STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215269	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of medical records, facility investigation and interviews, it was determined that the facility failed to ensure that a resident who required a Hoyer lift for transfer was transferred with a Hoyer lift which resulted in harm to Resident #156 who sustained a fracture of the distal femur. This was evident for 1 (Resident # 156) out of 11 residents reviewed during the annual survey. The findings include: Review of Resident #156's medical record on 09/30/2025 at 3:30 PM revealed Resident #156 had a Brief Interview of Mental Status (BIMS) score of 15/15 on 07/29/2025, and a Care Plan with a focus of Short-Term Care: the resident requires assistance with their activities of daily living due to impaired mobility; dated 07/20/2025 with inventions dated 07/22/2025 for transfers: Hoyer Lift Assist x 2; Ambulation: unable.Further review revealed a Radiology Results Report dated 09/15/2025 of Resident #156's right knee with the following findings: Previous arthroplasty with grossly displaced fracture of the distal femur extending to the arthroplasty hardware. Review of Facility Reported Incident Investigation on 10/02/2025 at 2:00 PM revealed that that the facility had verified Resident #156 having a witnessed fall while transferring to bed from a wheelchair sustaining a right acute fracture of the distal femur on 09/15/2025 due to Geriatric Nursing Assistant (GNA) staff #28 failing to identify transfer status of Resident #156 to be a mechanical lift assist of 2 persons for all transfers. The facility interviewed Geriatric Nursing Assistant (GNA) #28 on 09/17/2025 and GNA #28 statement stated that on 09/15/2025 at 10:50 AM therapy had gotten Resident #156 out of bed into a wheelchair, and he/she requested to go back to bed. GNA #28 stated to Resident #156 that he/she was going to put him/her in bed but Resident #156 stated, No I do not need help, stood to take a step and went down on his/her right knee, turned to his/her buttocks leaning back toward the bedside table. The facility interviewed resident #156 on 09/15/2025 and resident statement stated that he/she was trying to transfer from the wheelchair to his/her bed and that the bed was lowered for him/her to get in, he/she had been working with therapy for stand and pivot and did a car transfer the other day with therapy. He/she stated he/she stood, his/her feet would not move almost like glue to the floor, and he/she fell on to the right knee, then his/her buttocks then fell back and hit their head on the floor. The resident stated that the caregiver was at the foot of the bed near the window and the resident stated that he/she was trying to get into bed on the side closest to the door. Further review revealed that GNA #28 was terminated by the facility on 09/24/2025 for violation of company policy. During interview with 10/02/2025 at 2:10 PM Director of Nursing staff #2 stated that, [GNA #28] attempted to assist [Resident #156] with a transfer without a Hoyer Lift or a second person, did not try and stop resident from transferring, did not try and get help or clarification from the resident medical chart or ask a nurse regarding [Resident #156] transfer status. He/she should have known and did not. Director of Nursing staff #2 further stated, [GNA #28] was reported to the Maryland Board of Nursing.During an interview on 10/02/2025 at 4:31 PM Director of Rehabilitation staff #30 stated, [Resident #156] was a 2 person transfer with a Hoyer lift at the time of injury/fracture on 09/15/2025. Staff #30 also provided a PT Recert, Progress Report and Updated Therapy Plan Current dated 8/21/2025 revealing that Resident #156 was Substantial/ maximal assistance for chair/bed transfers. Staff #30 further stated, staff should have used a Hoyer lift with 2 persons assist with [Resident #156] on the day that he/she was transferred (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 0684 Level of Harm - Actual harm Residents Affected - Few	and sustained a fracture. Review of facility staff education on 10/03/2025 at 11:20 AM revealed that the facility completed all facility nursing staff, including agency staff, education as of 09/22/2025 regarding transferring a resident safely, checking Kardex for transfer status prior to transfer, and notifying nurse if resident insists on transferring in a manner inconsistent with safe transfer status. During an interview on 10/07/2025 at approximately 8:05 AM Director of Nursing stated that, audits were started on 09/29/2025 to ensure staff are able to demonstrate where the transfer status is found in the clinical record and that the residents that require a mechanical lift for transfer are transferred appropriately. During review of facility documentation on 10/07/2025 at 8:10 AM the facility audit sheets revealed a start date of 09/29/2025.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review it was determined the facility failed to ensure the hospice pain management orders for Resident #179 were followed which resulted in harm to the Resident due to unmanaged pain. This was evident for 1 out of 9 residents reviewed for pain management during the facility's recertification survey.The findings include: On 10/7/25 at 8:26AM the surveyor conducted a review of complaint #319265 submitted to the Office of Health Care Quality which alleged that on 6/15/25 evening shift and overnight shift into 6/16/25, Resident #179 suffered with pain that was not appropriately managed by facility staff.Review of the medical record by the surveyor on 10/7/25 at 8:31AM revealed that on 6/10/25 Resident #179 was admitted to hospice care with a terminal illness. The following hospice medication order for Resident #179 were observed to be actively in effect from 6/13/25 to 6/16/25: Morphine Sulfate Oral Solution 100/MG/5ML Give 0.75ml by mouth every 4 hours for pain/dyspnea if asleep wake pt. for med administration. Surveyor review of the medication administration record of Resident #179 revealed pain medication orders for both scheduled and hourly as needed Morphine medication for pain. On 6/15/25 at 1:55PM Resident #179 was given an as needed dose of pain Morphine medication. Further surveyor review of the medical record revealed that after the 6/15/25 1:55PM dose, no further Morphine pain medication was administered to the resident for approximately 18 hours and 39 minutes until 6/16/25 at 8:34AM. On 10/7/25 at 11:32AM the surveyor conducted an interview with Staff #47 who reported they were made aware of the hospice nurse's arrival to the facility on the morning of 6/16/25 at which time the narcotic medications were found to not be logged according to how they should've been given. Staff #47 reported to the surveyor that there were two forms of documentation, they didn't match, and the resident was not receiving the morphine pain medication as ordered, which resulted in the resident having a pain crisis. Staff #47 reported the resident's family communicated their concern to them for Resident #179's unmanaged