STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews and surveyor record reviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were coded accurately. This finding was found to be evident in 4 (Resident #1, #9, #33 and #103) out of 16 Residents reviewed for accuracy of assessments during the recertification/complaint survey.The findings include: A Minimum Data Set (MDS) assessment is a comprehensive, federally mandated clinical evaluation for Residents in Medicare/Medicaid-certified nursing homes in the United States. The purpose is to provide a standardized, uniform assessment of Resident health status, identify problems, strengths, and preferences, and inform care planning and payment. MDS assessments are completed by trained nursing home staff upon admission, quarterly, annually, and whenever a Resident's condition significantly changes. Functional capabilities, cognitive status, health conditions, treatment, therapies, psychosocial well-being and discharge planning are assessed in the MDS process. 1) The surveyor conducted a record review of Resident #103's closed medical record on 12/9/2025 at 2:38 PM. Record review revealed that Resident #103 was discharged home with home health services, Amedisys. Further review of the medical record revealed that the Discharge MDS – return not anticipated dated 9/22/2025 was coded that Resident #103 was discharged to home/community and the type of discharge was unplanned. The Discharge MDS – return not anticipated should have been coded as home under care of organized home health service organization and type of discharge coded as planned. The surveyor interviewed the RN (Registered Nurse) MDS Coordinator on 12/10/2025 at 11:10 AM and conveyed that the Discharge MDS assessment dated [DATE] for Resident #103 was coded that Resident was discharged to home/community and that the type of discharge was unplanned. The surveyor further reviewed that according to the documentation in the progress notes by social services, Resident #103 received discharge planning and was discharged home with home health services. The RN MDS Coordinator stated that she coded the discharge MDS assessment this way when Residents discharged home. 2) On 12/11/2025 at 7:15 AM the surveyor conducted a record review of Resident #33's medical record. Review of the medical record revealed that Resident #33 had physician orders for Aspirin 81 mg daily and Clopidogrel 75 mg daily (antiplatelet medications). Continued review of the medical record revealed that the MDS assessments for 8/28/2025 and 11/6/2025 did not indicate that Resident #33 was taking antiplatelet medications (prevent blood clots). Additionally, Resident #33 had a physician order for Lovenox 40 mg two times a day (anticoagulant medication – blood thinner) with a start date of 10/31/2025 and an end date of 11/14/2025, and the 11/6/2025 MDS assessment was not coded that Resident was taking an anticoagulant medication. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:35 AM on 12/11/2025 the surveyor conveyed to the Director of Nursing (DON) the inaccurate coding on the MDS assessments. DON acknowledged the surveyor and stated that she would notify the MDS Coordinator. In an interview with the RN MDS Coordinator at 8:50 AM on 12/11/2025 the surveyor reviewed with the RN MDS Coordinator that Resident #33 had physician orders for Aspirin and Clopidogrel and the 8/28/2025 and 11/6/2025 MDS assessments were not coded that Resident takes antiplatelet medications. RN MDS Coordinator stated that she does not usually code Clopidogrel as an antiplatelet, but she does code Aspirin as an antiplatelet medication on the MDS assessments. RN MDS Coordinator stated that she would correct and modify Resident #33's MDS assessments. During the survey exit conference, the Licensed Nursing Home Administrator (LNHA) was notified of the concern with inaccurate MDS assessments. 3) During an interview on 12/10/2025 at 12:38 PM Unit Manager #4 stated that Resident #1 did not have pneumonia, indicating a potential MDS discrepancy. During a record review on 12/10/2025 at 1:08 PM, the surveyor noted that the MDS Quarterly, dated 9/1/2025, coded Section I200 Pneumonia as yes. On 12/10/2025 at 1:40 PM, the MDS Coordinator acknowledged the error stating she hit pneumonia by accident when I coded. When asked what she does if an error if found she stated, Normally when I find out I made an error I file a modification so I will do that now. 4) On 12/11/2025 at 7:14 AM, the surveyor did not identify a significant weight loss during record review however Resident #9 was coded for weight loss on MDS Quarterly, dated 11/19/2025, section K300, Yes, not on prescribed weight-loss regimen. The MDS Coordinator stated Section K is coded by the dietician. On 12/11/2025 at 8:11 AM the Registered Dietician stated, I think I coded weight loss inaccurately. I look at weights in the electronic record. My note and care plan do not reflect weight loss. It is an entry error. The Director of Nursing stated, We will correct this right now.