the intervention no longer appearing on the TAR. She confirmed the omission and stated that the order would be entered.On 6/29/2026 at 1:14 PM, review of the physician orders revealed a new order stating, Turn and reposition resident every 2 hours every shift, entered at 12:42 PM, after surveyor inquiry.1b) On, 06/29/2026 at 1:16 PM a review of Resident #6's medical record revealed diagnoses of Hemiplegia (paralysis) and Hemiparesis (weakness) affecting right dominant side.Review of the Quarterly MDS assessment with an ARD of 6/3/2026 revealed bilateral upper and lower extremity range-of-motion limitations and coded the resident as dependent for bed mobility.Review of the care plan initiated 2/25/2026, included the intervention, Assist resident to turn/reposition at least every 2 hours. However, there was no corresponding physician order directing staff to provide this intervention.Further review revealed that neither the GNA Task Care Record nor the TAR included the turn-and-reposition intervention or provided a means for nursing staff to document completion.On 6/30/2026 at 9:24 AM, the Regional Clinical Nurse acknowledged the concern and stated the facility initiated an audit and staff in-service on 6/29/2026 to address the missing turn-and-reposition orders and documentation. 2) On 6/30/2026 at 8:13 AM, a review of Resident #1's medical record revealed a diagnosis of obstructive and reflux uropathy. Current physician orders included:Change catheter per physicians order. 16 French suprapubic catheter 10 mL Balloon.Change catheter site dressing: weekly and as needed.Change catheter tubing and drainage bag for malfunction, contamination, odor or sedimentation as needed.Place catheter in Foley privacy bag.However, the physician orders did not include the clinical indication for the resident's chronic urinary catheter.On 6/30/2026 at 9:34 AM, Registered Nurse (RN) #19 stated that the facility utilizes a batch order process when entering urinary catheter orders.On 6/30/2026 at 12:03 PM, the Director of Nursing (DON) stated that it was the facility's expectation that residents urinary catheters have (continued on next page)

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Future Care Homewood	2700 North Charles Street Baltimore, MD 21218

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders that include the appropriate diagnosis or clinical indication.On 6/30/2026 at 1:57 PM, a review of the facility's Urinary Catheter policy, revised on 8/24/22, indicated that a physician's order is required for indwelling, coude, suprapubic and straight catheterization.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review ad interview, it was determined that the facility failed to ensure that a resident with a pressure ulcer received treatment in accordance with the wound physician's recommendations to promote healing. This was evident for 1 (Resident #1) of 2 residents reviewed for pressure ulcer during the recertification and complaint survey.The findings include:A pressure ulcer, also known as a bedsore or pressure sore, is an open wound that occurs when skin is damaged by prolonged pressure. Pressure ulcers can range in severity from discoloration to open sores that expose bone or muscle. They can be painful and take a long time to heal. Pressure ulcers often develop on bony areas of the body, such as the heels, ankles, buttocks, hips, tailbone, and back. They can occur in people who are bedridden or use a wheelchair and are more likely to develop in areas where the body rests against the chair or bed. On 6/29/2026 at 8:04 AM, a review of Resident #1's medical record revealed that the resident was evaluated by the wound physician on 6/22/2026 for a Stage 4 pressure ulcer of the left lateral knee. The wound physician documented the following treatment recommendations: Sodium hypochlorite solution (e.g. Dakins) apply once daily and as needed: if saturated, soiled, or dislodged. For 10 days: Use 1/4 strength Dakins wet to moist; Santyl ointment apply once daily and as needed: if saturated, soiled, or dislodged for 10 days. However, a review of the active physician orders revealed that the resident continued to have an order dated 5/26/2026 that directed staff to: Cleanse wound to left lateral knee with normal saline, pat dry apply collagen powder and Hydrofera Blue Foam, cover with bordered gauze once daily every shift. The active physician order did not reflect the wound physician's treatment recommendations dated 6/22/2026.On 6/29/2026 at 9:05 AM, the Wound Physician stated that he conducts wound rounds every Monday with his assistant and the facility's wound nurse. He stated that wound notes and treatment recommendations are provided to the facility, uploaded into the medical record, and the nursing staff is responsible for entering the corresponding treatment orders into the electronic medical record. On 6/29/2026 at 9:17 AM, Registered Nurse (RN) #19 stated that following wound rounds, the wound physician provides treatment recommendations to the wound nurse, who then enters the order into the electronic medical record. On 6/29/2026 at 11:04 AM, Licensed Practical Nurse (LPN) #16, stated that he/she accompanies the wound physician during wound rounds every Monday and Thursday. LPN #16 stated that after wound rounds, he/she accesses the wound vendor's portal, uploads the wound physician's notes into the medical record, and notifies the attending physician for approval before entering the treatment orders into the electronic medical record. When informed that active physician order did not match the wound physician's documented recommendations, LPN #16 and the Regional Clinical Nurse stated they would verify the discrepancy. On 6/29/2026 at 11:29 AM, the Regional Clinical Nurse stated the Resident #1 had been receiving Santyl treatment for several months and was unsure why the updated wound treatment order had not been entered following the wound physician's recommendations. On 6/30/26 at 1:01 PM, a review of Resident #1's physician orders revealed that, on 6/29/26 at 2:08 PM, a new order had been entered that reflected the wound physician's recommendations. The new order directed staff to Cleanse wound to left lateral knee with Dakin's. Apply collagen sheet with Hydrofera blue to the wound base. Cover with dry dressing three times weekly on Monday, Wednesday, and Friday.