pain. Staff #47 reported that an occurrence report was documented regarding Resident #179's pain crisis. Staff #47 reported that the resident was foaming at the mouth, medications were ordered routinely and medications were not being given routinely, and no prn (as needed) pain medication was being given. Staff #47 reported that because the pain had not been managed according to orders, more orders were needed to then achieve pain control for the resident. Review of medical record documentation on 10/7/25 at approximately 12:00PM which was provided in response to the surveyor's request, revealed a client occurrence report dated 6/16/25 which detailed the following information regarding the medical care of Resident #179: Nature of occurrence: untoward outcome, Pt (patient) in pain crisis, tremoring, foaming at mouth, minimally responsive, moaning. The report additionally detailed 6 witnesses to the occurrence which included Staff #47, Physician #48, Certified Registered Nurse Practitioner (CRNP) #49, Unit Manager #50, ADON #45, and LPN Charge Nurse #46, and documented the date of physician notification about the occurrence as 6/16/25 with the following physician response to the pain crisis of Resident #179: medication dose and frequency increased (multiple prn doses given.)During surveyor's review of Resident #179's medical record on 10/7/25 at 1:45PM the June 2025 Medication Administration Record was observed documented as signed off by nursing staff as Morphine having been documented as administered, however, surveyor review of the facility's narcotic log revealed no controlled narcotic medication was logged as administered and reconciled in the facility's narcotic log from after 6/15/25 at 1:55PM until 6/16/25 at 8:34AM. Morphine orders for the resident were observed to be crossed out and re-written with different types of orders on 3 out of 3 morphine logs instead of new sheets having been started to account for the medication order changes, and only 1 out of 3 morphine logs was found to document an RX#. Further review of the medical record revealed a medical progress note documented by CRNP #49 with a service date of 6/16/25 which included the following information: Called to the unit for uncontrolled pain; Patient was seen and assessed at the bedside for uncontrolled pain. Hospice staff were also present at the time of evaluation, and we collaborated to address [his/her] significant discomfort. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the medication administration record indicated no breakthrough morphine was given overnight, contributing to [his/her] current level of pain. On 10/7/25 at 1:51PM the surveyor conducted an interview with LPN #46 who reported that Resident #179 was placed on morphine which started out as prn (as needed) then went on to a standard scheduled dose with prn's (as needed) for breakthrough pain, and the last few days when [Resident #179's] pain exacerbated I was working with the hospice nurse to manage [his/her] pain. I reached out to [hospice nurse] and asked them to review [Resident #179's] dose. The times I was not here, I'm sorry but [his/her] pain wasn't managed, [s/he] wasn't getting the doses. The family [of Resident #179] came in and spoke about the disgust of [Resident #179's] pain not managed. When the surveyor inquired to LPN #46 how they knew the resident wasn't receiving the pain medication doses they stated: I saw the book, (LPN #46 pointed to the narcotic log) and the count and you can see the gap in administrations. Family told me he wasn't getting [his/her] medications overnight. I learned the morning after when I came in for my shift. Oh I called hospice right away, [s/he] came every day and we made sure pain was managed. LPN #46 reported to surveyors that on the morning of 6/16/25 they found Resident #179's mouth filled with froth and when his/her mouth was cleaned s/he was moaning in pain and they observed the resident with facial grimacing. LPN #46 stated that after they reached out to hospice and the resident's primary care physician in the early morning on 6/16/25, the narcotic log was then observed by the hospice nurse. LPN #46 observed the narcotic log with surveyors and stated: usually we have separate logs for different administrations, but I don't think we got the medication from pharmacy. The surveyor asked for LPN #46 to show where in the narcotic log that the medication had been administered and they stated: It's not there, you won't see it. When the surveyor inquired as to if the concern was brought to facility staff they stated: Hospice spoke to the ADON. When the surveyor inquired as to if any further action was taken by the facility to prevent future occurrence or if any action was taken to address the overnight nurse/staff and medication administration, they stated: Not that I know of, no one was addressed. On 10/8/25 at 8:14AM the surveyor further reviewed the June 2025 medication administration record (MAR) of Resident #179 and compared this to the facility's narcotic log which revealed the following additional information: 1. the 6/15/25 9:00AM scheduled dose of Morphine was documented as given 1 hr and 28 minutes later at 10:28AM, and the narcotic log revealed there was only 0.5 ml left in bottle and a 0.5ml dose was given which was not the full dose of 0.75ml which was ordered for the resident's scheduled morphine for pain control,2. the 6/15/25 17:00PM scheduled dose of Morphine was documented as given at 16:55PM on the MAR, however, was not accounted for as having been given on the narcotic log, 3. the 6/15/25 21:16PM 0.75ml dose q 4hrs was documented as given per the MAR, however, was not accounted for as having been given on the narcotic log, 4. the 6/16/25 1:00AM scheduled dose of Morphine was documented as given on the MAR at 4:55AM, however, was not accounted for as having been given on the narcotic log, 5. the 6/16/25 5:00AM scheduled dose of morphine was documented as given per the MAR at 5:35AM, however, was not accounted for as having been given on the narcotic log, and6. the 6/16/25 scheduled 9:00AM Morphine dose was documented as given per the MAR at 8:21AM, however, was not accounted for as having been given on the narcotic log. On 10/8/25 at 8:50AM the surveyor conducted an interview with the facility's Director of Nursing (DON). When the surveyor inquired as to if Resident #179's pain crisis had been brought to their attention, they reported they were not aware and that no information had been provided to them from facility staff regarding the situation. Surveyors observed the narcotic log with the DON who reported that they did not know who had crossed out the orders on the narcotic log and stated that they shouldn't have crossed all that out and it's not matching the MAR (medication administration record). When the surveyor inquired to the DON as to how she would know the pain medications had been given, she stated I don't, it has to be signed on both the MAR and narcotic log, I wouldn't know, I assume the pain medication was not given. The DON further informed surveyors that