

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on review of complaints, medical record review, and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (Resident #10, #2, #7, #9) of 11 residents reviewed for complaints during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/27/26 at 12:21 PM a review of complaint 3040583 and Resident #10's medical record was conducted. Review of a 6/2/26 skin and wound note documented that Resident #10 was admitted with a left Achilles pressure injury that the patient stated he/she obtained in the hospital while his/her leg rested on a metal bar for a prolonged period of time. The wound was assessed to be a Stage 3 pressure ulcer that was 3 cm by 2 cm by 0.1 cm. Resident #10 was also admitted with a surgical wound on the left hip. The treatment for the pressure ulcer was to cleanse with wound cleanser/normal saline. Apply medical grade honey, calcium alginate to the base of the wound, secure with bordered gauze, and change daily and when necessary. Review of Resident #10's MDS assessment with an assessment reference date (ARD) of 6/7/26, Section M0100: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, was coded, no. Review of M0210: Unhealed pressure ulcers/injuries: Does this resident have one or more unhealed pressure ulcers/injuries, was coded, no. M1040: other ulcers, wounds and skin problems; surgical wounds was coded no. M1200: skin and ulcer/injury treatments E. pressure ulcer/injury care was coded no. On 7/30/26 at 12:39 PM an interview was conducted with MDS Coordinator #27 who confirmed the surveyor's findings. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 7/28/26 at 11:46 AM a review of complaint 3032786 and Resident #2's medical record was conducted. Resident #2 was admitted to the facility in May 2026 with diagnoses of end stage renal disease with dependence on dialysis, effusion of the right and left knee, and spinal stenosis. Review of a physician's history and physical dated 5/14/26 documented the resident received Cinacalcet at bedtime for hyperparathyroidism in chronic kidney disease on dialysis. The physician also documented the resident was to receive Dorzolamide Timolol Mal Ophthalmic solution in the left eye twice per day for glaucoma. Review of Resident #2's admission assessment with an ARD of 5/15/26, Section I, diagnoses, failed to capture glaucoma and hyperparathyroidism. Review of Section J0100A, pain management; Received scheduled pain medication regimen, was coded, No. This was inaccurate as the resident received Lidocaine External Patch 4 % (Lidocaine) that was applied to both knees every day for knee pain according to the documentation on Resident #2's May 2026 Medication Administration Record (MAR). On 7/30/26 at 12:31 PM an interview was conducted with the MDS Coordinator. The sections were reviewed along with the physician's note and the resident's MAR. The MDS Coordinator confirmed the findings. 3) On 7/29/26 at 7:58 AM a review of Resident #7's medical record was conducted along with facility reported incident 3094393. Review of Resident #7's annual MDS with an ARD of 6/3/26, Section N, Medications, had documented that Resident #7 had not received any high-risk medications. Review of Resident #7's June 2026 MAR documented that the resident received Furosemide (Lasix) 20 mg every morning for edema (fluid retention) to the right arm and bilateral lower extremities and Apixaban (Eliquis) 2.5 mg twice per day for atrial fibrillation. Atrial fibrillation is an abnormal heart rhythm that can lead to blood clots if not treated with an anticoagulant. Review of Resident #7's annual MDS assessment with an assessment reference date of 6/3/26 failed to capture the diuretic and anticoagulant. On 7/30/26 at 12:35 PM an interview was conducted with MDS Coordinator #27 who confirmed the findings. The Nursing Home Administrator was informed of the concern on 7/30/26 at 1:00 PM. 4) Review of Complaint 3044140 was conducted on 7/27/26 regarding the Resident #9's need for vision care. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's medical record on 7/27/26 revealed the Resident was admitted to the facility in April 2025 with a diagnosis to include Diabetes. Further review of the Resident's medical record revealed a picture of the Resident on the admission Record where the Resident is wearing glasses. Observation of Resident #9 on 7/27/26 at 12:53 PM revealed the Resident in bed with glasses on the Resident's bedside table. During interview with the Resident at that time, the Resident stated he/she would like to be seen by the eye doctor. Further review of Resident #9's medical record revealed the facility staff completed a Quarterly MDS (Minimum Data Set) assessment on 6/28/26 and coded the Resident in Section B-Hearing, Speech and Vision B1200 Corrective Lens as No. Interview of Director of Nursing on 7/29/26 at 12:10 PM confirmed the facility staff inaccurately assessed the Resident in the 6/28/26 MDS Quarterly MDS Assessment and should have coded the Resident as yes for Corrective Lens.		