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interviews, the facility failed to 1) ensure that oxygen was administered as ordered, and 2) ensure residents' oxygen tubing was labelled and placed in the resident's nose as ordered. This was evident for 2 (Resident #17 and Resident #98) out of 3 residents sampled for oxygen use during the recertification/complaint survey. The findings include: 1) On 6/23/2026 at 7:55 AM, during the initial screening process of the survey, Resident #17 was observed in bed receiving supplemental oxygen through a nasal cannula. The concentrator flow meter was set at 2.5 Liters per minute (L/min). The resident was unsure whether the oxygen flow should have been 2 L/min or 3 L/min. On 6/25/2026 at 10:40 AM, a review of Resident #17's electronic record revealed an active order dated 5/26/2026 for Oxygen via Nasal Cannula at 3 LPM every shift for COPD. An additional observation on 6/25/2026 at 11:03 AM, revealed that Resident #17's oxygen flow meter remained at 2.5 L/min. Staff #5 was present in the resident's room and verified the finding. On 6/25/2026 at 11:10 AM, during an interview with Staff #5, the surveyor asked how much oxygen the resident was supposed to receive? Staff #5 reviewed the order on the computer, stated that it should be 3 L/min, and immediately went to the resident's room to adjust the oxygen flow meter setting to 3 L/min. On 6/25/2026 at 11:12 AM, the unit manager (Staff #6) was informed of the findings and was notified that this was a concern because the resident was not receiving the amount of oxygen that was ordered. On 6/25/2026 at 12:17 PM, the Director of Nursing (DON) and the Regional Clinical Nurse were made aware of the concern. The DON stated that he had also been informed of the surveyor's finding by the unit manager (Staff #6). 2) During the initial tour of the facility this surveyor observed on 6/23/26 at 8:10 AM Resident #98's nasal cannula to be out of the resident's nose with no sign of tape or other measure used to ensure the nasal cannula stayed in the nose. It was further observed that the oxygen tubing was not labelled. This surveyor interviewed Nurse #21 on 6/23/26 at 8:23 AM. This surveyor showed him the resident and said the resident is on oxygen. He replied ok. This surveyor asked him if the nasal cannula should have been in their nostrils. He replied yes. He was asked if the tubing should have been labelled and he replied labelled? This surveyor then said the oxygen tubing should have been labelled and he replied ok. The Administrator was informed of the findings on 6/30/26 at 9:30 AM.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff interview it was determined that the facility staff failed to document attempts at non-pharmacological interventions prior to a resident being administered a pain medication. This was evident for 3 (Resident #124, Resident #18, and Resident #10) out of 5 residents sampled for unnecessary medications during the recertification/complaint survey. The findings include: Non-pharmacological 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. 1) On 6/25/2026 at 8:58AM, during a review of pain medications for Resident #124, the surveyor noted an order dated 6/16/2026 as follows: Acetaminophen (Tylenol) tablets 325 mg, give 2 tablets by mouth every 4 hours as needed for Pain 1-5 and oxycodone oral tablet 10, give 1 tablet by mouth every 4 hours as needed for pain 6-10. Further review of the Resident's Medication Administration Record (MAR) on 6/25/2026 at 09:05 AM, revealed that Resident #124 was administered Tylenol on 6/3/36, 6/16/26 and two times on 6/25/2026. Additionally, Oxycodone was administered two or three times everyday from 6/1/26 to 6/24/26. On 6/25/2026 at 09:30AM, a review of the resident's Treatment Administration Record (TAR) and Progress noted failed to show any documentation of nonpharmacological interventions attempted prior to administering these pain medications. On 06/25/2026 at 3:00 PM, in an interview with the Director of Nursing (DON), The DON acknowledged that staff were not completing the non-pharmacological interventions for pain management. He stated that he has initiated an in-service for staff to document in the progress notes the non-pharmacological interventions for pain management. 