STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Haven Nursing and Rehabilitation Ctr	701 Edmondson Avenue Catonsville, MD 21228

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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 medical record review and interview with staff it was determined the facility staff failed to report an allegation of abuse to the State Agency in a timely manner. This was evident for 1 resident (#2) during review of 1 of 9 complaints related to Resident Rights and 2 (#10, #28) of 7 residents reviewed for abuse. The findings include: 1) Resident #2's medical record was reviewed on 4/28/25 at 10:53 AM. The record revealed a progress note written by Staff #11 the Attending Physician on 2/3/25 at 12:15 PM which included but was not limited to: Patient initially irate, angry that s/he is not allowed to smoke marijuana for pain management at the facility, states I am a long-term advocate for marijuana for pain management and I will sue this place if I become addicted to morphine. Further review of the medical record revealed a nursing progress note written by Staff #9 on 2/7/25 at 5:06 AM. The note included: . resident was cussing, yelling and screaming that his/her marijuana was stolen, I, the nurse then call the supervisor, supervisor and the nurse went into residents' room . In an interview on 4/29/25 at 8:05 AM Staff #9 was asked about the events on 2/7/25. She stated it was early in the morning. S/he refused care, started yelling and cursing, said if I give him/her his/her marijuana s/he would not call the police. Staff #9 indicated that the resident did not identify who stole his/her marijuana or when. Staff #9 also stated I did not know anything about Resident #2's marijuana. Residents here can't have marijuana. I don't even know what it looked like. I asked other staff if they knew anything, no one saw or knew about his/her marijuana. When asked if she reported Resident #2's allegation to Administration she indicated that she wrote a note in the resident's chart and on the 24-hour report, reported what had happened to the oncoming nurse at shift change and that the nursing supervisor was present and heard the allegation. She indicated that the nursing supervisor no longer works in the facility. On 4/29/25 at 8:12 AM the Administrator was asked if the facility reported the allegation to the state or other agencies. She indicated she would check. On 4/29/25 at 10:48 AM Staff #10 the Clinical Services Director confirmed that the facility did not report the allegation. The above concerns were reviewed with the DON on 4/30/25 at 12:50 PM. Cross reference F 610. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 4/23/25 at 3:00 PM, a review of a facility reported incident MD000208346 alleged that during an altercation, Resident #28 hit Resident #10 on the head with his/her cane causing a laceration to Resident #10's head. The facility's investigation documented the incident occurred on 7/26/24 @ 4:30 PM. The facility's investigation did not include documentation as to when the incident was sent to OHCQ and when the final report was sent and the surveyor was not provided with documentation as to when the incident was sent to OHCQ and when the final report was sent. The above concerns were discussed with the Nursing Home Administrator (NHA), and on 4/23/25 at 3:22 PM, the NHA reported that email confirmations of when the incident was reported to OHCQ were permanently deleted and no longer available to provide to the surveyor. On 4/30/25 at 12:45 PM, the Director of Nurses (DON) informed the surveyor that moving forward, the facility would print the email confirmations when the facility reported incidents were sent to the survey agency.

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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 medical record review and interview with staff it was determined the facility staff failed to investigate an allegation of misappropriation of resident property for 1 (#2) of 6 residents reviewed for Resident Rights; and failed to conduct a thorough investigation and prevent other potential abuse or mistreatment while the investigation was in progress for 2 (#12 and #15) of 7 residents reviewed for abuse. The findings include: 1) Resident #2's medical record was reviewed on 4/28/25 at 10:53 AM. The record revealed a progress note written by Staff #11 the Attending Physician on 2/3/25 at 12:15 PM which included but was not limited to: Patient initially irate, angry that s/he is not allowed to smoke marijuana for pain management at the facility, states I am a long-term advocate for marijuana for pain management and I will sue this place if I become addicted to morphine. Further review of the medical record revealed a nursing progress note written by Staff #9 on 2/7/25 at 5:06 AM. The note included: .resident was cussing, yelling and screaming that his/her marijuana was stolen, I, the nurse then call the supervisor, supervisor and the nurse went into residents' room . In an interview on 4/29/25 at 8:05 AM Staff #9 was asked about the events on 2/7/25. She stated it was early in the morning. Resident #2 refused care, started yelling and cursing, said if I give him/her his/her marijuana s/he would not call the police. Staff #9 indicated that the resident did not identify who stole his/her marijuana or when. Staff #9 also stated I did not know anything about [Resident #2's] marijuana. Residents here can't have marijuana. I don't even know what it looked like. I asked other staff if they knew anything, no one saw or knew about his/her marijuana. When asked if she reported Resident #2's allegation to Administration she indicated that she wrote a note in the resident's chart and on the 24-hour report and reported what happened to the oncoming nurse at shift change. She added that the nursing supervisor was present and heard Resident #2's allegations. She indicated that the nursing supervisor no longer works in the facility. On 4/29/25 at 8:12 AM the Administrator was asked if the facility investigated after Resident #2's allegation that his/her property was stolen. She indicated she would check. On 4/29/25 at 10:48 AM Staff #10 the Clinical Services Director confirmed that the facility did not conduct an investigation of the allegation. 2) Facility reported incident #MD00209812 involving Resident #12 was reviewed on 4/23/25 at 10:45 AM. The complaint alleged that on 9/11/24 Staff #16 a GNA (Geriatric Nursing Assistant) threw cookies at resident #12 striking him/her on the nose. The facility's final report, submitted to the state agency on 9/18/24, indicated the facility was unable to substantiate abuse. The facility's investigation documentation did not include statements from staff or residents regarding the alleged event or mistreatment by staff #16. There was no evidence that Staff #16 was removed from resident contact pending the outcome of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 11:25 AM the Administrator was made aware of these findings. The Administrator returned on 4/23/25 at 12:10 PM with 2 statements: One dated 9/14/24 included 3 questions in which Staff #16 confirmed she cared for Resident #12 on 9/10/24, (the day prior to the date of the alleged incident); She denied throwing cookies or touching the nose of Resident #12. A brief statement at the bottom indicated [Resident #12] asked me to hand [him/her] cookies, and I put the cookies on [his/her] bedside table within [his/her] reach, and that Resident #12 called her a bitch. It was signed by Staff #16 and dated 9/18/22, 2 years prior to the incident. The second statement was dated 9/14/24 from Staff #17 an LPN (Licensed Practical Nurse). It stated [Resident #12] did not report to me on 9/12/2024 that any GNA threw cookies at [him/her] or touch [his/her] nose. No statements from other residents or staff were provided. On 4/23/25 at 12:55 PM the Administrator, DON (Director of Nursing) and Staff #10 the Clinical Services Director were asked if Staff #16 was removed from resident care pending the outcome of the investigation. The DON indicated that Staff #16 was a PRN (as needed) staff member and did not work from the time of the report until after the investigation was completed. Review of Staff #16's time punch log on 4/24/25 at 8:45 AM revealed that Staff #16 was scheduled off on 9/13/24, the day the facility received the report of the alleged abuse. However, she was not removed from resident care pending the outcome of the investigation on 4/18/24, and continued to work on the unit where Resident #12 resided, on: 9/14/24 6:57 AM - 3:02 PM, 9/15/24 6:57 AM - 3:02 PM, 9/16/24 6:57 AM - 2:51 PM, 9/17/24 6:56 AM - 10:52 PM, and 9/18/24 6:59 AM - 10:55 PM. The above concerns were reviewed with the DON on 4/30/25 at 12:50 PM. 3) On 4/28/25 at 9:54 AM, a medical record review for Resident R15 revealed an attending physician's note that documented the resident had a mental health disorder and dementia with disturbances. A review of the facility's investigation file for self-reported incident #MD00209883 on 4/25/25 at 1:38 PM revealed an initial report form. According to the form Unit Manager (UM) #6 reported that on 9/16/24 at 3:30 PM she was informed that R15 reported an allegation of abuse to a therapy staff member that morning at 10:00 AM. R15 reported that Geriatric Nursing Assistant (GNA) #27 had pulled his/her hair and hit him/her with a shoe. The final report form revealed that an interview with GNA #27 revealed she reported that she had not had contact with the R15 that morning. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the file revealed staff failed to obtain a statement from R15. Facility staff failed to obtain statements from everyone who may have witnessed the incident. In addition, staff obtained a statement from GNA #27 stating she had not provided care to R15 that day. However, they failed to further investigate to determine if there was any interaction between R15 and GNA #27 as she had been assigned to the resident from 7:00 AM and 10:00 AM. During an interview with the Administrator and Director of Nursing (DON) on 4/28/25 at 2:29 PM, the DON reported that the resident had denied this incident happened during an interview. However, she reported that she and the Administrator had failed to document the interview. The DON reported that social services staff documented the interview, but she was unable to provide the documentation. She confirmed that the statements included in the investigation file were the only ones obtained during the investigation.