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and facility staff interviews it was determined that the facility failed to have a safe/clean/comfortable/homelike environment for Residents. This finding was found to be evident in the following Resident rooms (room [ROOM NUMBER], 109, 111, 112 and 113) and the facility conference room during the recertification/complaint survey.The findings include:On the initial tour of the facility on 12/8/2025 at 8:45 AM the surveyor observed the facility environment not in good repair as there were doors chipped and marred, doors not shutting properly and a missing call light string for bathroom call light device. The following rooms were observed: room [ROOM NUMBER] - marred/chipped bathroom door; room [ROOM NUMBER] - marred/chipped Resident room door; room [ROOM NUMBER] and room [ROOM NUMBER] shared bathroom - missing call light string for call light device; room [ROOM NUMBER] - marred/chipped Resident room door. Additionally, the Resident room door for room [ROOM NUMBER] and the facility conference room door did not shut properly as there was a door stopper attached to both doors.In an interview with the Regional Administrator and the Director of Nursing (DON) at 3:05 PM on 12/8/2025 the surveyor conveyed that the Resident room door to room [ROOM NUMBER] did not shut properly as there was a door stopper attached to the door, and there was not a call light string attached to the call light device in the shared bathroom for Resident rooms [ROOM NUMBERS]. The Regional Administrator and the DON observed with the surveyor the Resident door not shutting properly and the door stopper, and the missing string to the call light device in Resident shared bathroom. They acknowledged the surveyor and stated that they would follow up with maintenance.Additionally, on 12/9/2025, the DON stated that the call light device in the Resident bathroom now had a string attached as it was found on the counter in the Resident room, the stopper to the Resident room door was removed by maintenance, and maintenance was going to remove the stopper from the conference room door.

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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 facility staff interviews and surveyor record reviews it was determined that the facility failed to develop and implement comprehensive care plans and follow care plan interventions for Residents. This finding was found to be evident for 3 (Resident #1, #29 and #41) out of 16 Residents reviewed for comprehensive care plans during the recertification/complaint survey. The findings include:A Care Plan is a written document that outlines a person's care needs and how they will be met. It's a key tool for health and social care professionals to ensure a Resident receives the right level of care. Care plans are usually created after care needs assessment and risk assessment, involving the person receiving care and their family. Care plans are used to guide health and social care professionals in delivering care and standardize evidence-based care. A Minimum Data Set (MDS) assessment is a comprehensive, federally mandated clinical evaluation for Residents in Medicare/Medicaid-certified nursing homes in the United States. The purpose is to provide a standardized, uniform assessment of Resident health status, identify problems, strengths, and preferences, and inform care planning and payment. MDS assessments are completed by trained nursing home staff upon admission, quarterly, annually, and whenever a Resident's condition significantly changes. Functional capabilities, cognitive status, health conditions, treatment, therapies, psychosocial well-being and discharge planning are assessed in the MDS process. 1) The surveyor conducted a record review of Resident #41's medical record on 12/10/2025 at 12:50 PM. Review of the physician orders for Resident #41 revealed a physician order for an anticoagulant medication (blood thinner) Eliquis 5 mg twice daily and a medical diagnosis of pulmonary embolism (blockage, blood clot in the lung's arteries). Further review of Resident #41's comprehensive care plan revealed that there was not a care plan for an anticoagulant medication or a diagnosis of pulmonary embolism. Continued review of Resident #41's medical record revealed that the MDS assessments indicated that Resident was receiving an anticoagulant medication and had a diagnosis of pulmonary embolism. The surveyor interviewed the Director of Nursing (DON) and the Unit Manager at 1:45 PM on 12/10/2025 and conveyed that Resident #41 was receiving Eliquis for a diagnosis of pulmonary embolism and that the anticoagulant medication and the pulmonary embolism diagnosis was not on the comprehensive care plan. Both acknowledged the surveyor and stated that the anticoagulant medication and the pulmonary embolism diagnosis were not on Resident #41's care plan, and the DON would follow-up with the MDS Coordinator. 2) The surveyor conducted a record review of Resident #29's medical record on 12/11/2025 at 10:49 AM. Review of Resident #29's medical record revealed that Resident had a comprehensive care plan for an anticoagulant medication as of 9/17/2024, however, review of the active, current physician orders revealed that Resident was not receiving an anticoagulant medication. Further review of the MDS assessments for Resident #29 revealed that Resident had not received an anticoagulant medication. The surveyor interviewed the RN (Registered Nurse) MDS Coordinator on 12/11/2025 at 11:30 AM and conveyed to the RN MDS Coordinator that Resident #29 did not have an active, current order for an anticoagulant, but had a care plan for anticoagulant medication. The RN MDS Coordinator reviewed the care plan, MDS assessments and physician orders for Resident #29, acknowledged the surveyor and stated that she would resolve the anticoagulant medication care plan for Resident #29 as the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was not receiving an anticoagulant medication. 