STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215253	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Cold Spring	4700 Harford Road Baltimore, MD 21214

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store food in accordance with professional standards for food service and safety. This was evident in 2 of 3 kitchen observations and 2 of 2 nourishment room observations during an annual survey. The findings included: On 9/29/25 at 8:10 AM, the surveyor made an initial tour of the facility's kitchen. Upon entering the kitchen, the surveyor noted dripping from the ceiling outside of the walk-in refrigerator/freezer. A bread cart was next to the refrigerator/freezer door, and a spice rack was across from it. Two containers collected the dripping water on the floor. On 9/29/25 at 8:17 AM, the surveyor interviewed the Food Service Director Staff #1. During the interview, Staff #1 stated he believed the dripping was from condensation. On 9/29/25 at 8:34 AM, the surveyor asked the Nursing Home Administrator if he was aware of the dripping from the kitchen ceiling. The NHA stated he was not but would follow-up. On 9/29/25 at 10:34 AM, the surveyor conducted a follow-up interview with the NHA. During the interview, the NHA stated that the leaking in the ceiling was due to a pinhole leak in the hot water return line and that the line was fixed. He further stated that they disposed of the bread and spices out of an abundance of caution. On 10/6/25 at 11:16 AM, the surveyor observed the 3rd floor nourishment room located close to the elevator. The surveyor observed a resident's food tray that appeared to have had a resident eaten from it on the counter in the nourishment room. Licensed Practical Nurse (LPN) #24 stated that she would dispose of the contents from the tray. On 10/6/25 at 11:23 AM, the surveyor observed the 2nd floor nourishment room located close to the elevator. Again, the surveyor noted a resident's left-over food trays on the counter in the nourishment room. The surveyor updated Unit Manager #12 of the observation. On 10/6/25 at 11:35 AM, the surveyor observed the lunch meal assembly at the steam table line in the main kitchen. On further observation, the surveyor noted a cell phone on the stainless-steel table parallel with the steam table assembly next to the coffee maker. When asked if there was a reason for the cell phone to be out, Dietary Aide #20 left the steam table assembly and removed the phone from the area. On 10/6/25 at 12:21 PM, the surveyor interviewed the NHA. During the interview, the surveyor revealed the observation from the kitchen. The NHA confirmed that personal items such as a cell phone should not be in the kitchen during meal preparation or meal assembly.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 3 (Resident #124, #127 and #137) out of 51 residents reviewed during the recertification survey. The findings include: 1) On 10/01/25 at 9:05 AM a review of the facility's investigation of an incident pertaining to Resident # 124 revealed the staffing sheet dated 06/25/25 Unit 3B on 06/25/25 7:00 AM -3:00 PM shift indicated Geriatric Nursing Assistant (GNA) #8 had an assignment on the unit. The surveyor asked the Administrator where the statement from GNA #8 was since he/she worked on the unit where the alleged incident occurred. The Administrator verbalized GNA #8 assignment was changed, and he/she was moved to Unit 3B. The surveyor asked the Administrator when the GNA assignment changed should the staffing sheet have been updated. The Administrator verbalized, yes. On 10/01/25 at 10:02 am a review of the Change in Condition Evaluation for Resident #124 dated 06/26/25 was completed by Registered Nurse (RN)#10 revealed the evaluation was not completed in totality. RN #10 failed to complete the section related to pain, Code Status, and whether the resident had medication changes within the past week. The surveyor reviewed the evaluation with Regional Clinical Services Manager #5. The surveyor asked was RN #10 supposed to complete the form entirely. Regional Clinical Services Manager #5 verbalized yes. On 10/07/25 at 11:15 am a review of Resident #127 electronic health record revealed the resident had a fall on 05/21/25. The resident sustained an abrasion to the forehead but there was no documentation to verify the location and size of the abrasion. The surveyor asked Assistant Director of Nursing (ADON) #25 should the nurse have documented where the abrasion was located and the size. ADON #25 verbalized yes. 2) On 9/29/25 at 9:11 AM, the surveyor observed Resident #137's Peripherally Inserted Central Catheter (PICC) line in his/her right upper arm. The dressing covering the site was dated 9/20/25. On further observation, the dressing to Resident #137's left posterior thigh was off, and the wound was exposed to the bed. The surveyor noted that the drainage was observed into the bed linen. Resident #137 stated that the wound dressing had come off after transferring to the wheelchair and then back to bed last evening. Resident #137 further stated that the staff yesterday evening was aware and told him/her that they would re-dress the wound later. On 9/29/25 at 9:15 AM, the surveyor conducted an interview with Resident #137's assigned nurse, Licensed Practical Nurse (LPN) #2. During the interview, LPN #2 stated that a PICC line dressing should be changed every 7 days. She further stated she was not aware that Resident #137's left leg dressing needed to be dressed and would follow up with the Resident. On 9/29/25 at 12:49 PM, the surveyor reviewed Resident #137's September 2025 Treatment Administration Record (TAR). Nowhere on the TAR was there an order or a place to document the PICC line dressing change. On further review, the dressing changes to Resident #137's two left leg wounds were documented as changed on the scheduled change on 9/28/25; however, the as-needed dressing change was left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/25 at 6:38 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview, the DON stated