routine and as needed medications both go on the narcotics log and if the dose is changed a new page is started. The DON stated to surveyors: No, procedure was not (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	followed. When the surveyor inquired as to if documented pain crisis is typical for a resident receiving hospice services, they stated: No, it (pain) should be controlled. On 10/8/25 at 9:08AM the surveyor conducted an interview with ADON #45 regarding the incident of pain crisis of Resident #179. ADON #45 reported I don't remember, I thought that happened on an off shift, 3-11 or 11-7. When the surveyor inquired to ADON #45 as to whether the facility took any actions in response to Resident #179's situation to prevent further occurrence, they stated the following: It should've been fixed, but whether it did or not I don't know, the unit manager should have done that. On 10/8/25 at 11:45AM the surveyor shared the harm level concern with the facility's Director of Nursing and the facility's Administrator who both acknowledged and confirmed understanding of the surveyor's concerns. At this time the surveyor additionally provided an opportunity for any and all further documentation to be provided by the facility for surveyor review. The Director of Nursing stated to surveyors that there was no further documentation to be provided.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, record reviews, and interviews with residents and staff, it was determined that the facility failed to maintain a system to ensure that resident council concerns were acknowledged and addressed timely, resolutions were communicated, and interventions were effective. This failure had the potential to affect all residents.The findings include: Resident Council is a group of residents that meets regularly on the behalf of all residents in the facility to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life. Facility staff are required to consider residents' views and act upon grievances and recommendations. Facility staff must consider these recommendations and attempt to accommodate them, to the extent practicable. On 9/28/2025 at 11:15AM, during an interview with representatives from the resident council, the Surveyor was informed that concerns discussed during the resident council meetings are not addressed and acted upon timely. The resolutions are usually unclear because the issues still occur. The residents feel like nothing is being done to address their majority of their concerns. On 10/3/2025 at 2:05PM, a review of the resident council minutes for July 15, 2025, failed to reveal a review of administrative resolutions and what was resolved from last meeting. There was a social service concern that residents are not sure the process to fill out grievances outside of regular business hours and resident rights were reviewed. An additional review of resident council minutes from August 12, 2025, failed to reveal a review of administrative resolutions (states none at this time) and what was resolved from last meeting. New concerns included: new tray times discussed, the front door will be locked at all times, GNA/nurses are not knocking or announcing themselves when they enter the room, residents request more outside time other than smoke breaks, problems with ants and flies in their room, and resident rights were discussed. An additional review of resident council minutes from September 16, 2025, failed to reveal a review of administrative resolutions (states none at this time) and what was resolved from last meeting. The Nursing Home Administrator (NHA), the Administrator in Training (AIT), and the Director of Nursing (DON) were at the meeting. New concerns included: staff members taking breaks during mealtimes, resident snacks are hidden behind the nurses' station making them less accessible, and residents would like to have more variety of snacks. On 10/7/2025 at 12:00PM, during an interview with the residents from the resident council group, the Surveyor was informed that the concerns/grievances process should be completed and discussed with the residents within 5 days. Grievance forms should be located outside the social services office, and they are not. Residents are demanding resolutions to their concerns expressed at the meetings and the facility staff are not updating them. On 10/8/2025 at 8:51AM, during an interview with the DON, the Surveyor was informed that the concerns addressed during the resident council meetings are forwarded to that specific department to review and provide a resolution for. The resolutions are sent back to the activity (the staff that take the resident council minutes) department to discuss with the president and the group during the next meeting. Each department is responsible for following up with their concerns and resolutions. On 10/8/2025 at 12:05 PM, during an interview with Director of Recreation (DOR) #10, the Surveyor discovered that after the resident council meetings the concerns/grievances are entered into a computer system to be managed by the administrator. After the review process, the Grievance Summaries are completed and attached to the Resident Council Minutes to be discussed at the next meeting. On 10/9/2025 at 8:00AM, during an interview conducted with the AIT, the Surveyor informed the AIT that after a review of the Grievance Summaries from July, August, and September 2025, the Surveyor had the following concerns: grievances from resident council are not reported on the same date the grievance was recorded by staff; grievances are not addressed timely; resolutions are not always communicated to the resident council; and, interventions are not monitored to ensure they are effective. The Surveyor also expressed the concern that the facility failed to ensure grievance forms were available outside the social service office and there was no bin or mailbox labeled for grievances. During the survey, (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	some nursing staff still failed to knock/ask permission before entering the resident's room, flies and ants were observed throughout the facility as well as in resident's rooms, and snacks were placed behind the nurses' station on Unit 2 and not passed out to residents. These were all concerns addressed by the resident council and have continued with no effective resolution.