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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 interviews conducted during a complaint survey, it was determined that the facility failed to have an effective process to maintain resident equipment. This issue affected 6 (Resident #17, #16, #18, #19, #20, #14) of 21 residents reviewed during a complaint survey. The findings include: On 7/29/26 at 1:30 PM the following observations were made during walking rounds: Resident Wheelchairs in Disrepair: Damage or missing components (including torn vinyl covering, missing foam padding, and missing armrests) were noted on wheelchairs for Residents #17, #16, #18, #19, #20, and #14. Additionally, one unattended reclining geriatric chair in the hallway by room [ROOM NUMBER] had a missing armrest. Interviews conducted on June 29, 2026, revealed a breakdown in the maintenance reporting process: - At 1:35 PM Geriatric Nursing Assistant (GNA) #29 stated she reported repairs verbally to the charge nurse or the unit manager. -At 1:37 PM Licensed Practical Nurse (LPN) #22 stated that she will tell the Assistant Director of Nursing (ADON) or the Director of Nursing. On 7/30/26 at 12:15 PM Director of Maintenance (DOM) #21 was interviewed and asked if he did wheelchair audits. DOM #21 stated, we have a TELS (electronic work order) system so anything in disrepair staff would normally put it in TELS. For wheelchairs we do not have any processes. The way it normally works is housekeeping normally cleans them and if they are in disrepair they will put in a work order for them to be fixed. I think it is more of an education piece that we need to do with the staff. We have techs on the floor and sometimes they will tell us on the fly, but our turnaround time is 24 to 48 hours. On 7/30/26 at 2:00 PM the Nursing Home Administrator was informed of the concern.		

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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 review of facility reported incidents, documentation review, and interviews, it was determined the facility failed to report an alleged abuse and misappropriation of resident property immediately to the Nursing Home Administrator and within 2 hours to the regulatory agency, the Office of Health Care Quality (OHCQ) for the alleged abuse. This was evident for 2 (Residents #8, #7) of 7 residents reviewed for facility reported incidents during a complaint survey. The findings include: 1) On 7/27/26 at 9:38 AM a review of facility reported incident 3090318 was conducted. The facility documented that Geriatric Nursing Assistant (GNA) #18 alleged that she walked onto the unit for her 11:00 PM to 7:00 AM shift on 7/5/26 and found Resident #8 sitting in a chair at the nurses' station restrained by a sheet. A review of the facility's investigation documented the alleged incident took place on 7/5/26 at 11:10 PM when found by GNA #18. Review of the email confirmations documented that the initial report was not submitted to OHCQ until 7/10/26 at 6:09 PM which was not immediately or within 2 hours of the alleged abuse. On 7/30/26 at 12:43 PM an interview was conducted with the Nursing Home Administrator (NHA) regarding the late reporting to OHCQ. The NHA stated that GNA #18 stated that she reported it to the nurse, which would have been the oncoming nurse who come in at 11:30 PM. GNA #18's story changed because there was a nurse on duty when she came on duty and from the interviews conducted Resident #8 was in bed. The NHA stated, Her story changed the entire time. I am the abuse coordinator, but she should have gone to the supervisor and she didn't. This happened on the July 5th, and she told me about it on July 10th. The NHA was informed that if this allegedly happened on July 5 then the staff member should have reported it immediately, and the staff member did not. 2) On 7/29/26 at 7:58 AM a review of facility reported incident 3094393 was conducted. Resident #7 alleged that someone took \$106 dollars from the resident's wallet. The facility reported the incident to OHCQ on 7/6/26 at 4:06 PM. Review of the facility's investigation revealed GNA #27's written statement that documented that he worked with Resident #7 on that day (July 3) and while working with his/her the resident told him the money was missing from his/her wallet and he told the charge nurse on that day. GNA #27 documented that the nurse told him that the resident, told her too. Review of Registered Nurse (RN) #25's written statement documented that Resident #7 reported to her on 7/3/26 that the money from the resident's wallet was missing and that the resident did not realize it until he/she went to add the monthly allowance to the wallet. The resident reported the money missing on the evening shift around 8 PM. Review of RN #15's written statement