that she had spoken to the nurse that took care of Resident #137 on the afternoon of 9/28/25. She further stated that Resident #137 refused to have both his/her PICC line dressing changed and wound re-dressed and that the nurse wrote a late entry to capture these events. The DON confirmed that the nurse should have documented at the time the resident refused and notified the provider of refusals of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain practices to help prevent the transmission of infections. This was evident in 1 (Resident #137) of 9 residents reviewed for indwelling medical devices/wounds and observations of the laundry area during the recertification survey.The findings include:Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).1) On 9/29/25 at 9:11 AM, the surveyor observed that Resident #137 had a Peripherally Inserted Central Catheter (PICC) line in his/her right upper arm, a foley catheter, multiple pressure ulcers, and an ostomy. The surveyor further observed no sign or indication to staff that they should be utilizing EBP while performing any high-contact care for Resident #137 related to Resident 137's multiple indwelling medical devices. On 9/29/25 at 12:49 PM, the surveyor reviewed Resident #137's September 2025 Treatment Administration Record (TAR). An order was written for Resident #137 to have Enhanced Barrier Precautions. On 9/30/25 at 9:44 AM, the surveyor conducted an interview with Resident #137's assigned nurse, Licensed Practical Nurse (LPN) #2. During the interview, LPN #2 stated Resident #137 was not in EBP and confirmed that he/she did not have a sign on the door. On 9/30/25 at 11:10 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview, the DON confirmed that Resident #137 was in EBP. The surveyor relayed the interview with LPN #2. The DON stated that Resident #137 should have a sign on their door to indicate the precautions staff should provide. She further stated that the order for EBP was updated on 9/29/25 to indicate the rationale for the precautions. 2) On 10/06/25 at 2:39 pm during a tour of the facility's laundry room the surveyor observed the door where the clean laundry was stored was opened, the laundry shoot was ajar with four bags of soiled laundry inside the shoot, three bags of soiled laundry were on the floor, and a yellow gown & googles were on top of the paper towel dispenser. Also, the chemicals used to clean the laundry were caked on the raised area where they were stored. On 10/06/25 at 2:45 pm when the door was closed to the clean laundry room, dust particles were floating in the air. The surveyor asked Environmental Services Director (EVS) #28 were they aware the door to the clean area is supposed to be closed, EVS Director #28 verbalized they were not aware. EVS Director #28 verbalized the floor tech would clean up the spilled chemicals. On 10/07/2025 at 10:32 am during an interview with EVS Director #28 the surveyor asked what the expectations of the staff in relation to infection control and cleanliness of the laundry room are. EVS Director #28 verbalized the laundry staff would be in-serviced on keeping the laundry room clean. The staff are not supposed to have bags of laundry on the floor and before the bin gets full, they must remove the dirty laundry. They are supposed to dust and clean the laundry area daily. The personal protective equipment (PPE) was removed and the area where the chemicals were was cleaned.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations and interview it was determined that the facility failed to maintain adequate conditions of equipment. This was evident during 2 of 3 observations of ice machines and 1 of 1 of the laundry room. The findings include:On 10/6/25 at 11:16 AM, the surveyor observed the 3rd floor nourishment room located close to the elevator. Upon opening the door, the surveyor noted water on the floor just below the ice maker machine, and the ice machine's tray was filled to the top with water. Next, the surveyor interviewed Licensed Practical Nurse (LPN) #24 and asked if she was aware of the ice machine's condition. She stated she was not and would let maintenance know. On 10/6/25 at 11:23 AM, the surveyor observed the 2nd floor nourishment room located close to the elevator. The surveyor noted moist tan particles at the bottom of the ice machine's tray. The Regional Director of Nursing (RDON) was on the floor and the surveyor asked if the ice machine was clean. The RDON stated she believed that cleaning could not remove some of the white areas seen on the tray. Next, the surveyor removed the tray and wiped the bottom of the ice tray. A tan substance smeared on the paper towel. The surveyor updated Unit Manager #12 of the observation. On 10/6/25 at 12:54 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview, the NHA administrator stated that maintenance serviced the floor ice machines every 4 months. He further stated that the Environmental Service (EVS) was responsible for cleaning the outside of the machine every day. The surveyor revealed the concern that both ice makers reviewed in the nourishment rooms were being utilized even with poor cleaning and working conditions. The NHA stated that maintenance had already fixed the clog that was causing backup in the 3rd floor ice maker and would update EVS.