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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. Based on medical record review and interview it was determined the facility staff failed to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights. This was evident for 2 (#12 and #18) of 16 residents reviewed for Quality of Care. The findings include: 1) Review of a complaint on 4/21/25 at 9:22 AM revealed an allegation that the facility was not assisting Resident #12 to get to medical appointments outside of the facility. Resident #12s medical record revealed A Social Services Progress note dated 8/29/23 which indicated that a Dentist from Health Drive examined Resident #12 and recommended antibiotics and to have his/her 17th and 18th tooth extracted. The resident refused the antibiotic and refused to be transferred out. When Social Workers encourage him/her to be evaluated by an oral surgeon as recommended, he/she became very hostile and stated s/he wanted to be transferred to the University of Maryland Geriatric ER (Emergency Room). When informed that EMS would likely transport him/her to the nearest ER s/he became hostile. S/he called 911 him/herself and when told the same thing agreed to be transferred. The Social Services progress note dated 7/29/24 revealed the social worker attempted to assist Resident #12 in making an appointment. The resident was noted to yell and curse at the social worker. A Nurses Progress note on 8/7/24 at 3:40 PM revealed the DON (Director of Nursing) and Unit Manager met with Resident #12 to address concerns regarding an Echocardiogram appointment. The resident indicated that only one specific cardiologist at John Hopkins could do his/her echocardiogram, but he/she had not seen the doctor for several years. They indicated they would attempt to locate him. Review of the physicians' orders revealed on 5/7/24 a Dental consult order, 6/11/24 an order for Cardiology, neurosurgery and neurology appointments, and on 8/28/24 an order for Neurology consult. No evidence was found in the medical record that the resident went for these consults. In an interview on 4/23/25 at 9:00 AM the Administrator was asked if the facility had a log of outside appointments for Resident #12. She indicated that the resident would make some appointments on her own and did not inform the facility of the appointments. When asked who arranged transportation she indicated that the resident did at times, or the facility did and provided an escort. She was asked to provide any documentation pertaining to the residents outside appointments. In an interview on 4/23/25 at 11:25 AM the Administrator provided the surveyor with a copy of a physician's order dated 5/13/24 for a dental appointment and included a transportation log reflecting the appointment on 5/28/24. She indicated that was the only appointment scheduled by the facility that the resident attended. She was then asked if there was documentation regarding the other appointments/consults ordered by the physician. She again indicated that the resident scheduled his/her own appointments. When asked if there was documentation reflecting when and where s/he went for the appointments she indicated no. When asked if the residents were permitted to come and go from the facility without notifying the facility of their whereabouts. She indicated no, then added that Resident #12 would schedule appointments for him/herself, then cancel them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/25 12:05 PM Staff #20 the Transportation/Scheduler indicated that she worked in facility since December 2023 and was familiar with Resident #12. When asked about the process for scheduling appointments she indicated that when the physician ordered a consult or outside appointment, nursing would notify her, and she would schedule it and arrange transportation. She was asked about Resident #12 going to appointments outside of the facility with Neurology, Neurosurgeon, Dental surgeon, cardiologist, etc. She indicated that Resident #12 made appointments for him/herself. She indicated that she was not involved in any appointments beyond what she was notified to schedule and that most of Resident #12's appointments were between the Physician, Nursing and the resident, and she was not notified. Review of Resident #12s Plan of Care revealed a plan related to behavior problems, including but not limited to false accusations, refusing medications, resists care, cursing at staff, verbal aggression, calling the police/OHCQ/ombudsman etc. The facility failed to develop a Plan of Care to address Resident #12's appointments including his/her desire to see specific providers and or arrange their own appointments in the community including approaches to assist the staff in meeting the residents' individual needs based his/her preferences/choices. The above concerns were reviewed with the DON on 4/30/25 at 12:50 PM. 2) 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. On 4/22/25 at 1:09 PM, a review of complaint MD00212978 alleged that since July 2024, Resident #18 had a rash on his/her shins (the front of the leg between the knee and the ankle) and, in mid-December 2024, the rash was still there and there wasn't a current treatment for the rash. On 4/25/25 at 11:24 AM, a review of Resident #18's electronic medical record (EMR) was conducted. The medical record documented Resident #18 resided in the facility for long term care since June 2022, and had diagnoses which included dementia, hypertension (high blood pressure), and hypothyroidism (underactive thyroid). Further review of Resident #18's EMR, revealed documentation that since July 2024, Resident #18 had a recurrent rash on the front of his/her lower legs that would improve with treatment, and then recur. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's progress notes, revealed on 7/29/24 at 11:47 PM, the nurse documented that there was a rash on both of Resident #18 legs, the physician assessed the rash and ordered triamcinolone cream to be applied to the rash twice a day. In a progress note on 7/29/24 at 4:00 PM, the physician wrote that Resident #18 was seen for a rash on his/her lower extremities, that labs were ordered, the resident was to start triamcinolone twice a day for 10 days, and for the resident to follow-up with dermatology. In a progress note on 8/14/24 at 10:45 AM, the physician wrote that Resident #18 was seen for follow-up of a rash, that the resident's ANA (antinuclear antibody blood test) was mildly positive and referred to rheumatology (study of rheumatic (inflammatory, autoimmune, and degenerative) diseases), the resident was on triamcinolone and was to follow-up with dermatology. In a progress note on 12/2/24 at 11:41 PM, the nurse wrote that Resident #18 was observed with a rash to the bilateral lower extremities, the practitioner was updated and to see new orders. In a progress note on 12/27/24 at 7:30 AM, the physician wrote that Resident #18 was following with rheumatology for a persistent rash, that a course of triamcinolone was repeated with little effect, and that a second dermatology opinion would be obtained. A review of the physician orders revealed a dermatology appointment for bilateral leg rash was ordered on 1/1/25. In a progress note, on 2/18/25 at 10:30 AM, the nurse wrote that Resident #18 was not seen by the Dermatologist that day, that the practitioner was notified and ordered the appointment be rescheduled. On 4/16/25 at 11:30 AM, in a progress note, the physician wrote that Resident #18 was followed by rheumatology for a rash that had persisted, and a second dermatology opinion was pending. Review of Resident #18's physician orders revealed Triamcinolone (synthetic corticosteroid) topical cream to be applied to Resident #18's leg rash was prescribed by the physician on 7/29/24, 8/14/24, 10/30/24 and 12/2/24. The medical record also documented Resident #18 was seen by Rheumatology on 10/22/24 and 12/4/24 and seen by the Dermatologist on 10/30/24 and had a 2/18/25 order for a Dermatology follow-up appointment. Review of Resident #18's care plans revealed a 6/3/22 care plan, Resident #18 has potential for impairment to skin integrity, with the goal, Resident #18 will maintain clean and intact skin by the review date, that had approach, keep skin clean and dry. The skin integrity care plan was not comprehensive, or resident centered. Continued review of the care plans failed to reveal a comprehensive, resident centered care plan had been developed to address Resident #18's recurrent rash. On 4/24/25 at 8:56 AM, the Director of Nurses (DON) was made aware of the above concerns. The DON acknowledged the concerns and not further comments were offered at that time.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on medical record review and staff interview it was determined that the facility staff failed to provide an activities program to meet the needs and preferences of the residents and failed to develop a resident centered care plan related to activities with achievable goals and measurable objectives. This was evident for 1 (#11) of 5 residents reviewed for quality of life. 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. On 4/18/25 at 2:52 PM, a review of complaint, MD00199947 alleged that activities were not provided for Resident #11. During the survey, intermittent observations of Resident #11 were made at various times on different days. During the observations, Resident 11 was found either in his/her room, or ambulating in the hallway. Resident #11 was never observed in engaged in an activity or having a one-to-one activity with facility staff. A review of the medical record on 4/24/24 at 4:10 PM, revealed Resident #11 resided in the facility for long term care since 11/2023, and had diagnoses which included dementia with behavioral disturbance. Review of the admission assessment for Resident #11, completed on 11/27/23, documented the resident's BIMS (Brief interview for Mental Status) summary score was 5, indicating Resident #11 had severe cognitive impairment. The admission assessment's Interview for Activity Preferences, documented it was very important for Resident #11 to have books, newspapers, and magazines to read, very important for the resident to listen to music s/he liked, very important to be around animals such as pets, very important to keep up with the news, very important to do things with groups of people, very important to go outside to get fresh air when the weather was good, and very important for the resident to participate in religious services or practices. Resident #11's care plans were reviewed, and no care plan was found for activities that would have addressed the resident's activity preferences. There was a care plan for Resident #11, initiated on 11/27/23 for the category, Activities, that stated the resident is independent for meeting emotional, intellectual, physical, and social needs but requires engagement, with the goal, to encourage [Resident #11] to attend group activities, that had one approach, engaging [him/her] in music and sensory stimulation groups. The care plan indicated Resident #11, who was the cognitively impaired, was independent with meeting his/her activity needs, and the care plan goal was a facility staff intervention. The care plan was not resident centered with measurable goals and individualized approaches to meet Resident #11's activity needs and preferences. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 11:43 AM, during an interview, Staff #28, Activity Director, stated that the activity staff provided one-to-one visits to Resident #11, and the resident was invited to attend appropriate group activities. When asked how resident participation in activities was documented, Staff #28 stated that one-to-one visits and group activities attended by the resident were documented in a monthly activities record. The concerns failing to have a resident centered care plan that addressed the resident's activity preferences were discussed with Staff #28 during the interview. Staff #28 acknowledged the concerns with no explanation offered at that time. Following the interview, the surveyor was provided with activity participation logs for Resident #11 for December 2024, January 2025, and February 2025 and Staff #28 reported that no activity participation logs were found for Resident #11 to indicate the participated in activities in March 2025, or April 2025. The December 2024 Activity Participation Log for Resident #11 documented activities were provided to the resident on 4 (12/9,12/12, 12/17, 12/19) of 31 days in December. The activity log documented the activities, hydration, music enjoyment, and snack social were provided on 12/9/24, the activity hydration was provided on 12/12/24, the activities, hydration, music enjoyment, and snack social were provided on 12/17/24 and the activities,, hydration, music enjoyment, and snack social were provided on 12/19/24. The January 2025 Activity Participation Log for Resident #11 documented activities were provided to the resident on 3 (1/14, 1/17, 1/22) 31 days in January, The activity log documented the activities, hydration, music enjoyment, and snack social were provided on 1/14/25, the activities hydration, and snack social were provided on 1/17/25, and the activities, daily chronicles, hydration, and snack social were provided on 1/22/25, The February 2025 Activity Participation Log for Resident #11 documented activities were provided to the resident on 4 (2/11, 2/14, 2/20, 2/27) of 28 days in February. The activity log documented the activities, daily chronicles and hydration were provided on 2/11/25, the activities, hydration and snack social were provided on 2/14/25, the activities. hydration, and music enjoyment were provided on 2/20/25, and the activities, daily chronicles, hydration and ice cream social were provided to Resident #11 on 2/27/25. There was no documentation found that other activities were offered or that a structured plan was created every day for the resident as some of the activities documented above took place on the same day and no further documentation was provided to the surveyor to indicate Resident #11 was provided one-to-one visits or attended group activities in March 2025 and April 2025. The above concerns were discussed with the Director of Nurses (DON) and the Nursing Home Administrator on 4/25/25 at 4:10 PM, who acknowledged the On 4/25/25 at 4:10 PM, the above concerns were discussed with the Director of Nurses (DON) and the Nursing Home Administrator. The DON and NHA acknowledged the concerns at that time with no further comments offered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record reviews and interviews, the facility staff failed to follow physician orders for a resident. This was evident for 1 (#18) of 1 residents reviewed for physician services during a complaint survey. The findings include: On 4/22/25 at 1:09 PM, a review of complaint MD00212978 alleged that the same ointment had been prescribed for a rash on Resident #18's shins (the front part of the leg between the knee and the ankle) 2 times and then the rheumatologist prescribed the same ointment for the rash. The complainant alleged that the resident still had the rash on 12/18/24, and there were no current treatments for the rash at that time. On 4/25/25 at 11:24 AM, a review of Resident #18's electronic medical record (EMR) was conducted. The medical record documented Resident #18 resided in the facility for long term care since June 2022, and had diagnoses which included dementia, hypertension (high blood pressure), and hypothyroidism (underactive thyroid). Further review of Resident #18's EMR, revealed documentation that since July 2024, Resident #18 had a recurrent rash on the front of his/her lower legs that would improve with treatment, and then recur The medical record review revealed physician orders for Resident #18 to be seen by Rheumatology (specializes in rheumatic (inflammatory, autoimmune, and degenerative) diseases)) and Dermatology (specializes in skin) for his/her bilateral leg rash, and documentation that Resident #18 was seen by Rheumatology on 10/22/24 and 12/4/24 and the resident was seen by the Dermatologist on 10/30/24. Further review of the medical record revealed Resident #18 had a dermatology appointment on 2/18/25 that was cancelled and had to be rescheduled. In a progress note on 2/18/25 at 9:30 AM, the nurse wrote that Resident #18 left for a dermatology appointment. On 2/18/25 at 10:30 AM, the nurse wrote that Resident #18 returned from the appointment without being seen by the doctor because the hospital elevator wasn't working, that the practitioner was notified and an order to reschedule the dermatology appointment was obtained. Review of Resident #18's physician orders revealed a 2/18/25 order for a dermatology follow-up appointment. Continued review of Resident #18's medical record failed to reveal documentation to indicate that a follow-up dermatology appointment had been scheduled for the resident. On 4/23/25 at 12:06 PM, during an interview, Staff #20, Transportation/Scheduler, stated that s/he was responsible for scheduling appointments and transportation for the facility's residents. At that time, when asked if a dermatology appointment had been rescheduled for Resident #18 when his/her appointment was cancelled in February 2025, Staff #20 reported the appointment was not reschedule, and stated that nursing should notify him/her when an appointment needs to be rescheduled. On 4/30/25 at 10:37 AM, during an interview, Staff #11, Attending Physician indicated Resident #18 had a rash on her legs that was mild and minor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 10:37 AM, when asked if Resident #18 continued to have a rash on her lower legs, Staff #11, Attending Physician, indicated that the resident had a rash that was mild and minor, and was being followed by rheumatology and dermatology. At that time, the physician was made aware Resident #18's dermatology appointment scheduled in February 2025 had been cancelled. The physician responded that the appointment should have been rescheduled, and stated that whenever a resident was unable to be seen for an appointment, his/her expectation would be to re-schedule the appointment. On 5/1/25 at approximately 3:30 PM, the Director of Nurses (DON) and the Nursing Home Administrator (NHA) were made aware of the above concern. The DON acknowledged the concern with no further comments made at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined the facility staff failed to implement appropriate individualized interventions for residents identified at risk of developing pressure ulcers. This was evident for 1 (#14) of 16 residents reviewed for Quality of Care. The findings include: Resident #14's medical record was reviewed on 4/29/25 at 11:42 AM. The Resident was admitted to the facility on [DATE]. An admission nursing progress note dated 12/8/23 3:45 PM revealed Resident #14's skin was warm and dry with redness to groin and redness to buttock. The progress note did not include the character of the redness such as size, or if the areas were blanchable. admission Physician orders written on 12/8/23 included but were not limited to: Daily skin check, weekly skin check by Licensed Nurse on Tuesday, Braden Scale weekly x 4 start day of admission, Hydraguard (a moisture barrier cream) to buttocks redness every shift. A Braden Scale for Predicting Pressure Sore Risk is a tool used to assess a patient's risk for developing a pressure injury. An admission Braden Scale dated 12/8/23 at 7:47 PM revealed Resident #14's score was 18 points which indicated s/he was at risk for developing pressure ulcers. No Braden Scale assessments were found for 12/15/23, 12/22/23 or 12/29/23. The next Braden Scale was completed on 1/4/24 12:45 PM. The facility staff failed to follow the Physicians' order to complete Braden Scale assessments weekly x 4. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Resident #14's 5-day admission MDS dated [DATE] indicated that during the 7-day lookback period Resident #14 utilized a manual wheelchair for mobility, was dependent on others for personal hygiene, and required substantial/maximal assistance to roll left and right in bed. Section M: Skin Conditions reflected that Resident #14 was at risk of developing pressure ulcers and had no ulcers at that time. A pressure reducing device for bed and Applications of ointments/medications other than to feet were identified as the Skin and Ulcer/Injury Treatments that were in place at the time of the assessment. A 48-hour interim Plan of Care dated 12/8/23 indicated Resident #14's goal was: immediate health and safety needs will be identified, one of the approaches indicated: SKIN INTEGRITY: (X) At Risk. The facility staff failed to identify the treatments and/or interventions staff were to implement to address the residents identified skin integrity risk. The initial comprehensive plan of care dated 12/11/23 identified the Problem: Potential for impairment to skin integrity r/t (related to) incontinence. The residents' goal was: [Resident #14] will maintain clean and intact skin by the review date 3/30/24. The approaches were: Incontinence care and preventative skin care per policy and Keep skin clean and dry. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another identified problem was: [Resident #14] requires assistance with ADL's (Activities of Daily Living). The goal was: [Resident #14 will maintain a sense of dignity by being clean, dry, odor free and well groomed over the next 90 days. The Approaches included BED MOBILITY [Resident #14] is dependent. The facility staff failed to develop a Plan of Care which included the individualized resident specific measures staff were to implement based on the resident's identified needs including but not limited to how staff should address Resident #14's dependence on staff for turning and repositioning, the prescribed moisture barrier cream, and the pressure reducing device that was being used on Resident #14's bed as indicated in the MDS. A nursing progress note and the Braden assessment dated [DATE] revealed that Resident #14 was identified to have an open area on his/her sacrum. The physician was notified, and treatment was ordered. A nursing progress note dated 1/9/24 3:52 PM revealed the wound first identified on 1/4/24 and was unstageable. A wound doctor was notified, and the treatment was changed. An APM2 (Alternating Pressure Mattress) was ordered, a urinary catheter was inserted to assist in wound healing and turning and repositioning put in place. Resident #14's plan of care was updated at that time to reflect the presence of the open area and the interventions as noted including Reposition Q [every] 2 hours and as needed. GNA Point of Care documentation revealed staff did not document that Resident #14 was assisted with turning and repositioning prior to the identification of the open area, from 12/8/23 - 12/18/23, 12/20/23 - 1/10/24; or after turning and positioning was added to Resident #14's plan of care, for the dates: 1/16/24, 1/25/24 - 1/28/24, 1/31/24, 2/3/24, 2/5/24, 2/18/24, 2/21/24, 3/15/24 and 3/17/24. Staff #11 the attending physician was interviewed on 4/30/25 at 10:34 AM. The resident's open sacral wound was reviewed. He was made aware that the intervention of turning and positioning was not ordered until 1/9/24 after the wound was identified. He indicated that usually there should be a general order in place at the time of admission. He was not clear if it was a written order or standard protocol for the facility. The above concerns were reviewed with the DON on 4/30/25 at 12:50 PM. She provided a change in condition progress note dated 1/4/24 which noted Resident #14 was observed scratching the skin on his/her sacrum causing a 2x2 area open area and a small amount of blood on his/her fingers. The physician was notified; treatment and wound physician follow up were ordered. She was made aware that the facility staff failed to implement appropriate interventions for a resident identified on admission to be at risk of developing pressure ulcers.