documented that on 7/3/26 she received a call from the charge nurse that the resident reported when he/she got new money for the month a few days ago that he/she lost the old money. The statement documented that RN #15 told the charge nurse to do a concern/grievance form and that RN #15 would come into the facility. Review of (9) staff statements all documented having or not having knowledge of the missing money on 7/3/26. On 7/30/26 at 10:28 AM an interview was conducted with RN #15 who stated, I did a grievance form for the Director of Nursing (DON). She wasn't here so I left it for her. When asked if she started a report she said, no, I just did the grievance form. On 7/30/26 at 12:50 PM the Nursing Home Administrator (NHA) was informed of the concern that the missing money was not reported within 24 hours to OHCQ.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of facility reported incident 3094393, medical record review, and interview, it was determined the facility staff failed to conduct a complete and accurate assessment by failing to assess a resident's cognition, mood, and behavior on an annual assessment. This was evident for 1 (Resident #7) of 7 residents reviewed for facility reported incidents during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. On 7/29/26 at 7:58 AM a review of Resident #7's medical record was conducted along with facility reported incident 3094393. Review of facility reported incident 3094393 reported that Resident #7 alleged that money was stolen from the resident's wallet. The resident initially reported it to a geriatric nursing assistant (GNA) on 7/3/26 and alleged the money had been stolen sometime over the past month. Review of Resident #7's annual MDS with an assessment reference date of 6/3/26, Section C, Cognitive Patterns was not assessed. There was no BIMS (Brief Interview of Mental Status) Summary Score. The resident's short term and long-term memory were not assessed or the resident's memory/recall ability and cognitive skills for daily decision making. Section D, Mood was also not assessed. On 7/30/26 at 12:35 PM an interview was conducted with MDS Coordinator #27. The MDS Coordinator was asked why Sections C and D were not assessed and she stated that social work was responsible for completing those sections. MDS Coordinator #27 stated at the time they missed the time period for when they could do the assessment due to staffing issues in the department. The Nursing Home Administrator was informed of the concern on 7/30/26 at 1:00 PM.		

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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 observation, interview, and medical record review, it was determined that the facility staff failed to provide thorough grooming and personal hygiene services for a resident. This was evident for 1 (Resident #9) of 3 residents reviewed for activities of daily living (ADL) care during a complaint survey. The findings include: A review of Complaint 3044140 was conducted on 7/27/26 regarding the facility staff failure to provide grooming services for Resident #9. Observation of Resident #9 on 7/27/26 at 12:53 PM revealed the Resident to be unshaven and have long untrimmed fingernails with black debris under the fingernails. During interview of Resident #9 at that time the Resident was asked if he/she would like to be shaved and have his/her fingernails trimmed. The Resident stated yes. Review of Resident #9's medical record on 7/27/26 revealed the Resident was admitted to the facility in April 2025 with a diagnosis to include cerebral infarction (stroke). Further review of Resident #9's medical record revealed the facility staff completed a Quarterly MDS (Minimum Data Set) Assessment on 6/28/26 and coded the Resident in Section GG Self-Care as dependent for Personal hygiene. Review of Resident #9's care plans revealed the Resident has a care plan entitled ADL Self Care Performance Deficit related to activity intolerance initiated 4/28/25 with an intervention of Complete grooming services including beard shaving, nails trimming weekly. Observation of Resident #9 on 7/29/26 at 12:50 PM revealed the Resident to still be unshaven with long untrimmed fingernails with black debris under the fingernails. During interview of Resident #9 at that time, the Resident was asked again if he/she would like to be shaven and have his/her nails trimmed. The Resident stated yes. The Resident added, I don't feel like I should have to beg them to do it. On 7/29/26 at 12:55 PM, the Surveyor had Unit Manager #30 come to Resident #9's room and confirmed the Resident was unshaven and had dirty untrimmed nails. On 7/29/26 at 1:05 PM the Director of Nursing was advised of the Surveyor's findings that Resident #9 was unshaven with dirty untrimmed nails confirmed by Unit Manager #30.		