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews, the facility failed to provide a resident with a reasonable accommodation of need, as evidenced during one (Resident #138) random observation on the survey. The findings included: On 9/29/25 at 10:07 AM, the surveyor interviewed Resident #138 and his/her family member. Resident #138 stated the facility recently removed his/her side rails, and he/she was not able to move in the bed. On 9/29/25 at 1:32 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA confirmed that the facility removed the side rails from Resident's beds and was reassessing if they needed them. He further stated that the facility was ensuring assessments were completed, and that residents were care planned for side rails. The surveyor requested Resident #138's side rail assessment. Next, the surveyor reviewed Resident #138's side rail assessment, completed on 9/20/25. The assessment recommended 1/4 siderail assist handles to serve as an enabler to promote independence. On further review, the surveyor noted in Resident #138's physical therapy evaluation that Resident #138 was documented as being bedbound for several years due to weakness. The rationale for treatment was to decrease the level of assistance from caregivers. On 9/29/25 at 2:41 PM, the surveyor interviewed the Director of Nursing (DON). The surveyor reviewed the concern that Resident #138 was assessed to need the side rails, yet they were removed after assessing the need. The DON stated that the side rails would be replaced.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interviews, it was determined that the facility failed to determine if a Resident had an Advanced Directive and/or offer to help formulate one if determined not to have one. This was evident in 2 (Resident #138 & #4) of 3 residents reviewed for Advanced Directives during an annual survey. The findings included: 1a) On 9/30/25 at 8:11 AM, the surveyor reviewed the paper medical record for Resident #138. The paper medical record did not contain Advanced Directives (AD)s. On 9/30/25 at 10:36 AM, the surveyor interviewed the Social Service Director, Staff #3. During the interview, the surveyor asked if Resident #138 was asked about AD or offered to make them. Staff #3 stated she had met with the resident and was not sure. She stated that recently she had help from the corporate social workers to help review residents' ADs and would follow back up. On 10/1/25, Staff #3 wrote a progress note related to reaching out for ADs. However, this was documented after the surveyor requested this documentation. At the time of exit, no documentation was provided to indicate the ADs were addressed prior to the surveyor's request. 1b) On 9/30/25 at 7:55 AM, the surveyor reviewed the paper medical record for Resident #4. The paper medical record did not contain Advanced Directives (AD)s. On 10/1/25 at 8:17 AM, the surveyor reviewed Resident #4's electronic medical record. The review revealed Resident #4 was admitted into the facility in the middle of August 2025. The review revealed no documentation to note if the Resident had ADs and needed to be obtained or if Resident #4 was offered the opportunity to create an AD on admission if he/she did not have them. On 10/2/25 at 10:34 AM, the surveyor interviewed the Social Service Director, Staff #3. During the interview, the surveyor asked if Resident #4 was asked about AD or offered to make them. Staff #3 stated she would review her documentation and follow up. On 10/2/25 at 11:29 AM, the surveyor conducted a follow-up interview with Staff #3, where she confirmed that there was no documentation to support that Resident #4 was asked about ADs or the opportunity to create one.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to appropriately prescribe psychotropic medication for a resident without documented need for one. This was found evident in 1 (Resident #4) out of 5 residents reviewed for unnecessary medications. The findings include: Psychotropic medications are used to treat mental health disorders and are considered any drug that affects behavior, mood, thoughts, or perception. There are five main types of psychotropic medications, and each type has its own specific uses, benefits, and side effects. The five main types are: antidepressants, anti-anxiety, stimulants, antipsychotics and mood stabilizers. On 10/1/25 at 7:30 AM, the surveyor reviewed Resident #4's medical record. The review revealed that Resident #4 was admitted on [DATE] and was ordered Quetiapine (also known as Seroquel) (an atypical antipsychotic medication used to treat mental health conditions like schizophrenia, bipolar disorder, and major depressive disorder) 50 mg at bedtime for depression with a start date of 8/16/25 and an additional order for Quetiapine 25mg twice a day for depression. On further review it was noted that Resident #4 was seen by Physician #33 in 8/18/25 and Olanzapine (also known as Zyprexa) (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) 5mg daily as needed for anxiety. There is no end date to the psychotropic medication. Physician #33 noted Resident #4 was on both Olanzapine and Quetiapine and asked for psychiatry (psych) to follow up. Next the surveyor reviews the Psych consult note written on 8/29/25 by psych Nurse Practitioner (NP) #34. NP #34 list Resident's Olanzapine dosage at 25mg twice a day for psychosis and Quetiapine 50mg once a day for depression. She further stated to continue these medications as ordered. These doses were incorrect, and an addendum to the note is made on 9/5/25 to the correct orders written for Quetiapine, however Olanzapine is written as daily, not as needed as actually prescribed. On 9/5/25 NP #34 recommends discontinuing Quetiapine bedtime dose and tapering Olanzapine over 5 days and then discontinuing. On review of Resident #4's Medication Regimen Review conducted on 9/3/25 it stated, Resident was admitted on Olanzapine as needed. Per regulatory guidelines, order for as needed antipsychotic medication as needed must be limited to 14 days with no exceptions. It further stated, please add a stop date to the current order or consider discontinuing medication. On the MRR form, the providers agreed, and the signature followed with a date o 9/10/25. On 10/1/25 at 8:01 AM, the surveyor reviews the order for the as needed Olanzapine started on 9/18/25 and notes it was discontinued on 9/8/25. On 10/01/25 at 12:02 PM, the surveyor interviewed Regional Clinical Service Manager Staff #5. During the interview, the surveyor reviewed the concern that an as-needed psychotropic medication was written without an end date of 14 days and continued to be ordered even after a pharmacy review requested a change on 9/3/25 and psych requested a change on 9/5/25. The order was finally adjusted on 9/8/25.