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. Based on observations, record reviews and interviews, it was determined that the facility failed to: 1) ensure the resident right to manage his or her financial affairs; and, failed to obtain written authorization for facility to act as a fiduciary of the resident's funds. This was evident for 1 (#58) resident out of 2 residents investigated for personal funds management; and 2) have a system in place that allows residents to access their personal funds on an ongoing basis and be available to the residents when they request. This practice has the potential to affect all residents who have allowed the facility to manage their personal funds.The findings include: 1. On 09/29/2025 at 12:28 PM during observation and interview, Resident #58 stated, I stopped getting money into my bank account from Social Security since about April, I spoke with someone there and was told that a facility doctor signed a statement that I cannot handle my finances anymore. When I ask the facility why this happened, or for funds or to see statements or transfer funds back to my bank, I am always told no. I have no money to obtain my lost documents (birth certificate and social security card) or to get a lawyer. When I asked for help from the Social Worker, they just give me a grievance form, but nothing is ever done. On 09/30/2025 at 8:39 AM during interview with Director of Nursing (DON) staff #2, Nursing Home Administrator (NHA) staff #1, and Administrator in Training (AIT) staff #3, this Surveyor shared Resident #58's concerns regarding personal funds and being told by Social Security that a facility doctor provided a letter to them that the resident was no longer able to handle their own funds. On 10/01/2025 at 12:59 PM during an interview with AIT staff #3, this Surveyor was informed that Resident #58 was seen and the Business Office cut a check for the agreed amount. AIT Staff #3 was then asked why payments stopped and if Resident #58 was informed and Staff #3 stated the Business Office would know why, I will look into this. On 10/07/2025 at 10:19 AM during record reviews and interviews regarding concerns for incompetence and resident funds, it revealed a BIMS Interview and Staff Assessment, dated 09/19/2024, with a Score of 15, indicating the resident is cognitively intact. The three Physician Certification Related to Medical Condition, Decision Making, and Treatment Limitations forms, dated 05/19/2022, 10/15/2023, and 6/5/2025; all indicate via the Certification Regarding Decision Making Capacity, that Resident #58 has adequate decision making capacity (including decisions about life-sustaining treatments). Of note, the last certification was completed by Resident #58 current physician (Physician #30). However, the facility filed form SSA-787, the Medical Source Opinion of Patient's Capability to Manage Benefits, the process used to make the facility Representative Payee, completed by Physician #30, citing Resident not capable of handling funds due to their medical condition." dated 3/17/25. Subsequently, the facility received a favorable decision letter dated May 7, 2025 assigning the facility as Representative Payee and that effective on or about April 30, 2025, Resident #58's direct deposit information was changed. This Surveyor received a copy of Resident #58's Activity Account from the Business Office, which revealed a Current Amount Owing: $42,559.12 and significant Note entries as follows: Oct. 2022-regarding rep payee process via SSA-787 to Social Services attempt; January 2023-If no payment by 2/15, trustee to be appointed; and June 2025-Income is now being received in RFMS. Of note, there were no progress notes about the change of decision-making ability regarding Resident #58 around the time of the filing of the changes to Social Security in March 2025 and no communication provided to the resident about the Social Security office decision received in May 2025 that granted the facility as Representative Payee and the redirecting of their personal funds now to the facility. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/07/2025 10:30 AM during an interview with Business Office Manager (BOM) staff #51, this Surveyor asked why the resident was not informed of the Resident Payee request and no statements or funds received until Surveyor intervention; BOM staff #51 states I am new here, but that resident had an outstanding unpaid bill of over $40,000 and that was why the Resident Payee process was started. Because resident had SSA-787 form on file indicating they no longer handle their own funds, I do not give them statements. Surveyor asked how Staff #51 was made aware of Resident #58's mental status or the inability to handle own funds and Staff #51 shared that Administrator in Training (AIT) staff #3 asked that I confirm the status of the (787) application. Surveyor received Email communication, dated June 11, 2025 12:17 PM from BOM staff #51 to AIT staff #3, which revealed that resident .income has been redirected to the RFMS account. The personal allowance is now available for (them) to use. I called to let (them) know but I didn't get an answer, (their) mailbox was full so I could not leave a message. I will make sure (they) are made aware before the end of business. Surveyor asked if this was shared with the resident and provided their funds and statements, or any further communication or documentation and staff #51, stated No. Staff #51 then shared, when I was informed that the resident wanted funds, I spoke with the resident. The resident wanted ACH (Automated Clearing House) payments back to their personal account and was told the facility was unable to that. I offered the resident a bank card and they refused the bank card. I did provide the resident with their statement and explained the options of receiving cash or check or both. I arranged for the resident to get their allowance amount last week, via the receptionist as this is our process. On 10/09/2025 at 10:30 AM during follow-up interview with BOM staff #51 regarding the filing process of the SSA -787, BOM staff #51 stated I started in April 2025 during an audit, the Medicare Specialist and prior BOM-both left within a few weeks of me starting here. The Representative Payee application, form 787 is from a physician, I did not file that application, but the resident had an outstanding bill that they were not paying over $40,000. BOM staff #51 again shared that because of the 787 on file, Resident #58 would not get a statement, these resident statements are signed by the BOM and filed. Staff #51 provided this Surveyor with 'Resident Fund Statement' for June 2025, which reflected BOM staff #51 signature and a note 'for ENR/Rep Payee' On 10/09/2025 at 1:09 PM during an interview Physician staff #52, confirmed they were the Primary Care Physician for Resident #58, stating yes, resident can make decisions, however, medical decision making only and not financial. This Surveyor asked, how capacity was determined and differentiated from medical and financial and if there were different capacity forms at the facility and Staff #52 stated No, but when talking with the [AIT staff #3] and the resident about the outstanding bill, resident was unable to have a plan. Surveyor asked Physician staff #52 was the signature on the SSA-787 form, dated 3/17/2025 completed and signed by Physician #52 and staff #52 stated Yes. This Surveyor then shared that Resident #58 had 3 signed Physician Certifications determining the resident had capacity, with the last one completed by Staff #52 dated 6/5/2025, but then this SSA-787 form was filed. Staff #52 was asked if this form used to determine resident mental capacity and why and staff #52 stated No, but there two types of capacity a resident can have: medical and financial, this resident does not have capacity to make financial decisions. This Surveyor asked was there any other consults or change in resident status that supported this change, Staff #52 stated No. Surveyor was not provided any additional information; facility was unable to provide any other physician certification regarding no capacity for personal financial management. 