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility staff failed to ensure 1) adequate supervision while positioning a resident in bed during the provision of care and 2) residents did not have access to medications. This was evident for 2 of 30 residents (#13 and #26) reviewed for complaints and resulted in harm to Resident #13. The findings include: 1. On 4/21/25 at 9AM, a record review was conducted which revealed that Resident #13 had diagnoses which included, but were not limited to, respiratory failure with hypoxia, heart failure, wedge compression fracture of fourth thoracic vertebra, Hospice, and dementia. The MDS (Minimum Data Set) is a screening tool that is utilized to ensure each resident's individual needs are identified. A review of the MDS assessment, with an assessment reference date of 4/22/2023, identified that to turn from side to side and position body when in bed, the resident was extensive assistance on staff for the activity and required 2 staff persons to physically assist. According to the facility report MD00203380 notes dated 03/07/2024 at 11:25 AM, Resident #13 fell from bed during activities of daily living (ADL) care and as a result, he/she sustained a fracture to the left superior pubic ramus. The facility incident report described how Staff #1, a Geriatric Nursing Assistant (GNA) and the only witness to the fall, had been providing care without the assistance of another staff member. Staff #1 left the resident unattended on her left side in bed to get additional supplies to care for the resident. When Staff #1 returned to the bed Resident #13 was on the floor on his/her left side. On 4/22/25 at 8:30 AM it was discovered that Staff #1 no longer works at the facility and his/her last day of employment was 3/28/2024. The phone number provided from Human Resources was disconnected, so the Staff was not interviewed. Resident #13 remained in the facility and staff followed hospice recommendations for pain management and the daughter's wishes. During an interview the Administrator confirmed the facility staff failed to provide supervision for Resident #13 according to the ADL policy. 2. An observation on 4/23/25 at 11:50 AM of Resident (R)26's room revealed the resident had the following medications sitting out in the open on his/her over-the-bed table: 1 can of medicated spray, a container of Desitin (diaper rash cream), Pepto Bismol ultra, liquid [NAME] pectate, severe congestion liquid medication, cough syrup. During this observation R26 was interviewed. The resident reported that s/he has these medications at his/her bedside because facility staff refused to get them for the resident. The resident reported that a family member purchased the medications and brought them to him/her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 4/29/25 at 11:04 AM revealed that residents were not allowed to have medications at their bedside. She reported that she was not aware that R26 had medications in their room. The DON reported that R26 will cover the over-the-bed table with magazines and paper to hide what was on it. During this interview on 4/29/25 at 11:15 AM an observation of R26's room was made with the DON present. The DON confirmed that the medications were on the over-the-bed table. The DON reported that facility staff had a meeting with R26 and his/her family to discuss behavioral concerns in 9/2024, and denied the medications were on the table at that time. Social Services staff #8 was interviewed on 4/30/25 at 9:38 AM. He confirmed a meeting was held with R26 and his/her family on 9/24/24, in the resident's room, to discuss behaviors. He reported that he has seen medications on the resident's over-the-bed table on multiple occasions. He reported he has seen Pepto-Bismal and cough syrup. He confirmed that medications were in the room during the meeting on 9/24/24. An interview with the attending physician on 4/30/25 at 10:39 AM revealed he was aware that R26 had medications at his/her bedside. He reported that he has discussed this issue with the resident on multiple occasions and offered to prescribe them for the resident, so staff could administer them. When asked if he had assessed the resident for self-administration, he stated that he felt the resident would take excessive amounts of the medication and not adhere to the prescribed dose. Furthermore, he stated the administrative team had discussed this issue on multiple occasions but were not sure how to handle it. Facility staff continued to allow the resident to keep the medications at the bedside and self-administer the medications when it was deemed unsafe to do so. The concerns were reviewed with the Nursing Home Administrator (NHA) and Clinical Services Director #10 on 5/1/25 at 3:15 PM. The scope severity for Example #2 remained at a D.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of employee files and interviews with staff it was determined the facility staff failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs. This was evident during review of 1 (#12) of 7 residents reviewed for abuse. The findings include: During review of an allegation of staff to resident abuse, the employee file for Staff #16, a GNA (Geriatric Nursing Assistant) was reviewed on 4/23/25 at 1:25 PM. The file revealed Staff #16 was hired on 5/30/18. A General Orientation Checklist was dated 5/30/18. The record failed to contain evidence that the facility conducted initial and periodic ongoing assessments of Staff #16's ability to competently perform the skills necessary to meet the needs of the resident population of the facility. On 4/23/25 at 8:00 AM the Administrator and Staff #10 the Clinical Services Director were informed that the surveyor was unable to find Staff #16's skills assessments. The Administrator returned on 4/23/25 at 1:55 PM and confirmed there were no skills assessments for Staff #16. An interview was conducted with the DON (Director of Nursing) on 5/1/25 at approximately 12:20 PM. When asked to identify the current nurse educator she stated: currently the DON is responsible for training. When asked who conducted evaluations of staff skills competency she stated. She indicated that the pharmacy conducted medication pass observations with the nurses, then added, we don't have formal competency evaluations. She was asked how nurse and GNA skill competencies were verified. She indicated that the facility did not have a skills lab. She indicated that she would have to check. She stated, since taking the DON position I have not done it, I don't have a formal way right now. During an interview on 5/1/25 at approximately 12:20 PM the HR (Human Resources) director indicated the DON started her position in March or April of 2024.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of employee files and interviews with staff it was determined the facility Administration failed to complete performance review of every nurse aide at least once every 12 months and provide regular in-service education that was based on the outcome of the reviews. This was evident during review of 1 (#12) of 7 residents reviewed for abuse. The findings include: During review of an allegation of staff to resident abuse, the employee file for Staff #16, a GNA (Geriatric Nursing Assistant) was reviewed on 4/23/25 at 1:25 PM. The file revealed Staff #16 was hired on 5/30/18. A General Orientation Checklist was dated 5/30/18. Only one annual performance evaluation was found in the file. On 4/23/25 at 8:00 AM the Administrator and Staff #10 the Clinical Services Director were informed that the surveyor was unable to find Staff #16's yearly evaluations. The Administrator returned on 4/23/25 at 1:55 PM. She confirmed that there were no yearly performance evaluations for Staff #16. An interview was conducted with the DON (Director of Nursing) on 5/1/25 at approximately 12:20 PM. She was asked to identify who was responsible for conducting the annual performance evaluations of the nursing staff. She stated: I should do it. But, I don't think we have that process. She confirmed that yearly performance evaluations were not done for any nursing staff since she took the DON position. During an interview on 5/1/25 at approximately 12:20 PM the HR (Human Resources) director confirmed the DON took her position in March or April of 2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a psychotropic medication prescribed as needed was limited to 14 days. This was evident for 1 (#11) of 5 residents reviewed for quality of life during a complaint survey. The findings include: As needed (PRN) orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. On 4/21/25 at 2:00 PM, a review of complaint MD00213514 alleged concerns with the care Resident #11 received at the facility. On 4/25/25 at 3:00 PM, a review of Resident #11's medical record was conducted. Review of Resident #11's March 2025 Medication Administration record (MAR) revealed a 2/26/25 physician order for Lorazepam (Ativan) (anti-anxiety medication), administer 1 tablet by mouth one time a day PRN (as needed) 30 minutes prior to blood draw for dementia with behavioral disturbance. The as needed order for Lorazepam was not limited to 14 days and the order did not have a duration with a discontinuation date. Review of the medical record failed to reveal physician documented rationale for continuing the order beyond 14 days. In addition, the March 2025 MAR documented the Lorazepam was administered to Resident #11 on 3/3/25 at 5:28 AM. Continued review of the medical record failed to reveal documentation to indicate non-pharmaceutical interventions had been attempted prior to the administration of the medication. On 4/25/25 at 4:10 PM, the above concerns were discussed with the Director of Nurses (DON) and Nursing Home Administrator (NHA). At that time, the DON indicated the Lorazepam was ordered as needed prior to having blood drawn because Resident #11 frequently refused to have blood drawn for labs. The DON acknowledged the concerns at that time and expressed understanding that psychotropic medications prescribed as needed, required a stop date.