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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 review and interview, it was determined the facility staff failed to administer a resident's medication in a timely manner. This was evident for 1 (Resident #15) of 3 residents reviewed for timely medication administration during a complaint survey. The findings include: During an interview with Resident #15's responsible party (RP) on 7/29/26 at 8:00 AM the RP stated the Resident received his/her cancer medication late this past weekend. During interview with Resident #15 on 7/29/26 at 8:46 AM, the Resident stated he/she received his/her cancer medication late this past weekend. The Resident stated he/she is supposed to have his/her medication with breakfast, but he/she knows Sunday it wasn't given until after 2 PM. Review of Resident #15's medical record on 7/29/26 revealed the Resident was admitted to the facility in November 2025 with a diagnosis to include Malignant (cancerous) neoplasm of prostate. A review of Resident #15's Medication Admin Audit Report for 7/25 and 7/26/26 was completed on 7/30/26. The Resident is ordered to receive Nubeqa 300 mg give 2 tablets twice a day for prostate cancer take with breakfast and dinner. The scheduled times are 8 AM and 5 PM. Further review of the Report revealed on 7/25/26 the Resident was administered his/her 8 AM dose at 11:14 AM and on 7/26/26 at 2:54 PM. The Resident was administered his/her 5 PM dose on 7/26/26 at 4:30 PM, therefore the Resident received 2 doses of Nubeqa 1 hour and 36 minutes apart on 7/26/26. Interview with the Director of Nursing on 7/31/26 at 8:35 AM confirmed the Surveyor's findings that Resident #15 was not administered Nubeqa timely on 7/25 and 7/26/26.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to follow physician ordered blood pressure parameters for administering blood pressure medications to a resident. This was evident for 1 (Resident #11) of 3 residents reviewed for unnecessary medications during a complaint survey. The findings include: Review of Complaint 3031582 was conducted on 7/27/26 regarding excessive dosing of medication to Resident #11. Review of Resident #11's medical record on 7/27/26 revealed the Resident was in the facility for 18 days in 2026 with a diagnosis to include Hypertensive Heart Disease. Review of Resident #11's April 2026 Medication Administration Record revealed the Resident was administered the following blood pressure medications when the Resident's blood pressure did not meet the physician ordered blood pressure parameters for administration: 1) Isosorbide Mononitrate ER 30 mg in the evening for hypertension, hold for systolic blood pressure less than 100a) 4/9/26 at 8:00 PM for blood pressure 86/54b) 4/10/26 at 8:00 PM for blood pressure 94/572) Losartan Potassium 25 mg in the evening for hypertension, hold for systolic blood pressure less than 100a) 4/9/26 at 8:00 PM for blood pressure 86/54b) 4/10/26 at 8:00 PM for blood pressure 94/573) Atenolol 25 mg twice a day for hypertension, hold for systolic blood pressure less than 100a) 4/9/26 at 8:00 PM for blood pressure 86/54b) 4/10/26 at 8:00 PM for blood pressure 94/57c) 4/16/26 at 8:00 PM for blood pressure 77/52 The Surveyor reviewed Resident #11 April 2026 Medication Administration Record with the Director of Nursing on 7/29/26 at 11:18 AM. Interview with the Director of Nursing on 7/29/26 at 12:31 PM confirmed Resident #11 was administered blood pressure medications on 4/9, 4/10 and 4/16/26 when his/her blood pressure did not meet the physician ordered blood pressure parameters.		