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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 record reviews and interviews, it was determined that the facility failed to develop and implement patient-centered comprehensive care plans to meet the needs of residents. This was evident for 2 (Residents #1 and #4) out of 51 residents reviewed during the annual survey.The findings include:A care plan is a formal document that outlines a nursing home resident's medical and personal care needs. 1) During a record review of Resident #1's Care Plan on 10/01/2025 at 12:17 PM, a care plan problem was identified that read, (SPECIFY Impaired memory / cognition) r/t (SPECIFY neurological disorder) as evidenced by _____. The Regional Clinical Service Manager (RCSM) was asked about the expectation was for filling in brackets when creating care plans. The RCSM stated Social Services was responsible for that entry and the expectation was that details should be documented when the care plan is written. Social Worker #3 acknowledged on 10/02/2025 at 12:09 PM that the care plan should be patient-specific and the bracketed information needed to be patient-centered. During an interview on 10/02/2025 at 12:11 AM, the Director of Nursing (DON) and the RCSM acknowledged the concerns related to the care plan not being patient centered. Need to be filled in. 2) On 10/1/25 at 8:17 AM, the surveyor reviewed Resident #4's medical record. The review revealed a note written by Physician # 27 on 9/25/25 that stated Resident #4 was recently admitted to the facility after functional decline in ambulation and Activities of Daily Living (ADLs) due to a fall with fractures and right upper extremity weakness. On further review, the surveyor noted a care plan created on 8/24/25 that stated Resident # 4 had pain related to. 11 days later, a care plan was added on 9/5/25 that stated Resident #4 was at risk for pain related to chronic physical disability. Additionally, a care plan created on 8/24/25 stated Resident #4 was at risk for falls related to. On 8/27/25, a new care plan was added that stated Resident #4 had an actual fall as evidenced by the resident was observed being on the floor. On 10/1/25 at 12:02 PM, the surveyor conducted an interview with Regional Clinical Service Manager Staff #5. During the interview, Staff #5 stated that the care plans created on 8/24/25 were not person-centered and should have been specific to Resident #4's plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was evident in 1(Resident #4) out of 2 Residents reviewed for Activity of Daily Living (ADL) care. The findings included: On 10/1/25 at 8:17 AM, the surveyor reviewed Resident #4's medical record. A note written by Physician # 27 on 9/25/25 stated Resident #4 was recently admitted to the facility after functional decline in ambulation and Activities of Daily Living (ADLs) due to a fall with fractures and right upper extremity weakness. On 9/30/25 at 9:35 AM, the surveyor observed Resident #4 in the lounge area in a reclining chair. The surveyor noted long nails on all of Resident's left fingers which all appeared to be 1/2 inch long and had a dark substance under them. The surveyor reviewed the TASK documentation for Activity of Daily Living (ADL) cares for personal hygiene for Resident #4 for the month of September. Resident #4 was documented as dependent for ability to maintain personal hygiene. No refusals were noted in the documentation. On 10/1/25 at 12:02 PM, the surveyor conducted an interview with Regional Clinical Service Manager Staff #5. During the interview, the surveyor reviewed the TASK documentation and asked if maintaining and cleaning fingernails would be included in ADL care. Staff #5 confirmed that it would be part of the care. The surveyor reviewed the observations of Resident #4's nails and the concern that nail cares were not provided. On 10/2/25 at 7:53 AM, the surveyor conducted a follow-up interview with Regional Clinical Service Manager Staff #5. During the interview, Staff #5 stated that she had a regional nurse look at the nails and the nurse described them as needing some care and that the nails were addressed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interviews and record reviews, the facility failed to maintain acceptable parameters of nutrition for residents and address significant weight gain. This was evident for 1 (Resident #8) out of 5 residents reviewed for nutrition during the annual survey. Significant weight change is defined as a gain or loss of 5% of a person's weight within 30 days, 7.5% within 90 days, or 10% within 180 days. Significant weight change requires clinical evaluation and, if the change is not beneficial, intervention. The findings include: On 10/1/25 at 12:42 AM, the surveyor reviewed the medical record for Resident #8. The review revealed that Resident #8 was admitted to the facility in January of 2024. Resident #8's past medical history included major depressive disorder, peripheral vascular disease, acquired absence of the leg above the knee, and dementia. Further review of Resident #8's medical record revealed weights taken:9/1/25 212.6 Pounds (lbs)8/13/25- 211 lbs8/8/25- 202.8 lbs7/31/25- 203.4 