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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, record review, and interview, it was determined that facility staff failed to ensure that all medications were stored in a locked compartment that was temperature controlled. This was evident for 1 (26) of 30 residents reviewed for complaints. The findings include: An observation on 4/23/25 at 11:50 AM of Resident (R)26's room revealed the resident had the following medications sitting out in the open on his/her over-the-bed table: 1 can of medicated spray, a container of Desitin (diaper rash cream), Pepto Bismol ultra, Liquid [NAME] pectate, severe congestion liquid medication, cough syrup. During this observation R26 was interviewed. The resident reported that s/he had these medications at his/her bedside because facility staff refused to get them for him/her. The resident reported that a family member purchased the medications and brought them to him/her. An observation on 4/29/25 at 11:15 AM with the Director of Nursing (DON) confirmed the resident had medications stored on his/her over-the-bed table, however, she reported that staff had not reported this to her. During an interview with the attending physician on 4/30/25 at 10:39 AM, he reported that he was aware of the medications that R26 kept at his/her bedside. He stated he had discussed this with the resident and administration on multiple occasions. However, they failed to ensure that the medications were stored properly. The concerns were reviewed with the Nursing Home Administrator (NHA) and Clinical Services Director #10 on 5/1/25 at 3:15 PM.

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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 that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents who eat food prepared by the facility. The findings include: On 4/28/25 at 11:57 AM, the surveyor conducted a lunch tray line observation and requested the Certified Dietary Manager (CDM) to include a test tray on the cart that was going to the unit. On 4/28/25 at 9:45 AM, the surveyor and the CDM followed the cart that was brought out to the unit to conduct the test tray. The cart was parked in one area in the hallway while the nursing staff were walking back and forth to the cart and to the residents' rooms to deliver the trays. The CDM proceeded to test the food on the test tray using the facility's food thermometer. The temperatures were as follows: Egg omelet with cheese 98 degrees Fahrenheit Sausage 90 degrees Fahrenheit Milk 2% 42 degrees Fahrenheit The CDM was informed of the concern and confirmed the food temperature. On 4/28/25 at 11:30 AM, the Administrator was made aware of the food temperature concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation during the initial tour of the main kitchen with facility staff it was determined that the facility staff failed to store food items in a manner that maintains professional standards of food service safety and prepare food under sanitary conditions. This was evident during 2 of 2 tours of the kitchen. The findings include: 04/21/2025 11:02 AM, a tour of the kitchen revealed the following: 1. Grease was layered in the tiles in the cooking area near the wall. 2. Paper, cupcake paper, plastic lids, parts of boxes, and other debris were found behind and under items in the kitchen. 3. There was dust and dirt on the floors under things and behind things. There was mouse traps set up throughout the kitchen, however no droppings were found. 4. The prep supply area was littered with debris and dirty. 5. Under the sink there was a pipe with insulation around it and the insulation was coming off near the bottom. 6. There was a mouse trap under the sink. 7. A piece of bread was lying next to the ice machine. Elbow noodles were laying on two gray carts and on the floor near the refrigerator. 8. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A large bag of flour on a cart sitting open. The manager stated he was waiting for a container to dry so he could put the flour in there. He confirmed he had not even attempted to roll it up to close it until he could transfer the flour. 9. The clean food cart storage area is noted with water stain ceiling tiles, dirty floors with debride. Large hole in the wall exposing pipes and dirt. Tiles missing from the floor. On 04/21/2025 11:14 AM, An interview with the Dietary Manager was conducted. When asked about a cleaning schedule he stated he did not have one for staff to sign off on, but it was part of their duties. On 04/21/2025 12:20 PM, reviewed the cleaning schedule provided and it failed to mention cleaning the dry storage area which is downstairs. It failed to reveal that all floors were assigned to be mopped, and trash cleaned up. 4/25/25 at 8:30 AM a tour of the kitchen revealed the following: 1. Dirty mouse traps with food particles by the dishwasher. 2. Sticky floors with debride. 3. The vents from the dishwasher with a build up of grease, dust and dirt. 4. The dishwasher with dirt and food particles underneath the system. 5. Pipes under sinks with a build up of dirt and dust. 6. Black seal from the refrigerator hanging on the outside of door on the floor. 7. Bulletin board with dirt, and stain with grease. 8. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The air conditioning with black dirt, dust and debride with rolls of foil and plastic wrap sitting in front of it with the air blowing on it. 9. Dirt and debride around the piping on the floor. 10. Hand sanitizer with blacken area at the hand pump and a buildup of dirt on top of the container. 11. The stove with a buildup of dirt, dust and debride on the sides underneath and behind the stove. 12. The overhead piping with a build up of dust and grease. 13. Stove nobs filled with dirt and grease, that you cannot identify the numbers. 14. Hand sink blocked by carts. 15. Hand sinks with a build up of dirt and rust alongside of sink. 16. Clean Mixer and meat slicer left uncovered. 17. Open container with sugar and the lid sitting on the side. 18. The food carts had a buildup of dirt and food crumbs. 19. The metal connection box next to the stove and the fire suppression system had a buildup of dirt, food crumbs and mice droppings on top of the box. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	20. The Fire suppression system next to the stove had a buildup of dirt and grease. You were unable to read the gauge because of this. 4/25/25 at 9:34 AM, the Administrator made aware of the kitchen findings and had no additional comments. Cross Reference: F921 and F925

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation during tour of the facility's dumpster area, and smoking area it was determined the facility staff failed to dispose of garbage and refuse properly. This deficient practice has the potential to affect all residents. . The findings include: On 4/24/2025 at 12 PM, a tour of the Residents smoking area revealed the following: 1. The ground litter of cigarettes butts. 2. Broken Pallets and chairs sitting next to the side of the building in front of the back gate. 3. One of the front gates to the side has a latch hook that can be open by Residents and putting them at risk to elope. The gate does not close tightly. 4. The area by the back gate has a pile of plywood, broken air conditioner, buckets, and trash. 5. Another area in front of the back gate had more plywood, and 3 air conditioners. 6. The food serving cart was in disrepair in the back of the yard. 7. Commercial hair drying unit in the back yard leaning on metal doors. 8. Four air conditioners sitting in the back of the yard with 2 more food carts. 9. 2 ladders up against the wall. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. The open shed was litter with debride. 11. Multiple pieces of trash and debris were present on the ground including wood pallets and old furniture such as dressor and chairs On 4/25/25 at 8:30AM a tour of the dumpsters area revealed the following: 1. The facility's dumpsters were observed with open side doors. All doors and lids on dumpsters should remain closed to maintain cleanliness and reduce the risk of pests. 2. A pile of pallets was observed. 3. A stack of milk containers piled up and scatter around the area. The findings were reviewed with the Administrator on 4/25/25 at 10 AM. Cross Reference: F921 and F925

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined the facility Administration failed to establish and ensure: 1) a system was in place to evaluate staff performance and provide required education as determined by staff performance reviews and the facility assessment; 2) policies and procedures were available and accessible to all staff; 3) the facility had an effective pest control program. This was evident during the complaint survey and has the potential to affect all residents in the facility. The findings include: 1) The employee file for Staff #16, a GNA (Geriatric Nursing Assistant) was reviewed on 4/23/25 at 1:25 PM. The file revealed Staff #16 was hired on 5/30/18. Staff #16's electronic training transcript revealed her last training pertaining to Resident Rights was 1/16/24. She received 0.5 hours of training related to cognitive Impairment and 0.25 hours related to Dementia on 6/23/24. There was no evidence that Staff #16 was provided with additional training on cognitive impairment and mental illness to total a minimum of 2 hours annually. The file contained one annual performance evaluation during her 7 years of employment in the facility. The Administrator and Staff #10 the Clinical Services Director were made aware of these findings on 4/23/25 at 8:00 AM. On 4/23/25 at 1:55 PM, the Administrator confirmed that no additional performance evaluations were conducted for Staff #16. In an interview on 5/1/25 at 12:20 PM the DON (Director of Nursing) indicated she was the person responsible for ongoing staff training. She indicated that she conducted in-services regarding issues in the building and any new procedures, and that GNA's and licensed nursing staff received ongoing training in the electronic system. When asked how she determined what the staff training needs were, she stated, training is based on what we see. When asked to explain the process she stated we don't have a process. Training is based on identifying concerns spotted. We don't have a formal competency program. She confirmed that there was no periodic verification of staff skill performance except for the pharmacy conducting medication pass observations. She was asked to identify the person responsible for conducting the annual performance evaluations of the nursing staff. She stated: I should do it. But I don't think we have that process. She confirmed that yearly performance evaluations were not done for any nursing staff since she took the DON position. The HR (Human Resources) Director confirmed on 5/1/25 at approximately 12:20 PM that the DON took her position in March or April of 2024. 