2. On 10/7/2025 at 12:10PM, during an interview with Resident #39, the Surveyor was informed that residents are allowed to withdraw money from their accounts Monday through Friday, while the day (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	receptionist is working. If a resident needs money for the weekend, they would have to withdraw the money on Friday. Sometimes the facility runs out of money to dispense to the residents. On 10/9/2025 at 9:45AM, an interview with Business Office Manager (BOM) #51 revealed that the resident's funds are distributed by the day receptionist Monday through Friday, from about 9AM to 4PM, or whenever she leaves for the day. A representative from the business office can also distribute resident funds during office hours, Monday through Friday, from 10AM to 4:30PM, if the receptionist is not available. There is no money distributed after business hours or on weekends. If a resident needs money for the weekend, they must request it on Friday. The Surveyor expressed the concern that the facility does not provide ongoing access to their funds and that the facility cannot restrict the resident's access based on the time of day. In addition, BOM #51 stated that the facility recently ran out of petty cash one day in October to dispense to the residents. Residents seemed to be taking out more money than in past months. BOM #51 informed the Surveyor that the business office will ensure there is enough petty cash available to accommodate the resident monetary needs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, interviews and facility environmental rounds, it was determined that the facility failed to 1) provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable homelike environment. This was evident throughout the facility; and 2) protection from loss for a resident's belongings. This was evident for 2 (Resident #3) out of 2 residents reviewed for personal property during the annual survey.The findings include: 1) On 9/28/25 the surveyor observed the following conditions present during the initial tour of the facility: At 9:18AM the surveyor observed an area on the wall which appeared to be missing signage adjacent to the signage for the Northwest 2nd floor sign in the resident hallway which was observed to have letters missing from it. At 9:20AM the surveyor observed white and brown liquids present and pooling on the floor in room [ROOM NUMBER] underneath the window bed and leaking into the door on the bed side of the room along and under the resident fall mat situated between the two resident beds. A resident family member expressed to the surveyor their concern that the spills happen frequently and are not cleaned up. At this time the surveyor shared the concern with Licensed Practical Nurse #7 who acknowledged and confirmed understanding of the concern. At 9:29AM the surveyor observed room [ROOM NUMBER] with damaged wall conditions along the cove molding which was observed to be separated from the wall. Uncovered cable cords were observed protruding from a cut out section of the wall. On 9/28/25 at 9:44AM the surveyor observed room [ROOM NUMBER] with white areas of missing paint behind the door bed. The floor safety mat was observed to be visibly soiled with areas that appeared to be wet and greasy. Areas of chipping paint and spackled unfinished areas were observed to be present behind the bed on the window side of the room. A crack was observed extending approximately 2 feet in length extending up the bathroom wall exposing the materials present within the wall. Another crack was observed in the bathroom flooring along the wall extending approximately 2.5 feet in length. Areas of missing and chipping paint were observed on the bathroom wall and there was no toilet paper roller bar present. On 9/28/25 at 10:06AM the surveyor observed the room signage was missing for room [ROOM NUMBER] and the room number was observed written on the wall in permanent marker. On 9/28/25 at 10:07AM the surveyor observed the room signage in worn condition for room [ROOM NUMBER] with medical tape applied to the signage and the room number written on it in permanent marker. On 9/28/25 at 10:11AM the surveyor observed room [ROOM NUMBER] with areas of missing cove molding and the cove molding observed to be present near the corner of the room nearest to the window was separated from the wall revealing areas of thick black matter present. Spackled and unpainted areas were observed on the walls and areas of missing paint were present on the wall behind the bed headboards. Cove molding was additionally observed to be separated from the wall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	near the sink area. On 9/28/25 at 10:18AM the surveyor observed an area of wall damage without cove molding present on the corner of the wall located between the bathroom and the resident's bed area in room [ROOM NUMBER]. On 9/28/25 at 10:29AM the surveyor observed scrapes present on the walls and areas of chipping paint present behind the bed head boards in room [ROOM NUMBER]. On 9/28/25 at 10:33AM the surveyor observed the call light above the door in the resident hallway to room [ROOM NUMBER] without a cover and 1 out of 3 light bulbs was observed to be missing. On 9/28/25 at 10:33AM the surveyor shared concerns with Licensed Practical Nurse #7 who observed and acknowledged surveyor concerns. On 9/28/25 at 10:44AM the surveyor observed the room signage for room [ROOM NUMBER] which was observed to be missing and with cracked plastic present. In room [ROOM NUMBER], the window, between the glass and the screen, was filled with dead insects and a thick, stringy cobweb-like material that filled the entire window. Resident #142 stated that they have been residing at the facility for about 5 years and the window has never been cleaned. In room [ROOM NUMBER], the floor was dirty and sticky with a large area of black stains covering the floor by the bathroom. The black molding for the over the bed table, by the window, was hanging off.In room [ROOM NUMBER], the ceiling tile, above the bed by the door, had a large brown stain on it. There were 3 other brown stains on ceiling tiles by the doorway. In room [ROOM NUMBER], the window, between the glass and the screen, was filled with dead insects and a thick, stringy cobweb-like material that filled the entire window. Resident #181 stated that they liked to look out the window at the birds but, it was bothersome to see the cobweb like material interfering with their view. In room [ROOM NUMBER], the footboard for Resident #155's bed was sitting on the floor next to the bed. The resident stated that the footboard keeps falling off and