2) On 06/25/2026 at 9:09 AM, a review of Resident #18's current physician orders revealed the following active PRN (as-needed) narcotic orders for pain control: Oxycodone 5mg PO (oral) PRN every 4–6 hours for moderate pain (pain scale level 4–6) start date 05/12/2026. Oxycodone 10mg PO PRN every 4–6 hours for severe pain (pain scale level 7–10) start date 05/07/2026. On 06/25/2026 at 09:10 AM, a review of Resident #18's Medication Administration Record (MAR) revealed that oxycodone 10mg was administered 13 times in June 2026 and Oxycodone 5mg was administered 6 times in June 2026. On 06/25/2026 at 12:01 PM, a review of Resident #18's medical records revealed that the at risk for pain care plan was initiated on 05/12/2026 and it identified that staff would implement non-pharmacological approaches such as relaxation, guided imagery, music, distraction and massage before, after and if possible, during painful activities or before pain occurs. Further review of the resident's record showed that Resident #18 received oxycodone starting on (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/07/2026; however, an actual pain care plan was not initiated until June 25, 2026. On 06/25/2026 at approximately 12:08 PM, a review of Resident#18's medication and/or treatment administration record revealed no documented evidence to support that the facility implemented non-pharmacological interventions prior to the administration of opioids. On 06/25/2026 at 3:13 PM, in an interview with the Director of Nursing (DON), the DON was notified that the facility failed to document non-pharmacological pain management interventions as care planned. The DON acknowledged that they were not completing the non-pharmacological interventions for pain management. He stated that he has initiated an in-service for staff to document in the progress notes the non-pharmacological interventions for pain management. 3) A review of Resident #10's clinical record on 6/26/26 at 12:50 PM revealed that the resident was prescribed Tylenol 325 mg every 6 hours as needed for pain. The resident had a care plan to address pain that was created on 11/28/23. One of the approaches, created on 4/15/26, was Implement non-pharmacological approaches such as relaxation, guided imagery, music, distraction, and massage before, after, and if possible during painful activities or before pain occurs. A review of the clinical record revealed that there was no evidence that staff documented that they attempted non-pharmacological interventions and failed to document whether the interventions were successful. The Administrator was informed of the findings on 6/30/26 at 9:30 AM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility staff failed to lock a medication cart. This was evident for 1 (Resident #86) out of 45 residents that were in the survey sample.The findings include:During an environmental tour of the facility on 6/29/26 at 8:37 AM an unlocked medication cart with an open laptop was observed outside room [ROOM NUMBER]. Closer inspection revealed that Resident #86's medications and some personal information were onscreen and visible. This surveyor then stood two feet away from the medication cart to continue the observation.Licensed Practical Nurse (LPN) #5 came out of the room at 8:38 AM, went to the cart and opened the controlled substance logbook. He searched for information regarding whether the resident was administered a particular medication or not. LPN #5 came out of the room again, went to the cart, looked at the computer screen, closed the window on the computer screen, and then locked the cart. Another nurse approached the cart; LPN #5 informed her of the medication issue. They went into the room and talked to the resident. When LPN #5 came out of the room again at 8:43 AM this surveyor interviewed him. This surveyor shared the above observations and asked if what he did was appropriate. LPN #5 acknowledged the observations, did not deny leaving the medication cart unlocked, and stated he would correct his actions.The findings were shared with the Administrator on 6/30/26 at 9:30 AM.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on record review and interviews, it was determined that the facility failed to provide or obtain from an outside resource routine dental service to meet the needs of each resident. This was evident for 1 (Resident #19) of 1 resident reviewed for dental services during the recertification survey process.The Findings Included:On 06/24/2026 at 11:20 AM, during Resident #19's interview the resident revealed that he/she would like to see a dentist because his/her dentures were not fitting well. The surveyor observed that the resident had no teeth in his/her mouth.On 06/26/2026 at 9:31 AM, a review of the Resident #19's medical record revealed that oral screenings where conducted on 4 separate occasions (7/18/2025, 10/18/2025, 1/18/2026 and 4/18/2026) and each dental screen revealed that the oral assessment identified the resident's mouth condition as edentulous and dental consult needed; however, there was no documented evidence to support that dental consult was obtained at anytime since the resident's admission in April 2025.On 06/26/2026 at 11:55 AM, in an interview with the Director of Nursing (DON), the DON was asked how often dental visits were provided to the residents. The DON reported that the dentist was to complete annual assessments for each resident and once the dental visit is completed the company will send a copy of the resident's assessment and the medical record staff will upload the document into the resident's electronic health record, under the documentation section/tab. The surveyor and DON reviewed the resident's chart to find that there was no documentation that a dental visit was completed for this resident. The DON stated that it is possible that the documentation was sent but have not been uploaded into the medical record and therefore he will check and provide further update to the surveyor.06/26/2026 at 1:28 PM, in an interview with the DON, he clarified that through an outside company the facility offered one dentist visit and 2 dental hygienists visit per year; however, Resident #19 was not enrolled in the dental program. The DON was asked to explain why the resident was not enrolled and he reported that it was an oversight. [He/She] was enrolled today. The DON was notified that the above-mentioned finding was a concern.