2) During interviews on 5/1/25 from 9:11 AM - 9:40 AM several staff were asked where the facility's policies and procedures were located. Staff #5 an LPN (Licensed Practical Nurse) indicated that there was a book in the nurse's station that contained the policies and procedures. The surveyor looked in the nurse's station and found no policy books. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's pest control policy on 4/23/25 at 9:08 AM revealed there was no implementation date, and they failed to fill in their designated pest management coordinator. The policy read that outdoor garbage receptacles would have lids on them and kept closed, they would dispose of garbage in a manner that does not create a breeding place for insects and rodents, and repairs to the building and equipment should be maintained to ensure prevention of pests. On 4/21/25 at 1:06 PM the pest control notebook was reviewed. There were log sheets for staff to document pest sightings that were dated 1/18/25 to current. Staff documented several sightings of pests each month, that included but were not limited to cockroaches and mice. In the notebook there were receipts from the pest control company each time they came out that included what services were provided and the recommendations they had for preventing pests. Review of the receipts for the last 6 months revealed the pest control company came to the facility once a month except in 1/25 the visits were more frequent. The pest company continually recommended that the facility maintain a more sanitary kitchen and resident rooms. In addition, they continually recommended that the facility maintain the building structures to prevent pest from entering. However, the facility failed to do so. On 4/23/25 at 2:08 PM an interview with the current Maintenance Director #15 and Maintenance Assistant (MA) #14 revealed MA #14 had been covering the maintenance department since the end of 2/25. He stated that he had not completed any recommendations from the pest control company because he was not receiving any report from them. He stated that the previous Maintenance Director received the reports via email. An interview with the previous Maintenance Director Staff #13 on 4/25/25 at 12:05 PM revealed he was not receiving a copy of the pest control report via email and was not following up with structural recommendations. The Nursing Home Administrator (NHA) was interviewed on 4/30/25 at 1:46 PM regarding pest control. She reported that they would treat the areas that pests were seen based on the log. When asked about the structural recommendations, she stated that those reports were going to the Maintenance Director to act on. She reported that when there were continued sightings of pest, she increased the frequency of the pest control company's visits to weekly. However, she was unable to provide proof that these weekly visits were requested and based on the documentation the visits were monthly. Cross reference: F812, F814, F921, and F925.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review on record review of facility documentation and staff interview, it was determined that the facility staff failed to conduct and document an accurate and comprehensive facility-wide assessment. This was evident during a complaint survey and had the potential to affect all residents within the facility. The findings include: The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services during both day-to-day operations and emergencies. The assessment must be reviewed as necessary and at least annually. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully. On 5/1/25, during an extended survey, a copy of the Facility Assessment was requested, and a binder with the facility assessment was provided. In front of the binder was a Facility Administrative Review Sheet that documented The contents of this policy manual have been reviewed and have been accepted as practice guidelines in this health center, that was signed by the Administrator, the Medical Director and the Director of Nurses on 3/27/25. Review of the facility assessment revealed a document labeled Facility Profile that documented the facility had 167 licensed beds with no average resident census listed on the profile. The profile listed the average number of staff on days was 35 and the space to record the average number of staff on nights was blank. In addition, the facility profile was not accurate and up to date. The name and contact information of the previous Administrator and the previous Maintenance Director were listed on the profile, and there was no documentation to indicate the facilities average daily census. Continued review of the facility assessment failed to reveal evidence the facility conducted and documented a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. 1) Comorbidity means having two or more diseases or conditions at the same time. A Comorbidity Code is a specific International Classification of Diseases (ICD) code used to identify a secondary medical condition that co-exists with a primary diagnosis. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility assessment included a report with the heading Diagnoses, the date range 4/27/24 - 7/26/24, and the description Diagnosis breakdown. The second page was labeled Comorbidity Analyzer, the facility's name and Resident's 122 followed by table with that listed 19 comorbidity codes, a description of the heath conditions associated with the code, such as mental, behavioral and neurodevelopmental disorders diseases of the digestive system and endocrine, nutritional and metabolic diseases) the percentage of residents in the facility with health conditions that aligned with the comorbidity code. For example, Comorbidity code F01-F99, mental, behavioral and neurodevelopmental disorders, documented that 99.2% of 121 residents were identified with mental, behavioral and neurodevelopmental disorders. Page 3 to 5 of the report had 3 columns. The 1st column was labeled resident name, followed by 50 resident names, listed in alphabetical order from A to H. The 2nd column was labeled Provider Name, followed by the name of the facility, and the 3rd column was labeled Relevant Diagnoses that listed multiple ICD codes (International Classification of Diseases) (a standardized system used to code diseases and medical conditions) for each resident on the list. Though the comorbidity analyzer identified the diagnosis codes of residents, the report was limited to 50 residents, and there was no documentation to indicate and Continue review of the facility assessment failed to reveal an assessment of the resident population including an evaluation of diseases, conditions, physical function or cognitive abilities, and overall acuity to determines the resources required for their care. The facility assessment failed to include an assessment of the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent information about the residents that may affect and plan for the services the facility must provide. 2) The facility assessment included a document labeled with the facility's name and Competency followed by table with 4 columns and 66 rows. The columns were labeled 1. Staff Competencies & Education; 2. Competency = C, Education = E; Both = CE; 3. Licensed Nurses and 4.Aides. Each row was labeled with a name of a competency, and/or an education, and followed by space in each column to document. The licensed nurse column documented CE next to 11 (Activities of Daily living, Aging Process, Antibiotic Stewardship, IV, TPN, Medication Administration, Medication Storage & Labeling, Psychoactive Medication Reduction (GDR), Respiratory Assessment & Therapeutic Modalities, Restorative, Wound Care Basic, Wound Care Complex) of the 66 competencies/education listed. The aide column documented CE next to 3 (Activities of Daily living, Respiratory Assessment & Therapeutic Modalities) of the 66 competencies/education listed. The facility's Comorbidity Analyzer report identified an average of 121 residents a month had behavioral health needs, an average of 99.2%. The facility assessment failed to address or include: the staff competencies that are necessary to provide the level and types of care needed for the resident population. There was no other documentation to indicate an assessment of their education and/or training and any competencies that are necessary to provide the level and types of care needed for the resident population, and any health information technology resources. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Continued review of the facility assessment found no documentation in the assessment of the facility's resources, such as the facility's building(s) and vehicles, medical and non-medical equipment, services provided i.e. rehabilitation therapies and pharmacy, all personnel, including managers, staff (employees and contracted providers) and volunteers, 4) There was no documentation to indicate the facility assessed residents for any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. 5) The facility assessment included a document with the heading List of Contracts, followed the name of the facility's contracted providers for rehab, hospice, pain management, wound care, psychogeriatric services and health care services. There was no documentation to indicate an evaluation of these contracts and the facility's process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements. 