lbs7/2/25- 203.2 lbs6/24/25- 203.26/17/25- 211.2 lbs6/11/25- 212.3 lbs6/6/26- 209 lbs5/1/25- 202.4 lbs4/9/25- 197 lbs3/6/25- 171.8 lbs2/8/25- 171.3 lbs1/13/25- 171.5 lbs12/5/24- 171 lbs11/11/24-164.5 lbs10/3/24- 154.6 lbs From 10/3/24 to 3/6/25, approximately 6 months, Resident #8 had an 11.13% weight gain.From 3/6/25 to 9/1/25, approximately 6 months, Resident #8 had a 23.75% weight gain. Next, the surveyor reviewed the dietary progress notes. On 10/3/24, a quarterly assessment note written by Dietitian #31 indicated that the weight on 9/3/24 was most likely an error. She further stated that Resident #8 had an above-the-knee amputation in July and requested a reweight. On 10/22/24, a note written by Dietitian #31 acknowledged the re-weigh done on 10/3/24 with the plan to continue to monitor weights. On 11/19/24, a readmission note written by Dietitian #31 for nutrition assessment documented Resident #8's weight on 11/11/24 was 165.5 lbs. She further stated this triggered a 6.5% weight gain over one month and requested a reweight to confirm weight change. The surveyor noted the next weights completed on 12/5/24- 171 lbs. This was one month after the request. On 2/18/25, a quarterly assessment note written by Dietitian #31 noted the resident was triggered for an 11.8% weight gain and stated it was likely related to fluid shifts or scale discrepancy and noted the weight at 171.3 lbs on 2/8/25. The plan was to continue to monitor monthly weights. On 5/23/25, a quarterly assessment note written by Dietitian #31 questioned a 37 lb weight gain x 3 months, with no edema or congestive heart failure noted. She further stated the weight gain might be due to a possible scale discrepancy and noted the weight of 202.4 lbs on 5/1/25. The plan was to monitor weight trends and labs. On 6/10/25, a note written by Dietitian #31 acknowledged a Minimum Data Set assessment that documented a 10% weight change over 180 days. She further requested a reweight to confirm, with the next weight taken the next day on 6/11/25- 213.3lbs. On 6/12/25, a note written by Dietitian #31 confirmed weight gain from the reweight obtained and wrote she continued to question a +41 pound weight gain in 6 months. She wrote the provider was to be made aware by nursing. On 6/13/25, a readmission note written by Dietitian #31 asked for a weight to be obtained and also to obtain weights weekly. The next weight was obtained on 6/17/25-211.2lbs, 4 days after the request. On 6/25/25, a note written by Dietitian #31 documented a weight loss, however questioning 6/6- 6/17 weights as possible outliers with the plan to monitor weight trends. On 7/4/25, a note written by Dietitian #31 documented questioning weight gain x 6 months for a possible scale discrepancy. Dietitian #31 wrote Resident #31 was on mirtazapine (also known as Remeron) (an atypical antidepressant used primarily to treat major depressive disorder and can have an appetite-stimulating effect). Dietitian #31 suggested considering discontinuing this medication. On 8/13/25, a quarterly assessment note written by Dietitian #31 documented a trigger for weight gain x 6 months with weights trending up. The stated goal was for weight maintenance and again documented to consider discontinuing the appetite stimulant mirtazapine. On 10/3/25 at 9:14 AM, the surveyor interviewed Dietitian #31 along with Regional Clinical Service Manager Staff #5. During the interview, Dietitian #31 stated that she was aware of Resident #8's weight gain and documented the monitoring. She stated that her assessments and (continued on next page)

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	215253	A. Building B. Wing	10/07/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations should be communicated to the physician by the nursing staff. She further stated that re-weights were not always completed by nursing, but she continued to request them if not performed. The surveyor relayed concerns that the resident continued to gain weight after the same monitoring was happening for months and when re-weights and medication adjustments were requested they were not acted on. Additionally, there was no follow-up to inquire if the scales utilized were calibrated and accurate. Staff #5 confirmed that scales utilized were validated quarterly. At the time of exit no documentation was proved to the surveyor to indicate that Resident #8's weight gain was according to his/her plan of care and/or intervention were adjusted or acknowledged. Cross reference F710