the maintenance department constantly has to replace it. In room [ROOM NUMBER], the floor was sticky and there were thick tan stains located on the floor, by a pole which had enteral formula with uncapped tubing hanging on it, near the bed by the door. In room [ROOM NUMBER], the floor was dirty and sticky, paint was chipped on the wall behind the resident's beds, paint was chipped and there were black scuff marks on the wall across from the resident's beds, and baseboard, near the bathroom, was damaged. In room [ROOM NUMBER] was found to have walls with holes that were rotting and crumbling, black in color and surrounding the base of the room's p-tac unit then extending approximately 5 feet down the wall near the cove base. The cove base and floor tiles below the wall were cracked and separated. The was a large crack in the wall on the left side of the window. Throughout the white-cream color floor tiles of the room were layers of buildup of black brownish color substance. The bathroom was noted to have a bathtub/shower with a buildup of a green and brown color (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	substance throughout the bottom and inner sides of the bathtub/shower. On 09/28/2025 at 08:25 AM the surveyor interviewed the resident in room [ROOM NUMBER] -D who stated that the floors are always sticky and are not guaranteed to have the floors cleaned every day. The surveyor observed that the floor by the resident's bed was sticky and the linoleum was dull and dirty. The resident's roommate in 229-W agreed with the statement that the floors in their room were not cleaned daily. On 09/28/2025 at 08:27 AM the surveyor observed that there were three large clear plastic bags with clothing inside that the Resident #166 acknowledged were his/her belongings. Resident #166 stated that there no attempt by staff members to place his/her personal belongings off the floor and store them appropriately. On 09/28/25 at 08:32 AM the surveyor observed that floor in room [ROOM NUMBER]-D and W had dirty floors with large brown spots outside the bathroom door approximately 4inches x 6inches in diameter. The floor of room appeared to be dirty with black coating from the wax built up on the linoleum flooring. On 09/28/25 at 08:45 AM the surveyor observed that floor in the room occupied by the residents in 224 D and W was dirty and the linoleum had black wax buildup. Resident # 19, stated that the floors were dirty routinely. Resident # 114 stated that the floors are cleaned every other day and stated that they are unable to open the window to get fresh air. On 09/28/2025 at 09:08 AM the surveyor observed that the floor in room [ROOM NUMBER] D and 222 W was dirty with brownish sticky substance. Resident #102 stated the substance on the floor was food and NGT feeding that spilled and was never clean up by nursing and/or the housekeeping staff. The surveyor also observed that the linoleum flooring had built up wax which displayed grayish black marks. On 09/28/2025 at 09:15 AM the surveyor observed that the floor in 221-D and W room had a dirty floor with wax buildup on the linoleum floor. The resident # 115 stated that the staff do not clean up food spills. On 09/28/2025 at 09:20 AM the surveyor observed that two large clear bags containing resident # 8's clothing were piled up on the floor. Resident # 8 stated that there is not enough space in the room to store his/her belongings. On 09/28/2025 at 10:40 AM the surveyor observed the floor was dirty and sticky in room [ROOM NUMBER] D and W. On 09/28/2025 at 10:48 AM the surveyor observed missing paint on the wall beneath the TV in room [ROOM NUMBER] D and W. On 10/02/2025 beginning at 10:02 AM an environmental rounding with the Administrator, Maintenance Director, the Housekeeping Director and all the surveyors was conducted throughout the facility. The Housekeeping Director stated during the rounds that the facility does maintain a list of what resident rooms require stripping of the linoleum floors and are in the process of creating schedule for completing this project. The Housekeeping Director, the residents' floors are expected to be cleaned every day and stated that there is only one housekeeping staff member available on evening shift and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no housekeeping staff on night shift. During these rounds the following was observed: Resident room [ROOM NUMBER]-bathroom was observed with walls of peeling paint and uneven drywall plaster, cracks in the wall above the cove base, the toilet floor base seal had black in color rings where the floor and toilet meet, the white bathroom grab bar was not secure separating from the wall and throughout the bathroom beige color floors there was a sticky thick layer buildup of a black brownish color substance. Resident room [ROOM NUMBER] was observed to have large cracks and damaged walls on the left side of the room, around and under residents' beds and bathroom floors were noted to have a thick layer of dark black-brownish substance. Around the toilet floor base seal, it was noted to have dark layers of black-brown substance around it with the seal [NAME] being a black and rust color. The bathroom ceiling was noted to have water stains around the air vent grate and the grate appeared rusted and not secure. Resident room [ROOM NUMBER] was observed to have several red, yellow, orange and black in color spots, used tissues, used medication cup and food particles scattered throughout the tiles of the floor. Resident room [ROOM NUMBER] bed D was observed with a worn white in color fitted sheet, with 10 holes present, measuring anywhere from 3 to .5 inches x 3 to .5 inches. Resident room [ROOM NUMBER] was observed with a hole with missing drywall on the bathroom wall. Marring with black in color scuffs along the wall above the cove of the floor. There was black in color substance around the base of the toilet where the toilet meets the floor with some areas of the toilet base not sealed to the floor. The white cream and beige in color flooring throughout the room and bathroom were noted to have a buildup of a black in color layer of substance. Unit 1 shower rooms stalls were observed to have cracked crumbling floor and cove base tiles, missing cove base tiles, black colored substance within the mortar of the floors and wall tiles. The last shower room stall on the right-hand side of the room was missing a privacy curtain. The 2nd to last shower stall on the right-hand side was noted to be leaking water within the shower cove base tiles with a black colored substance surrounding it. 2 out of 4 stalls were unable to be used for/by residents due to the facility using them for storage. Unit 1 shower room bathroom was observed to have a sink with running water that was unable to be turned off, a ceiling air vent grate that was rusty brown in color with a 2inch x 2inch hole on the left-hand side of the grate. The area around the ceiling air vent grate had peeling paint with cracks and dry wall separating from the grate sides. Unit 2 shower room entrance door hinge to be broken, and the entrance door was overall in disrepair. 