6) There was no documentation to indicate an evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. The concerns with the facility assessment were discussed with the Nursing Home Administrator (NHA) on 5/1/25 at 2:22 PM. The NHA acknowledged the concerns at that time and indicated she understood the purpose of the facility assessment and the concerns identified by the surveyor.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews it was determined that the facility failed: 1) to have a process to prepare and update an inventory of all property that the resident brought to the nursing facility. Including whether the resident retained possession of each item or entrusted the item to the facility for safekeeping, and identification of items valued at $100 or more and, 2) to have accurate and complete documentation regarding resident's end of life choices. This was evident for 1 (#2) of 9 residents reviewed for Resident Rights and evident for 1 (#11) of 5 residents reviewed for quality of life during a complaint survey. The findings include: 1) Resident #2's medical record was reviewed on [DATE] at 10:53 AM during review of a complaint alleging that Resident #2 was not permitted to utilize his/her motorized wheelchair while residing in the facility. No inventory of personal items was found in the record. Further review of the record revealed a nursing progress note dated [DATE] 5:06 AM by Staff #9 an LPN (Licensed Practical Nurse) which included the resident was cussing, yelling and screaming that [his/her] marijuana was stolen. In an interview on [DATE] at 8:05 AM Staff #9 indicated that she recalled the incident. When asked if the resident indicated who stole his/her marijuana or when? She stated No, and I did not know anything about [his/her] marijuana, residents here can't have marijuana. I don't even know what it looks like. I asked other staff if they knew anything, no one saw or knew about [his/her] marijuana. On [DATE] at 8:12 AM the Administrator was made aware of the above allegation and that the surveyor was unable to find an inventory of personal belongings in the resident record including the presence and disposition of Resident #2's marijuana, electric wheelchair and other belongings. She was asked to provide an inventory of personal items. On [DATE] at 10:48 AM Staff #10 the Clinical Services Director indicated that she was not able to find an inventory of belongings for Resident #2. However, she spoke to Resident #2 on [DATE] at 10:37 AM by phone. She indicated that Resident #2 reported/confirmed that [s/he] brought marijuana to the facility which was stored by the facility as well as [his/her] electric wheelchair. Staff #10 indicated that the resident reported a family member picked up the wheelchair and marijuana after Resident #2 transferred to the hospital on [DATE]. Staff #10 indicated that she was not able to find documentation regarding the marijuana, the wheelchair nor their final disposition. No personal inventory list was found. These concerns were reviewed with the DON (Director of Nursing) on [DATE] at 12:50PM. She provided the surveyor with a nursing progress note by Staff #18 an LPN, dated [DATE] 11:17 PM which indicated the resident had cannabis, a pipe and 1 pack of cigarettes on admission. They were retrieved and put in the nurse's cart. The DON also indicated that she seemed to recall Resident #2s electric wheelchair was dropped off and stored in the lobby of the facility the evening prior to [his/her] hospital transfer on [DATE]. However, there was no documented inventory of Resident #2s belongings or their disposition upon discharge from the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Policy and Procedure regarding Inventory of Residents belongings was requested. Staff #10 indicated she was unable to find a policy but provided a Leadership Policies and Procedure Subject: admission move in, new resident. The policy was Developed on [DATE] and revised on [DATE]. It described implementing infection prevention and control procedures of newly admitted residents and their belongings. #6. Stated: Personal items will be marked for identification and noted on the Resident Inventory form, signed by staff and patient or resident, or the responsible party. No other policy or procedure was provided. 2) The MOLST (Maryland Medical Order for Life Sustaining Treatment is a portable and enduring medical order form that includes medical orders for Emergency Medical Services and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. Code status refers to a patient's wishes regarding emergency medical hospitalization interventions, particularly if their heart or breathing stops On [DATE] at 2:52 PM, a review of complaint, MD00213520 alleged Resident #11 was not provided adequate care at the facility. On [DATE] at 3:00 PM, a review of Resident #11's electronic medical record (EMR) revealed Resident #11 resided in the facility for long term care since the fall of 2023, then transferred to the hospital in mid to late February 2025 and readmitted to the facility following an acute hospitalization. In the EMR, Resident #11's profile documented the resident's age, his/her date of birth , sex, location, admission date and Full Code which was highlighted to stand out in the profile and indicated Resident #11 wanted to be resuscitated if his/her breathing or heart stopped. Further review of the EMR failed to reveal a MOLST for Resident #11 in the electronic record. Review of Resident #11's progress notes revealed on [DATE] at 2:15 PM, in a physician note, the attending physician indicated Resident #11 was hospitalized for a change in mental status, and while the resident was in the hospital, Resident #11's code status was changed to DNR/DNI. On [DATE] at 3:40 PM, a review of the paper medical record for Resident #11 revealed the resident had an active MOLST form that was signed and dated [DATE] and documented Resident #11's health care agent elected No CPR, Option A-2 Do Not Intubate (DNI): comprehensive efforts may include limited ventilatory support by CPAP (Continuous positive airway pressure) or BIPAP (Bilevel Positive Airway Pressure). and do not intubate (insertion of a breathing tube for mechanical ventilation). On [DATE] at 8:25 AM, during an interview, staff were asked how they would know a resident's current code status and responded as follows: a) Staff #29, Licensed Practical Nurse (LPN) reported that in the EMR, the resident's code status would be highlighted, however s/he would confirm the accuracy of the code status with the MOLST in the resident's paper chart. b) Staff #30, LPN stated s/he would look at the MOLST in the resident's paper chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Staff #31 stated that you could see the resident's code status in the computer, however s/he would check the MOLST in the resident's paper chart, because sometime the computer was not updated. d) Staff # 5, LPN stated s/he would check the MOLST in the resident's paper chart. e) Staff #32, CMA (certified medicine aide) stated s/he would check the MOLST in the paper chart. During an interview, on [DATE] at 9:46 AM, Staff #8, Social Worker (SW) stated that a resident's active MOLST would be in the paper chart, and a copy of the active MOLST would be uploaded to the Social Service tab the resident's EMR. The SW stated that social services (SS) would confirm a resident only had one active MOLST, and when a new MOLST was developed, the previous MOLST was voided and filed in medical records. The SW stated that the highlighted code status in the resident's profile in the EMR should reflect the code status on the resident's active MOLST and could be added to the EMR by admissions, nursing or social services. Following the interview with the SW, a review of the EMR found there was not a social service tab in the electronic record for the surveyor to view or access. On [DATE] at 10:54 AM, during an interview, Staff #11, Attending Physician, stated that when Resident #11 was in the hospital, the resident was seen by the palliative care team and the resident's representative gave his/her permission to make Resident #11 a DNR (do not resuscitate). The physician stated that Resident #11's active MOLST, which documented the resident's DNR status was created in February, during the resident's last hospitalization. A continued review of the EMR revealed on [DATE] in a Comprehensive Monthly Note, the Certified Registered Nurse Practitioner (CRNP) wrote that Resident #11's was seen for a comprehensive evaluation and documented Code Status/Advanced Directives: Per hospital MOLST - No CPR, Option A. The CRNP also wrote under the heading, Advance Care Planning, that Resident #11's code status was full code, that s/he spoke to the resident's representative, that no changes were made to the resident's advanced directives during that visit, the plan of care was reviewed, and the advanced directives form was reviewed and updated. The CRNPs' documentation in the [DATE] comprehensive note was conflicting and inaccurate. The CRNP wrote that per the hospital MOLST, Resident #11 was No CPR, Option A, then further documented Resident #11 was a full code which contradicted the resident's MOLST, signed on [DATE], that documented the resident's resuscitation status was No CPR. Review of Resident #11's care plans revealed a care plan initiated on [DATE], [Resident #11] is a full code, per surrogate wishes. The care plan was inaccurate and contradicted Resident #11's active MOLST in the paper chart which documented Resident #11's health care agent elected No CPR, Option A. On [DATE] at 12:30 PM, in a facility computer, the DON, along with the surveyor, reviewed documents for Resident #11 that were uploaded to the social services tab in the resident's EMR and found an uploaded MOLST form that was signed and dated [DATE] that documented the surrogate for Resident #11 had elected CPR (resuscitation) status: Attempt CPR. The MOLST form was not voided, indicating the MOLST was active, and Resident #11 had 2 active MOLST forms in his/her medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the DON was made aware Resident #11 had 2 active MOLST forms in the medical record and the concerns with having more than 1 active MOLST forms in the medical record, the concerns with inaccurate medical records related to the resident's highlighted code status in the EMR, the concerns with conflicting documentation about Resident #11's code status by the CRNP on [DATE] in a comprehensive monthly note, and concerns with the care plan which inaccurately documented Resident #11 was a full code, were discussed with the DON. The DON acknowledged the concerns at that time, and indicated the discrepancies with the resident's code status needed to be addressed and education needed to be initiated with the social worker and with the Nurse Practitioner.