3) The surveyor reviewed Resident #1's Treatment Administration Record (TAR) on 12/11/2025 at 7:50 AM and no documentation was found for evaluating the effectiveness or side effects of pain medicine, which were indicated as interventions in the Care Plan dated 12/1/2025. The Director of Nursing (DON) stated on 12/11/2025 at 9:26 AM, that the facility would only monitor pain levels for as needed pain medications if it was given, but staff should have documented the care plan interventions on the TAR. The DON added that the facility would correct the issue.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility staff interviews and surveyor record reviews, it was determined that the facility failed to update and revise a Resident's care plan. This finding was found to be evident for 1 (Resident #29) out of 6 Residents reviewed for revision of Resident's care plans during the recertification/complaint survey.The findings include:A Care Plan is a written document that outlines a person's care needs and how they will be met. It's a key tool for health and social care professionals to ensure a Resident receives the right level of care. Care plans are usually created after care needs assessment and risk assessment, involving the person receiving care and their family. Care plans are used to guide health and social care professionals in delivering care and standardize evidence-based care. Care plans should be regularly reviewed to monitor their effectiveness. Care plans are updated and revised periodically and as care needs and conditions change with Residents.A Minimum Data Set (MDS) assessment is a comprehensive, federally mandated clinical evaluation for Residents in Medicare/Medicaid-certified nursing homes in the United States. The purpose is to provide a standardized, uniform assessment of Resident health status, identify problems, strengths, and preferences, and inform care planning and payment. MDS assessments are completed by trained nursing home staff upon admission, quarterly, annually, and whenever a Resident's condition significantly changes. Functional capabilities, cognitive status, health conditions, treatment, therapies, psychosocial well-being and discharge planning are assessed in the MDS process.The surveyor conducted a record review of Resident #29's medical record on 12/11/2025 at 10:49 AM. Review of the medical record revealed that Resident #29 had a care plan for an anticoagulant (blood thinner) medication that was initiated on 9/17/2024 and a revision on 8/26/2025 with a target date of 2/12/2026. Further review of Resident #29's medical record revealed that there was no current physician order for an anticoagulant medication.Continued record review of Resident #29's medical record on 12/11/2025, specifically the MDS assessments dated 5/19/2024, 9/23/2024, 8/14/2025 and 11/12/2025 revealed that these assessments did not indicate that Resident was receiving an anticoagulant medication. In an interview with the Registered Nurse (RN) MDS Coordinator on 12/11/2025 at 11:30 AM the surveyor conveyed that Resident #29 had a current care plan for an anticoagulant medication since September 2024, but Resident was not on an anticoagulant medication. The RN MDS Coordinator reviewed the care plan, physician orders and MDS assessments, acknowledged the surveyor and stated that she would resolve the anticoagulant medication care plan for Resident #29 as Resident was not receiving an anticoagulant medication.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, review of facility policy, and interviews it was determined that the facility failed to utilize professional standards during medication administration. This was found evident in 2 (Resident #59 and #6) of 3 medications administrations on the recertification/complaint survey.The findings include:1) On 12/8/25 at 9:30 AM, the surveyor conducted an interview with Resident #59. During the interview, the surveyor observed 4 medications cups on Resident #59's over-the-bed table. Two contained liquid (one orange, one yellow) and the other two contained what appeared to be medications (one with a crushed substance and the other with 12 pills in the cup). Resident #59 stated that the medications were left for him/her to take. Resident #59 stated he/she was not sure what they were but knew the orange substance was Potassium.On 12/9/25 at 11:31 AM, the surveyor reviewed the observations with the Director of Nursing (DON). During the interview the DON confirmed that medications should not be left out at the bedside, and it is the nurses' responsibility to make sure the medications are taken.On 12/10/25 at 1:18 PM, the surveyor reviewed the policy titled, Administering Medications. In the Interpretation/Implementation it stated in step number 24; Never leave a medication unattended in a resident's room.2) On 12/9/25 at 8:35 AM, the surveyor observed Licensed Practical Nurse (LPN) #12 prepare and administer medications to Resident #6. LPN #12 reviewed the electronic Medications Administration