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, staff interviews and clinical record review, it was determined that the facility staff failed to ensure that a tube feeding bag was labeled. This was evident for 1 resident (#89) of 3 residents reviewed for tube feedings during the annual survey. The findings include: On 09/29/2025 at 10:57 AM during an initial observation of Resident #89, both the tube feeding formula bag and the flush bag were found hanging on the tube feeding pump. The formula bag was full, and the flush bag was half full. Neither bag was labeled with the resident's name, the type of formula, the date and time the bag was hung, or the name/initials of the staff member who hung them. On 09/29/2025 at 11:15 AM Staff #6, a Registered Nurse (RN), confirmed that Resident #89 receives daily tube feedings. When shown the unlabeled bags and asked about the formula, the recipient, the hanging time, and the staff member responsible, Staff #6, RN stated, I am not sure if Resident #89 received the tube feeding because another shift hangs the bag and night shift takes the bag down by 6:00 AM. Staff #6, RN also added, I am not sure what formula this is or when it was hung because there is no label on the tube feeding bag. Following this, Staff #6, RN removed both the tube feeding and flush bags. On 09/30/2025 at 10:50 AM a review of Resident #89's medical records revealed an order from September 11, 2025, for Jevity 1.5 at 35ml/hour for 10 hours from (8 PM to 6 AM) or until a total nutrient volume of 350ml was infused. The order specified administering the enteral feeding once daily, with downtime at 6 AM or until the total volume of 350ml was administered, and to hang the enteral tube feeding at 8 PM each day. The tube feeding was observed the day before still hanging at 10:57 AM. On 10/7/2025 at10:34 AM, Staff #25, the Assistant Director of Nursing (ADON), was interviewed regarding the facility's procedure for nurses hanging tube feedings. The ADON explained that nurses should verify the order, perform hand hygiene, and label the tube feeding with the resident's name, formula type, date, time hung, and their initials or name. The same procedure applies to the flush bag and syringe. The ADON was informed that this procedure was not followed for Resident #89, raising concerns about potential errors in administering the correct formula to the right resident at the right time, as well as the risk of infection due to untimely disposal of the formula. The ADON acknowledged and understood these concerns.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on interviews and record review, it was determined that the facility's physician failed to acknowledge and/or address recommended interventions for a resident with significant weight gain. This was evident in 1 (Resident #8) out of 5 residents reviewed for nutrition. The findings included: On 10/1/25 at 12:42 AM, the surveyor reviewed the medical record for Resident #8. The review revealed that Resident #8 was admitted to the facility in January 2024. Resident #8's past medical history included major depressive disorder, peripheral vascular disease, acquired absence of the leg above the knee, and dementia. Further review of Resident #8's medical record revealed weight changes over a year. Resident #8 had an 11.13% weight gain from 10/3/24 to 3/6/25 during this 6-month time period, and a 23.75% weight gain from 3/6/25 to 9/1/25, during this 6-month time period. Next, the surveyor reviewed the dietary progress notes. On 6/12/25, a note written by Dietitian #31 confirmed weight gain from the reweight obtained and stated she continued to question a +41 pound weight gain in 6 months. She wrote the provider was to be made aware by nursing. On 7/4/25, a note written by Dietitian #31 documented questioning weight gain x 6 months for a possible scale discrepancy. Dietitian #31 wrote Resident #31 was on mirtazapine (also known as Remeron) (an atypical antidepressant used primarily to treat major depressive disorder and can have an appetite-stimulating effect). Dietitian #31 suggested considering discontinuing this medication. On 8/13/25, a quarterly assessment note written by Dietitian #31 documented a trigger for weight gain x 6 months with weights trending up. The stated goal was for weight maintenance and again documented to consider discontinuing the appetite stimulant mirtazapine. On 10/2/25 at 1:48 PM, the surveyor conducted an interview with the Regional Clinical Service Manager Staff #5. During the interview, the surveyor reviewed concerns that the dietitian's recommendations related to weight gain were not being acknowledged or implemented by the physician. The surveyor requested medical notes that addressed the weight gain. On 10/3/25 at 9:14 AM, the surveyor interviewed Dietitian #31 along with Regional Clinical Service Manager Staff #5. During the interview, Dietitian #31 stated that she was aware of Resident #8's weight gain and documented the monitoring. She stated that her assessments and recommendations should be communicated to the physician by the nursing staff. On 10/3/25 at 11:35 AM, the surveyor conducted an interview with Resident #8's Physician #30. During the interview, Physician #30 stated she was monitoring Resident #8's weight gain through labs and a heart failure workup. When the surveyor asked for documentation that addressed the weight gain and response to the dietitian's recommendation, Physician #30 stated she did not have that documented. The surveyor reviewed the concern that the dietitian documented quite often Resident #8's continual weight gain and recommended discontinuing mirtazapine in July and in August, and in both months the resident continued to gain weight. Nowhere in the medical records is it noted that these notifications or recommendations were addressed. Cross reference F692