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview it was determined the facility staff failed to maintain a quality assessment and assurance committee that included the Medical Director and an Infection Preventionist. This was evident during review of the Quality Assurance Performance Improvement program. The findings include: The attendance sheets for the QAPI (Quality Assurance Performance Improvement) committee meetings held from 4/2024 - 4/2025 were reviewed on 5/1/25 at 2:59 PM. The 2024 and 2025 QAPI meeting schedule reflected the dates of the monthly meetings and that Quarterly (Q) meetings were scheduled for January, April, July and October of both years. Review of the meeting sign-in sheets for each month revealed the following: 4/25/24 (Q) - The Infection Preventionist was not in attendance. 5/23/24 - The Infection Preventionist was not in attendance. 6/27/24 - The Medical Director and the Infection Preventionist were not in attendance. 7/25/24 (Q) - The Infection Preventionist was not in attendance. 8/29/24 - The Medical Director and the Infection Preventionist were not in attendance. 10/24/24 (Q) -The Medical Director and the Infection Preventionist were not in attendance. 12/19/24 - The Medical Director and the Infection Preventionist were not in attendance. 2/13/25 - The Medical Director and the Infection Preventionist were not in attendance. 3/27/2025 - The Medical Director and the Infection Preventionist were not in attendance. There were no sign-in sheets or evidence that meetings were held during: 9/2024, 11/2024, 1/2025 (Q), and 4/2025 (Q). The Administrator and Staff #10 the Clinical Services Director were made aware of these findings on 5/1/25 at 3:30 PM. The Administrator indicated that Staff #21 became the ADON (Assistant Director of Nursing) and Infection Preventionist within the past month and provided the surveyor with the names of 2 former Infection Preventionists. Re-review of the sign-in sheets revealed that neither former Infection Preventionist attended the meetings. Staff #21 was present for several meetings in the role of an MDS (Minimum Data Set) nurse, not the Infection Preventionist.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **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 maintain a safe and homelike environment for their residents. This was evident throughout the facility and had the potential to affect all residents. The findings include: An observation of the second floor on 4/23/25 at 11:38 AM revealed that the heaters in the hallway were covered with dust. In room [ROOM NUMBER] the bathroom door had scuff marks that ran up about 2 feet and the veneer was coming away from the door near the doorknob, the sink was dripping water, veneer was coming away from the door at the doorknob. In the resident's room the flooring was cracked in 2 places in the middle of the floor, the wall was damaged outside the bathroom and repaired with spackling but was damaged again and unpainted. The heating vent that was under the sink was caked with dust. On 4/21/25 at 10:44 AM an observation of room [ROOM NUMBER] revealed there were gaps where the pipes runs into the wall. The vent under the window was caked with dust. The vents that ran along the hallway outside the room were caked with dust. An observation of room [ROOM NUMBER] on 4/21/25 at 10:53 AM revealed there was no door on the resident's closet or bathroom. An interview with the Maintenance Assistant #14 on 4/23/25 at 2:08 PM revealed the facility had no preventative maintenance program to ensure that the resident rooms were maintained in a safe and homelike environment. He stated that they will fix things identified by nursing staff. When asked who was responsible for cleaning the vents that ran along the floors in the hallways and resident rooms, he reported that maintenance staff were responsible, however, he was the only maintenance person since 2/25 and did not have time to clean them. The findings were reviewed with the new Maintenance Director on 5/1/25. He acknowledged the concerns.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **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 have an effective pest control program to ensure the facility was free of pest. This was evident throughout the facility and had the potential to affect all residents. The findings include: Review of the following complaints on 4/21/25 at 9:30 AM revealed: 1. In complaint #MD00199947, the complainant noted that the facility was mice infested, and mice feces could be found all over the resident's rooms. Unable to interview the complainant as they were anonymous. 2. In complaint #MD00205374, the complainant, who did not give their name, reported while visiting a family member in the facility they saw a mouse in their room. 3. In complaint #MD00210666, the complaint, who wished to remain anonymous, reported the facility had a history of pests in the building and there was presence of rodent droppings in the kitchen. An observation on 4/21/25 at 10:25 AM of the 2nd floor revealed a room that was used to store the clean tray carts between meals. There was a 2' x 3' hole in the wall and a cockroach was crawling across the floor towards the kitchen. A bathroom that was across the hall from the clean tray cart storage room had a spider web beside the mirror. Further down the hallway was a room with no door, situated across from the soiled utility room. A small brown bug was crawling up the wall behind the sink. An observation of room [ROOM NUMBER] on 4/21/25 at 10:44 AM revealed a dead cockroach beside the resident's over-the-bed table and a mouse trap between the wardrobe and the wall. The resident stated that s/he had turned on the light in the bathroom and found more cockroaches. An observation of the bathroom revealed gaps where the pipe to the sink enters the wall. A tour of the kitchen and prep area on 4/21/25 at 11:02 AM revealed multiple mouse traps were placed under equipment and near the back doorway. The kitchen floor was dirty with layers of grease, equipment had built up dirt and grease on it, and layers of dust on hand sanitizers. A dead cockroach was observed on the first-floor landing in the stairway on 4/21/25 at 1:00 PM. On 4/24/2025 at 12 PM, a tour of the Residents' smoking area, which was enclosed in a courtyard revealed building materials, trash, and unused/broken equipment and furniture littered the area. There was an open shed that was littered with debris. An observation on 4/25/25 at 8:30 AM of the dumpsters area revealed the side doors and lids were open. There was a pile of pallets and a stack of milk containers scattered around the area. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 4/29/25 at 2:33 PM of the bathroom shared by room [ROOM NUMBER] and 203 revealed an unfinished spackled patch that measured 12 x 12. The area around the pipe was cut out in a square shape that left a 2 gap where the pipe went into the wall, allowing space for pests to enter the bathroom. A review of the facility's pest control policy on 4/23/25 at 9:08 AM revealed there was no implementation date, and they failed to fill in their designated pest management coordinator. The policy read that outdoor garbage receptacles would have lids on them and kept closed, they would dispose of garbage in a manner that does not create a breeding place for insects and rodents, and repairs to the building and equipment should be maintained to ensure prevention of pests. On 4/21/25 at 1:06 PM the pest control notebook was reviewed. There were log sheets for staff to document pest sightings that were dated 1/18/25 to current. Staff documented several sightings of pests each month, that included but were not limited to cockroaches and mice. In the notebook there were receipts from the pest control company each time they came out that included what services were provided and the recommendations they had for preventing pests. Review of the receipts for the last 6 months revealed the pest control company came to the facility once a month except in 1/25 the visits were more frequent. The pest company continually recommended that the facility maintain a more sanitary kitchen and resident rooms. In addition, they continually recommended that the facility maintain the building structures to prevent pest from entering. However, the facility failed to do so. On 4/23/25 at 2:08 PM an interview with the current Maintenance Director #15 and Maintenance assistant (MA) #14 revealed MA #14 had been covering the maintenance department since the end of 2/25. He stated that he had not completed any recommendations from the pest control company because he was not receiving any report from them. He stated that the previous Maintenance Director received the reports via email. An interview with the previous Maintenance Director Staff #13 on 4/25/25 at 12:05 PM revealed he was not receiving a copy of the pest control report via email and was not following up with structural recommendations. The Nursing Home Administrator (NHA) was interviewed on 4/30/25 at 1:46 PM regarding pest control. She reported that they would treat the areas that pests were seen based on the log. When asked about the structural recommendations, she stated that those reports were going to the Maintenance Director to act on. She reported that when there were continued sightings of pest, she increased the frequency of the pest control company's visits to weekly. However, she was unable to provide proof that these weekly visits were requested and based on the documentation the visits were monthly. Cross reference: F812, F814, F835, and F921.