Record (eMAR) and then gathered the medications. During the preparation the surveyor noted that LPN #12 gathered some of Resident #6's medications from a prepackaged pouch that came from the pharmacy and others from bubble packs or floor stock bottles located in the medication cart. 15 different medications (one being an inhaler) were prepared to be given to Resident #6.On 12/9/25 at 10:35 AM, the surveyor reconciled the medications. The review compared the medications that were observed given to the ordered medications for Resident #6 in the MAR. During the reconciliation the surveyor noted that Resident #6 was given sulfa/trim ds 800/160mg (a combination antibiotic containing 800 mg of sulfamethoxazole and 160 mg of trimethoprim, used to treat a variety of bacterial infections) however, Resident #6 did not have an order for that medication to be given.On 12/09/25 at 1:30 PM, the surveyor conducted an interview with LPN #12. During the interview the surveyor asked LPN #12 why the sulfa/trim ds 800/160mg medication was administered to Resident #6. LPN #12 stated that he did not realize it was not on Resident #'s MAR. He further stated he knew Resident #6 had cellulitis and thought maybe the antibiotic was ordered but recently discontinued.On 12/09/25 at 1:43 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated she would follow-up to find out why the medication was given without an order.The surveyor reviewed the policy titled, Administering Medications. In Interpretation/Implementation #3 states; Medications must be administered in accordance with the orders, including any required time frame. In #7 it states; The individual administering the medication must check the label to verify the right resident, the right medication, right dosage, right time and right method (route) of administration before giving the medication.At the time of exit no additional documents were provided to the surveyor.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observations and interviews it was determined that the facility failed to provide treatment/services to maintain hearing. This was found evident in 1 of 3 consults reviewed for Resident #59 on the recertification/complaint survey. The findings include:On 12/8/25 at 9:44 AM, the surveyor conducted an interview with Resident #59. During the interview Resident #59 expressed concerns about the facility's coordination regarding his/her appointments.On 12/15/25 at 10:33 AM the surveyor reviewed Resident #59's medical record. The review revealed that Licensed Practical Nurse (LPN) #23 wrote a progress note stating that Resident #59 was complaining about left ear wax build up and difficulty hearing. The note stated that the Nurse Practitioner (NP) was contacted and ordered Debrox ear drops for 5 days (11/15/25-11/19/25) and an Ear Nose Throat (ENT) consult. The LPN wrote, as this is a recurring problem.Next the surveyor reviewed a consult note from Resident #59's consult provider Staff #24. A note was written on 11/17/25 recommended that the left ear be irrigated to remove wax.On 11/26/25 LPN #23 wrote a note stated that the NP saw Resident #59 and again ordered Debrox for 5 days (11/26/26-12/1/25) and then to flush.On 12/3/25 LNP #23 wrote an additional note that stated Resident #59 continued to complain of left ear fullness and wax build up. It further stated that the Resident had been receiving the Debrox drops and after an ear flush there was minimal to no results.Following the progress notes the surveyor reviewed orders. The review revealed that Debrox drops were first ordered on 8/12/25 (for 5 days), and then again as follows; 8/26/25 (for 5 days), 9/1/25 (for 3 days), 9/5/25 (for 10 days), 11/14/25 (for 5 days) and on 11/26/25 (for 5 days). No ENT consult was noted in the orders.The surveyor reviewed a Psychiatry Nurse Practitioner NP #25's note written on 12/3/25. In the note NP #25 documents that Resident #59's behavior is calm, however mildly tense when Resident #25 expresses his/her recent frustration with communications. The note further states that nursing staff reports Resident #59 had been encouraged to participate in facility activities despite occasional frustration with scheduling and communication regarding appointments.On 12/15/25 at 11:57 AM, the surveyor conducted an interview with the Unit Manager # 4. During the interview the surveyor asked if Resident #59 had an ENT consultation. UM #4 stated she would check and follow-up. On 12/15/25 at 12:16 PM, the surveyor conducted a follow-up interview with UM #4 and the Director of Nursing (DON). During the interview the surveyor relayed the concern that Resident #59's ENT consult was never ordered despite having a reoccurring problem. The UM #4 stated she was unaware that Resident #59 needed an ENT consult.On 12/15/25 at 12:45 PM, an order was placed for Resident #59 to have an ENT consult due to left ear pain/wax build up.