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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, staff interviews, and documentation review, it was determined that facility staff failed to keep medication carts locked when unattended and discard expired medications/biologicals. This was evident on 2 of 4 nursing units observed during random observations made during a complaint survey. The findings include: 1) On 7/29/26 at 11:57 AM observation was made on the Gateway nursing unit of (2) unlocked and unattended medication carts sitting at each end of the nurse's station. The surveyor was able to open the drawers in both carts and observe resident medications such as over-the-counter medications and prescription medications that included but were not limited to cardiac, blood pressure, neuropathy, antipsychotic, antidepressants, antianxiety, diabetic, and other types of medications. In the Gateway 2 medication cart, observation was made of a vial of Lidocaine 2 percent NDC 0409-4277-16 that was opened with approximately one third of the contents of the vial used. There was no date opened on the vial. The surveyor stood at the medication cart for approximately 4 to 5 minutes as residents were mobile in the area and other staff walked around the unit. No licensed staff were present at the nurse's station. On 7/29/26 at 12:02 AM Licensed Practical Nurse (LPN) #14 walked up to the Gateway 1 medication cart and the surveyor informed her that the medication cart was left unlocked. LPN #14 stated she was sorry and it was a mistake. At 12:03 PM LPN #3 walked into the nurse's station to sit at the desk. The surveyor asked which nurse was working with the Gateway 2 medication cart. LPN #14 answered the surveyor and stated it was another nurse who was currently on a different floor at the time. The surveyor informed LPN #3, who was the unit manager, that both medication carts were unlocked when the surveyor arrived on the unit. The surveyor also presented the opened vial of Lidocaine to LPN #3 to show her it was not dated. LPN #3 stated that the carts should have been locked. 2) On 7/30/26 at 10:25 AM observation was made on the Gateway nursing unit of an unlocked treatment cart sitting in the hallway outside of room [ROOM NUMBER]. The surveyor opened the treatment cart and observed ointments, emollients, and other various treatment supplies. In the second drawer observation was made of an opened 100 ml. bottle of 0.9% sodium chloride irrigation, lot number 260512029, that was not dated when opened. In the fourth drawer was another opened 100 ml. bottle of 0.9% sodium chloride irrigation that was not dated when opened. On 7/30/26 at 10:28 AM, LPN #3 was given the bottles and informed of the concern. LPN #3 confirmed the surveyor's findings. An opened 100 ml 0.9% sodium chloride (normal saline) bottle without preservatives should be either discarded immediately or within 24 hours because it lacks antimicrobial agents to stop germ growth. Once the seal is broken, airborne bacteria and fungi can quickly multiply in the liquid at room temperature. 3) On 7/30/26 at 10:30 AM observation was made of an unlocked and unattended medication cart sitting in the hallway outside of room [ROOM NUMBER] on the Chesapeake unit. The surveyor was able to open the drawers to the medication cart and observed in the top drawer a plastic 30 ml. medication cup with 9 pills in the cup. No name was on the medication cup. On the other side of the top drawer was another 30 ml medication cup with 6 pills in it. No name was on the cup. The surveyor stood at the medication cart approximately 2 to 3 minutes until LPN #16 rushed up to the cart and got in front of the surveyor to get an item out of the cart. LPN #16 then started to walk away, and the surveyor stopped her and asked her if she realized she had left the medication cart unlocked. LPN #16 stated, they were calling me about a dialysis patient, so I had to go check on [him/her]. On 7/30/26 at 10:40 AM a review of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Medication Storage Policy that was given to the surveyor from the Director of Nursing (DON) documented, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments, (i.e., medication carts, cabinets, drawers, refrigerators, medications rooms) under proper temperature controls. B. only authorized personnel will have access to the keys to locked compartments. On 7/30/26 at 12:17 PM the DON was informed of the concerns.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews, it was determined the facility staff failed to ensure food was served at a palatable temperature and all the items on a resident's meal ticket were delivered. This was evident for 1 (Resident #15) of 3 observations during a complaint survey. The findings include: During an interview with Resident #15's responsible party (RP) on 7/29/26 at 8:00 AM, the RP stated the Resident has complained he/she doesn't receive coffee, milk for his/her oatmeal and the food is cold at breakfast. Interview with Resident #15 on 7/29/26 at 8:30 AM the Resident stated he/she doesn't always get coffee and milk. The Resident also stated that often the food is cold so he/she doesn't eat it. On 7/31/26 at 8:28 AM the Surveyor asked Unit Manager #23 who was already in the Resident's room to observe a test temperature of the Resident's pancakes as it was served to the Resident. At that time the temperature of the pancakes was 110 degrees. Hot foods are to be maintained at 135 degrees. Observation at that time also revealed no milk on the Resident's breakfast tray. Interview with Unit Manager #23 at the time confirmed the Surveyor's findings. Review of Resident #15's 7/31/26 breakfast meal ticket revealed the Resident is to receive 8 ounces of milk. The findings were reviewed with the Administrator on 7/31/26 at 8:35 AM.		