4 out of 6 shower stalls were unable to be used for/by residents due to the facility using them for storage. Unit 3 shower room was observed to have 1 out of 4 shower stalls were unable to be used for/by residents due to the facility using the shower stall for storage. 2nd floor dining room door on the right side of the room, the patio door concrete slope going outside of the door was observed to be uneven with raised areas where the slope meets the cement tiles of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	patio. Approximately 10 -12 feet from the same patio door was a cracked cement tile protruding upwards with water collecting underneath it. During environmental rounds on 10/02/2025 with the Director of Maintenance (DOM) #16, Director of Housekeeping (DOH) #15, the Nursing Home Administrator (NHA), and Administrator in Training (AIT) #3 all surveyor's findings were acknowledged. The Surveyor's expressed the concern that these conditions do not describe a homelike environment for the residents. DOM #16 and DOH #15 both stated that they were currently working on repairs. On 10/2/25 at 10:06AM surveyors observed 13 ceiling tiles with brown staining present in the occupational therapy gym and the concern was shared with the facility's Administrator and Director of Maintenance #16. On 10/02/2025 at 10:12 AM the surveyor observed a commode chair with rusty metal legs over the toilet used by residents in the PT exercise room area and the maintenance and housekeeping directors were present during this observation. The maintenance director stated the commode chair would be replaced. On 10/09/2025 the environment/housekeeping/maintenance concerns were reviewed with the DON and Administrator during the exit conference. 2) On 10/1/25 at 9:13AM during an interview with Resident #3 they reported to the surveyor that their personal wallet which included my important credentials, driver's license, insurance card, and social security card were missing. Resident #3 reported having looked through their room for the items and reported having needed their important credentials for a medical appointment approximately a month ago and could not find them and recalled having had a hospital visit in which they had brought back the items into their room and then subsequently could no longer find them. On 10/1/25 at 9:15AM an anonymous source reported to the surveyor that other residents of the facility come into Resident #3's room and mess with (Resident #3's) stuff, and there has been no response as to how the facility staff will stop this from occurring. On 10/2/25 at 3:15PM the surveyor requested all documentation the facility had regarding the resident's personal belongings to include inventory sheets, from Administrator in Training #3. Surveyor review of the facility provided documentation on 10/3/25 at 9:16AM which consisted of only one inventory sheet dated 9/11/24 at the time of Resident #3's initial admission to the facility, revealed there was no wallet, identification, or other cards documented for the resident as the facility having accounted for the belongings. Review of the census documentation of Resident #3 revealed they had been re-admitted to the facility on [DATE] and again on 7/28/25. No corresponding inventory sheets for these re-admission dates could be provided to the surveyor by the facility. On 10/3/25 at 9:23AM the surveyor conducted an interview with the Director of Nursing (DON) who reported that when residents return from hospitalization typically it is the role of the admission Assistant (AA) #65 to complete an inventory sheet of personal belongings. The DON confirmed with the surveyor that this was the only way the facility documents a resident's personal belongings. At this time the surveyor requested an interview with AA #65. On 10/3/25 at 9:32AM the surveyor conducted an interview with AA #65 who reported that when a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident leaves the facility, they pack their belongings up in boxes with their names on it and include an inventory sheet with the personal belongings listed on it. AA #65 reported to the surveyor that the resident did have a hospital admission and that it was the responsibility of the nursing aides to pack up resident personal belongings and if they are busy with getting an admission, they pack the belongings up to have the resident's room ready for an admission. AA #65 reported they were not aware of Resident #3's missing belongings and that they would check with Unit Manager #67 because their role was to lock up wallets. On 10/3/25 at 11:34AM the surveyor conducted an interview with AA #65 who reported to the surveyor that there was no inventory sheet completed for Resident #3 to show what belongings were given back to them. The surveyor noted that additionally there was no documentation of belongings the resident returned with upon their re-admissions to the facility. AA #65 confirmed with the surveyor that no wallet had been locked up for the resident and that it is the responsibility of the Geriatric Nursing Assistant to communicate if a resident has a wallet as part of their belongings. On 10/3/25 at 12:25PM the surveyor conducted an interview and shared the concern with the Assistant Director of Nursing (ADON) #45 who confirmed with the surveyor that they had previously been made aware of an issue concerning other residents entering the room of Resident #3 and redirection of other residents was provided and they had not heard of this being an issue lately. Upon medical record review by the surveyor on 10/3/25 at 1:15PM the surveyor observed the resident's identification, social security card, and insurance card which had previously been scanned into the resident's medical record.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations, interviews and review of resident medical records, it was determined that the facility failed to: 1) Ensure that residents received the correct prescribed diet orders and serve the correct diet listed on meal tray tickets; and 2) Ensure resident dietary preferences were honored. This was evident for 6 (#172, #52, #12, #170) residents out of 28 residents reviewed and 2 random observations made during the surveyor's tray line observation as part of the kitchen review and has the potential to affect all residents. The findings include: 1. During observation rounds on 10/08/2025 at 8:15AM resident #172 was found lying in bed with a food tray in front of him/her eating the breakfast that was provided by the facility. The tray was found to have a paper meal ticket with the following printed on it: resident #172 name and room number, current unit number, 10/08/2025, Breakfast, Regular- Diabetic, Thin liquids, 6oz Hot Cereal, 2@ Waffles, 1-each Diet Syrup & Margarine, 2@ Breakfast Sausage Links, Orange Juice Cup – 4oz, Milk 2% - 8oz and Coffee – 8oz. The paper meal ticket was also noted to have on it; Tray Notes, Instructions and Dislikes which had no information listed. The tray was observed to not have hot cereal but 1- 0.75oz container of Tootie Fruities cold cereal, a 1-1.5oz container of Lucky regular Table Syrup and no coffee. All other items were observed on the breakfast tray as listed. During an interview on 10/08/2025 at 8:48AM staff #44 stated, Yes and confirmed the information listed on Resident #172's meal ticket. Staff #44 further stated, Resident #172 should not be getting regular syrup or sugary cold cereal like that, but that is what the kitchen sent him/her. Review of Resident #172's medical record on 10/08/2025 at 9:30AM revealed a diet order dated 04/22/2025 stating Diabetic diet regular texture, Thin Liquids consistency, double protein and an active diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. 