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interviews, it was determined that the facility failed to administer oxygen and maintain continuous positive airway pressure (CPAP) therapy in accordance with professional standards of practice. This was found to be evident for 2 (Residents #1, #58) out of 2 residents receiving oxygen and 1 (#1) out of 1 resident receiving CPAP therapy reviewed during the recertification/complaint survey.The findings include:CPAP, or Continuous Positive Airway Pressure, is a common treatment for sleep apnea, using a machine to deliver pressurized air through a mask to keep airways open during sleep, preventing breathing pauses, improving sleep quality, and reducing risks of heart disease and stroke.On 12/8/2025 at 10:28 AM, the surveyor observed Resident #1 was receiving oxygen and had a CPAP machine, which he/she stated was used at night. No oxygen in use signage was found outside the room. On 12/9/2025 at 11:50 AM, the surveyor observed Resident #58 using oxygen and no oxygen in use signage outside the room. During a record review on 12/9/2025 at 1:22 PM, no order was found for cleaning and maintenance of the CPAP device. The facility policy for CPAP administration required an order to clean and maintain the CPAP device.During an interview on 12/10/2025 at 8:29 AM, the Director of Nursing (DON) and Administrator stated they were told by the Fire Marshall that we need to post oxygen in use outside the building and not at each door. They acknowledged the concern and stated they would put the signs back up. At 9:13 AM, the Maintenance Director was observed placing oxygen signage outside of rooms.During an interview on 12/10/2025 at 12:38 PM, Unit Manager #4 stated there was no order to clean and maintain the CPAP and she would review the policy and obtain the orders from the physician. The Director of Nursing acknowledged the concern and stated the facility would obtain an order to clean and maintain the CPAP on Resident #1. During a follow up interview on 12/11/2025 8:20 AM, the DON stated the facility had implemented orders for CPAP cleaning and maintenance.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, facility staff interview and surveyor record review it was determined that the facility failed to ensure that the posted nurse staffing information document displayed the required information. This finding was found to be evident in the review of sufficient and competent nurse staffing during the recertification/complaint survey. The findings include:The facility's staffing data document may be a form or spreadsheet, and all the required information displayed clearly and in a visible place. The information should be displayed in a prominent place that was readily accessible to Residents, staff and visitors and presented in a clear and readable format. This information posted must be up to date and current. The facility must post the nurse staffing data on a daily basis at the beginning of each shift. The facility must ensure staffing information was accurate and current. The data requirements for the daily posted nurse staffing information document must include facility name, current date, the total number and actual hours worked per shift for licensed and unlicensed nursing staff (Registered Nurses, Licensed Practical Nurses, Nurse Aides) directly responsible for Resident care, and Resident census. The facility must maintain the daily posted nurse staffing data documents for a minimum of 18 months. On 12/9/2025 at 10:40 AM the surveyor conducted a record review of the posted nurse staffing information documents for the time period of 11/17/2025 - 11/30/2025 that were provided by the Licensed Nursing Home Administrator (LNHA). Review of the posted nurse staffing information documents revealed that the facility name and Resident census were not indicated on the nurse staffing documents for this time period. The surveyor observed the posted nurse staffing information document that was posted at the time clock in the facility on 12/9/2025 at 11:45 AM. The current posted nurse staffing information document did not include the facility name and the Resident census. In an interview with the Human Resources Director/Staffing Coordinator (HRD/SC) on 12/16/2025 at 8:50 AM the surveyor conveyed to the HRD/SC that the review of the posted nurse staffing information documents for the time period of 11/17/2025 - 11/30/2025 did not include the facility name and the Resident census, and that the current posted nurse staffing information document at the time clock did not include the facility name and the Resident census . The HRD/SC reviewed the posted nurse staffing information documents, acknowledged the surveyor and stated that going forward the posted nurse staffing information documents would be corrected to include the facility name and the census.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 surveyor record review, review of consultation notes and Resident and staff interviews, 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 finding was found to be evident in 4 (Resident # 6, #33, #59, and #112) out of 41 Residents reviewed for identifiable information in the Resident medical records during the recertification/complaint survey. The findings include: A Medication Administration Record (MAR) is a legal document used by healthcare professionals to track all medications administered to a Resident. It is a crucial component of a Resident's medical chart, serving to ensure patient safety, accountability, and communication among care teams. The purpose of the MAR is to ensure safe and accurate medication management by providing a clear, trackable history of every medication dose given or missed. A Care Plan is a written document that outlines a person's care needs and how they will be