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, resident interview, and staff interview it was determined that the facility staff failed to ensure a resident's showers were documented accurately. This was evident for 1 (Resident #8) out of 1 reviewed for showers during the recertification/complaint survey.The findings include:During the initial tour of the facility Resident #8 was interviewed on 6/23/26 at 9:09 AM. This surveyor asked if the resident receives two showers each week. The resident replied that they would like to get showers but has not received one. Resident said they only get bed baths because staff would not take them to the showers. A review of the resident's annual minimum data set (MDS) on 6/25/26 at 8:12 AM under Section F the resident replied that it was Very Important for them to choose whether they received a shower or a bath. Further review of the resident's clinical record revealed that under the Documentation Survey Reports for April, May, and June 2026 the resident did not receive a shower but only bed baths. This surveyor interviewed the Fourth Floor Unit Manager (Staff #14) on 6/29/26 at 8:20 AM. This surveyor asked if the resident takes showers or gets bed baths. She said the resident took a shower last week, but the resident almost always refuses. The resident especially refused on dialysis days. This surveyor asked why haven't you changed the resident's shower days to ones not on dialysis days. Staff #14 responded, oh, [he/she] doesn't have an issue with showers on dialysis days. We just have to encourage [him/her]. She then added that the resident received showers on 6/18/26 at 4:09 PM and on Friday 6/25. Later, she shared with the surveyor several shower sheets. Two were for 6/18 and 6/19 which showed the resident received a shower and the staff person for both was Staff #13.This surveyor interviewed Staff #13 on 6/29/26 at 11:41 AM. This surveyor asked if she gave the resident a shower in the last three months. She replied she has given the resident many showers. This surveyor showed her the documentation that suggests the resident has not received a shower in the last three months. She replied that she did not put the showers provided into the system because she doesn't normally give showers. She was asked why she doesn't normally give showers. She replied because she is a certified medication aide (CMA) but did it because it was easy to give the resident showers. She added that the resident does not fight or resist showers. She was not able to explain why the resident was documented as not getting showers. She confirmed that she understands what the documentation suggests but she stated, again, that she gave the resident showers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility staff failed to follow enhanced barrier precautions. This was the result of a random observation during the recertification/complaint survey.The findings include:During a tour of the facility on 6/25/26 at 9:15 AM Staff #11 and Staff #12 were observed entering room [ROOM NUMBER]. The door had a sign alerting anyone entering the room that there were enhanced barrier precautions in place.Enhanced barrier precautions required using hand sanitizer prior to entering the room and prior to exiting the room. The precaution also required using gloves, gown, and mask prior to contact with the resident as well as contact with the resident's linen.The two staff entered without using hand sanitizer prior to entry. The two were observed to have touched the bed several times, they touched the sheets, the air mattress and the air mattress device which maintained the air content. The two left the room after approximately two minutes. While they were gone this surveyor used hand sanitizer from a hallway dispenser and entered the room. This surveyor, after looking at what the staff had touched, attempted to use the hand sanitizer dispenser in the room but nothing dispensed. This Surveyor tried two more times and nothing dispensed. Surveyor then used the closest one in the hallway. Staff #11 re-entered the room at 9:19 AM with the unit manager (Staff #14) and neither used hand sanitizer prior to entering the room. Upon walking to the doorway two minutes later they were just about to go out the door when Staff #14 saw this surveyor observing them. She touched Staff #11's arm and appeared to tell her to use the sanitizer dispenser inside the room. They put their hands under the dispenser and then they rubbed their hands together. This surveyor interviewed Staff #11 at 9:21 AM. She was informed of the observations. She made no statement and provided no explanation. This surveyor stated it was for her welfare as well as the residents for her to pay attention to the infection control signs and to practice hand hygiene. She replied, is that everything? This surveyor said yes. She turned around and walked away.This surveyor interviewed Staff #12 on 6/25/26 at 9:23 AM. He was informed of the observations. He replied oh no, I forgot. I'll pay more attention next time. Thank you for reminding me. This surveyor told him it was for his benefit, the benefit of the residents, and for his family. He replied oh yes, I have a daughter at home I don't want to bring anything back to her. Thank you for reminding me to look for the signs.The Administrator was informed of the findings on 6/30/26 at 9:30 AM.