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant personnel files and staff interview, it was determined that the facility failed to complete required annual performance reviews for Geriatric Nursing Assistants (GNAs) at least once every 12 months. This finding was identified for 2 of the 3 GNA staff members (GNA #22 and #23) reviewed during the annual survey. The findings include: On 10/6/2025 at 9:45 PM, annual competencies for three random GNA's were requested. Record reviews revealed that Staff #22, GNA and Staff #23, GNA did not have their annual performance reviews for 2024 and 2025. On 10/06/2025 at 11:56 AM Staff #5, the Regional Clinical Service Manager (RCSM), was interviewed and asked if any additional documentation could be provided for Staff #22 and Staff #23's annual GNA performance reviews. Currently, Staff #22's last annual GNA performance review was on 6/27/2023 and Staff #23's last annual GNA performance review was on 6/29/2023. Staff # 5 RCSM stated what I have given you is all the documentation that I have for these staff members. Staff #5, the RCSM, verbalized understanding that GNA's should have competencies/performance reviews annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews, and interviews, the facility staff failed to 1) obtain and administer medications according to procedures and, 2) failed to accurately and safely to conduct and apply before each meal's insulin sliding scale. This was evident for two residents (#133 and #43) out of 10 reviewed for medications. The findings include:1) On 10/6/25, at 1:06 PM, the surveyor reviewed Resident #133's medical record. The Medication Administration Record (MAR) for May 2024 indicated that four different medications were coded 9 (other, see progress notes) in the administration documentation. Three of those medications had progress notes that stated the medication was ordered, but the pharmacy still needed to deliver them to the facility. The medications were: Famotidine (start date of April 9, 2024) coded 9 on May 3, 2024. Levothyroxine (start date of December 2, 2023) coded 9 on May 29, 2024. Nasal Moist Nasal Solution (start date of May 25, 2024) coded 9 on May 26, 2024. On 10/6/25, at 1:02 PM, the surveyor interviewed Staff #5, the Regional Clinical Service Manager. During the interview, the surveyor reviewed the concern that Resident #133 did not receive his/her medication as ordered on multiple occasions because the medications were unavailable. Staff #5 stated that the pharmacy dispensed medications with three days' worth and replaced them accordingly. She further stated that the medications should have been available for administration. A review of the facility's policy, Medication Administration- Timeliness, revealed that the expected outcome stated, Medications will be administered within appropriate time frames. 2) On 10/2/2025 at 8:30 AM, this surveyor was on the floor to observe the medication administration with Registered Nurse (RN) Staff #16; noticing the residents' breakfast cart was arrived around 8:30 AM. Resident #43 had a standing order started 8/29/2025 for Humalog Kwikpen Subcutaneous Solutions pen- injector 100 Unit/ML (Insulin Lispro) injections as per sliding scale of the blood sugar (BS) fingerstick: if 0-200 =0, 201-25-=2, 251-300=4, 301-350=6, 351-400=8, 401+ =10 Notified MD if less than 60 or greater 400, subcutaneously before meals and at bedtime for Diabetes mellitus type 2. Humalog Kwikpen Insulin lispro U-100 (Humalog) is a short-acting insulin which Onset: 10-15 minutes Peak: 1-3 hours Administer 30-60 minutes before meals. Fingerstick is a method used to test blood glucose by using a puncturing device (like a lancet) to take a small sample of blood from the finger. Diabetes mellitus type 2 is a chronic metabolic disorder characterized by persistent high or low blood sugars. It may be due to impaired insulin secretion, resistance to peripheral actions of insulin, or both. Observed Staff #16 was giving Resident #43's morning medications, he did not conduct the before breakfast BS check nor provided the proper coverage as an omission error. Noted on the Medication Administration Record (MAR) standard meals and before sleep hours BS checks were set for 6:30 AM, 11:00AM, 16:00 PM & 20:00 PM which it was also a concern. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review, on 10/2/2025 at 09:05 AM, MAR revealed that there was a discrepancy of breakfast sliding scale time set at 6:30 AM, however, the breakfast cart did not arrive until 8:30AM which it still required a before meal BS check to this resident. Interview, on 10/2/2025 at 09:20 AM, Unit Manager Staff #15 reviewed the MAR and stated that the night shift RN Staff #32 did a one time BS check around 6:00 AM the reading was 287 and she mistakenly utilized the before meal breakfast regiment then she covered Resident #43 with 4 units of Humalog Kwikpen Subcutaneous which it was an error. The day shift Staff #16 did not check at 8:30 AM when breakfast was served because he saw the before breakfast BS check was already filled in as 287 -2 hours ago. Staff #15 stated that the breakfast for that floor was always the last cart from the kitchen around 8:30 AM. Staff #15 was to correct all the before meal BS check times on MAR immediately to align with the actual meal serving times, to educate the nursing staff to conduct before meal time insulin scaling scale correctly and not to utilize the before meals insulin regiment for one time BS check needs. Interview, on 10/3/2025 at 10:00 AM, shared above finding with the Regional Clinical Service Manager Staff #5 as a practice concern. And she recognized that the above finding was a practice deficiency.