met. It's a key tool for health and social care professionals to ensure a Resident receives the right level of care. Care plans are usually created after care needs assessment and risk assessment, involving the person receiving care and their family. Care plans are used to guide health and social care professionals in delivering care and standardize evidence-based care. A Minimum Data Set (MDS) assessment is a comprehensive, federally mandated clinical evaluation for Residents in Medicare/Medicaid-certified nursing homes in the United States. The purpose is to provide a standardized, uniform assessment of Resident health status, identify problems, strengths, and preferences, and inform care planning and payment. MDS assessments are completed by trained nursing home staff upon admission, quarterly, annually, and whenever a Resident's condition significantly changes. Functional capabilities, cognitive status, health conditions, treatment, therapies, psychosocial well-being and discharge planning are assessed in the MDS process. 1) On 12/08/25 at 9:02 AM, the surveyor interviewed Resident #6. During the interview Resident #6 stated that he/she had not had any teeth in years. On 12/10/25 at 10:20 AM, the surveyor reviewed Resident #6's nursing admission assessment dated [DATE]. The assessment documented Resident #6 had an oral exam completed for this assessment. In a section titled, Describe Natural Teeth (if applicable) Resident #6 was coded, no decay. The Missing some or all Teeth option was left blank. Next the surveyor reviewed Resident #6's most recent Minimum Data Set (MDS) assessment dated [DATE]. In the oral dental assessment, there was a list that gave options to capture an abnormal evaluation. One option was, no natural teeth or tooth fragment(s) (edentulous) but this option was left blank. Resident #6 was coded as none of the above were present. On 12/10/25 at 10:47 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #6's assessments were inaccurate. The DON stated she would look into the concern. On 12/10/25 at 11:02 AM, Director of Admissions Staff #7 confirmed that Resident #6 did not have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, and interviews, it was determined that the facility failed to maintain practices to help prevent the transmission of infections. This was found evident on 2 (Resident #6 & #70) out of 2 observations of medication administration during the recertification/complaint survey.The findings include:1) On 12/9/25 at 8:34 AM, the surveyor observed Licensed Practical Nurse (LPN) #12 prepare medications to be administered to Resident #6. The medications were gathered from a shared medication cart. LPN #12 gathered medications from multiple drawers and bottles. After preparing the medications the surveyor observed LPN #12 walk into Resident #6's room, move a wheelchair and table, and then administer medications. No hand hygiene was utilized before administering the medications.On exiting Resident #6's room the surveyor asked LPN #12 if it is the expectation to perform hand hygiene prior to providing medications to the Resident. He confirmed hand hygiene should be performed before medications are given.2) On 12/9/25 at 9:20 AM, the surveyor observed Licensed Practical Nurse (LPN) #13 prepare medications to be administered to Resident #70. The medications were gathered from a shared medication cart. LPN #13 gathered medications from multiple drawers and bottles. After preparing the medications the surveyor observed LPN #13 walk into Resident #70's room and then administer the medications. No hand hygiene was utilized before administering the medications.On exiting Resident #70's room the surveyor asked LPN #13 if it is the expectation to perform hand hygiene prior to providing medications to the Resident. She confirmed hand hygiene should be performed before medications are given.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews it was determined that the facility failed to provide a safe, functional, sanitary environment for a resident. This was found in 1 (Resident #59) of 26 Resident rooms reviewed in the initial sample during the recertification/complaint survey.The findings include:On 12/08/2025 at 9:26 AM, the surveyor observed Resident #59's bathroom. The toilet had what appeared to be urine in the toilet bowl. The surveyor noted that around the bowl, on the bathroom floor, it was wet. Resident #59 stated that the toilet had been leaking for some time and that the facility was aware it was leaking. Resident #59 asked the surveyor to flush the toilet and see that it continued to leak. When the surveyor flushed the toilet, the toilet leaked additional water onto the bathroom floor.On 12/08/25 at 11:42 AM, the surveyor interviewed the Maintenance Director Staff #10. During the interview Staff #10 stated he was aware the toilet was leaking and that he had ordered the parts to repair it. He further stated that he was going to repair the toilet today now that the parts came in. The surveyor asked why Staff #10 why the toilet continued to be used when it was known to leak. He stated that he was informed it only leaked every once in a while.On 12/9/25 at 11:33 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed she was unaware of the toilet concern and that the bathroom should not have been utilized while it was not functioning correctly.