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on a review of the medical record and interviews with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists. This was evident for 1 (#12) of 51 residents reviewed during the annual survey.The findings include:During a review of the consulting pharmacist's monthly recommendations for Resident #12 on 10/03/2025 at 8:30 AM, it was recommended that the prescriber document a rational for use and a duration date for lorazepam. The physician reviewed the recommendation and signed that they would refer to end of life consultant. The current order read, LORazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 6 hours as needed (PRN) for anxiety, agitation end of life care -Start Date08/05/2025 1045. No end date was written. The review was signed as completed by Physician #30. During an interview Physician #30 acknowledged on 10/03/2025 at 11:40 AM, that although the recommendation for the indication for end of life care was made, there was no stop date added as recommended by the Clinical Pharmacist. On 10/03/2025 at 11:41 AM, the Regional Clinical Service Manager (RCSM) acknowledged the concern that there was no stop date for PRN medications. She later confirmed that there was no stop date on the record and stated it would be corrected. The Director of Nursing is responsible for following up with the Clinical Pharmacist recommendations.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on a record review and interviews, the facility failed to obtain laboratory services in a timely manner. This was found evident of 1 (Resident #2) of 1 resident reviewed for laboratory services reviewed during the annual survey The findings include: On 10/1/25 at 11:47 AM, the surveyor reviewed Resident #2's medical record. The review revealed Resident #2 had a past medical history of dementia and behavioral disturbances. Resident #2's care plan listed a risk for complications related to aphasia and apraxia, affecting response to care, and noted refusal of laboratory (Lab) samples. Next, the surveyor reviewed the progress notes. On 9/26/25, Registered Nurse (RN) #29 documented that a Basic Metabolic Panel (BMP) result was cancelled due to a missing date of birth (DOB) identifier. The note further states that the provider was informed, and a new order for a BMP for Monday 9/29/25 was given. On 10/1/25 at 12:59 PM, the surveyor reviewed Resident #2's orders. No order was found for a redraw of the BMP lab. On 10/2/25 at 1:46 PM, the surveyor interviewed the Director of Nursing (DON) and asked for the lab results from the redraw that was described to have occurred on Monday 9/29/25. On 10/3/25 at 6:59 AM, the surveyor conducted a follow-up interview with the DON. During the interview, the DON stated that an order should have been placed to communicate the redraw, and it was missed. She further stated that the order was now entered, and the lab would be drawn.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record reviews and interviews it was determined that the facility staff failed to ensure two Geriatric Nursing Assistants (GNA) received Dementia training upon hire and failed to complete an annual employee evaluation. This deficient practice was evidenced in three GNA records reviewed during the recertification survey. The findings include: On 09/30/25 at 2:47 pm a review of Geriatric Nursing Assistant (GNA) #17 employee training record revealed the GNA was hired in March 2025 and did not receive Dementia training. On 10/01/25 at 2:22 pm a review of GNA #18 employee training record revealed there was no documentation to verify the GNA received Dementia training. The GNA was hired on 07/08/24 and was terminated on 04/04/25. A review of GNA #36 employee record revealed the GNA was hired on 04/24/24 and is currently working in the facility. The GNA did not have their annual evaluation after one year of employment. On 10/01/25 10:06 am during an interview with Regional Director of Operations #37 verbalized they don't have evidence to verify GNA#17 received Dementia training, but they do Dementia training throughout the year. On 10/03/25 at 10:40 am during an interview with Regional Clinical Service Manager #5 reported GNA #18 started the Dementia training but did not complete the course. When asked if a GNA is supposed to have a yearly evaluation. Regional Clinical Services Manager #5 verbalized yes. On 10/03/25 at 12:10 pm during an interview with Director of Education #19 the surveyor asked GNA's required to have Dementia training. Director of Education #19 verbalized Dementia training must be completed within the first 90 days of employment. The course should be completed In Health Stream. The facility staff are responsible for ensuing the training was completed.