2. During an interview on 10/08/2025 at approximately 9:00AM resident #52 stated, I am not getting the correct diet, they send me food all the time that I cannot eat or do not like and they give me things to drink that I cannot drink. I am not getting the right food, too many fluids or not enough when I am supposed to be watching my fluid intake. During an interview and review of facility documents on 10/08/2025 at approximately 9:05AM at request, surveyor was provided by the Dietary Manager staff #54, the paper meal ticket that the kitchen used for breakfast and was using to prepare remaining daily meal trays for the Resident #52 for 10/08/2025. The paper meal ticket revealed the following: Resident #52 name and room number, current unit number, 10/08/2025, Breakfast, Regular, Thin liquids, 6oz Hot Cereal, 2@ Waffles, 1-each Syrup & Margarine, 2@ Breakfast Sausage Links, Orange Juice Cup – 4oz, Milk 2% - 8oz and Coffee 8oz. The paper meal ticket was also noted to have on it; Tray Notes and Instructions which had no information listed and Dislikes: which had the food Pork listed. There was no documentation noting that there was a substitute for the Resident #52 dislike of pork. A second paper meal ticket labeled Lunch, revealed for Resident #52 to be served a Regular Diet, Thin liquids, 4oz of Beer Battered Fish, 4oz of Coleslaw, 1-2x2 Cake with Icing, no Tray notes or Instructions and Dislikes: Pork, Apple Juice – 4oz. A third paper meal ticket labeled Dinner, revealed for Resident #52 to be served a Regular Diet, Thin liquids, 1 Cheeseburger on a bun, 4oz of Potato Salad, 4oz of Broccoli Cuts, Chilled peaches, no Tray notes or Instructions and Dislikes: Pork, Cranberry Juice Cup – 4oz. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When reviewing the Resident #52's meal tickets for the day with staff #54, staff #54 stated, We use the paper meal ticket to plate the residents food, the last person on the meal tray line checks that the resident is trayed the proper food against what is on the resident's meal ticket, and we have been having some problems with consistency of correct food being served to the residents. Review of resident #52's medical record on 10/08/2025 at 9:35AM revealed a diet order dated 05/19/2025 stating Renal Diabetic Diet regular texture, Thin Liquids consistency, 1500ml/day fluid restrictions: double protein and an active diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified and End Stage Renal Disease. Resident #52 was also noted to be on Dialysis. During an interview on 10/08/2025 at approximately 9:50AM the Nursing Home Administrator staff #1 and Director of Nursing staff #2 were shown and made aware of the concerns with the discrepancies of the residents prescribed diets verses the diets listed on the meal tickets, as well as the accuracy of what is being placed on residents trays verses the meal tickets being used by the Dietary staff. Staff #1 stated that they would look into the concerns and talk with the Regional Manager staff #55 overlooking the Dietary Department to fix the problems. 3. On 9/29/2025 at 12:10PM, during an interview conducted with Resident #12, the Surveyor was informed that the meal ticket, included on the meal tray, does not always match what is being served. The resident continued to say that preferred food items are sometimes not included, even though it may say it on the meal ticket. During a continued conversation with Resident #12 at 12:15PM, the lunch tray was served by Geriatric Nursing Assistant (GNA) staff. The resident and the Surveyor compared the meal tray and the meal ticket. According to the meal ticket, the resident should have received broth and there was no broth on the tray; the resident should have received ice cream and received a cream-colored pudding-like textured food instead. Resident #12 informed the Surveyor that they haven't received broth on their tray in about a week. On 10/8/2025 at 9:01AM, during an interview conducted with Dietary Manager (DM) #54, a surveyor was informed that she was having issues with the staff responsible for ensuring the meal tickets and the meal trays match and are correct. DM #54 was aware that the residents have verbalized concern and that there is a problem with consistency. 4. On 10/8/2025 at 1:23PM during a dining observation in the Unit 2 dining room, the Surveyor observed 3 residents sitting at a table and 3 meal trays pushed to the side containing uneaten food. During an interview with Resident #170, the Surveyor was informed that the food was cold and unappetizing. The resident expressed the concern that there was always something wrong with the food, the meal trays, and the meal tickets. The Surveyor observed Resident #170's tray and compared what was on the meal ticket to what was actually served on the meal tray. Resident #170's meal ticket read: alternate required (entrée), French fries, coleslaw, cake w/icing, apple juice and chocolate milk. Resident #170's meal tray included a light brown, flat, oval shaped meat like food, a scoop of a creamy white, soft, mashed potato-like food, a bowl of a cooked leafy green food, a piece of cake with dark brown icing, apple juice, and chocolate milk. The meal tray failed to have the French fries or coleslaw. The resident stated that they were unsure what the meat entrée was; however, the facility served mashed potatoes and spinach for dinner the night before. On 10/9/2025 at 3:45PM during an interview with DM #54 and Regional Dietary Manager #55, the Surveyor expressed the on-going concerns with meal tickets discrepancies, actual food served, (continued on next page)

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	215269	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident food preferences, and requests. DM #54 informed the Surveyor that they are aware of the concerns and were working on a resolution. 5. On 10/9/25 at 12:10PM Regional Dietary Manager (RDM) #55 reported to the surveyor and showed them on the steam table, that cheese ravioli and meat sauce was being served for the lunchtime entree. On 10/9/25 at 12:10PM the surveyor observed the tray ticket of Resident #70 at random which was observed to state: no cheese, however, the resident was prepared a tray of food which was observed to be cheese ravioli and meat sauce although the menu entree item was listed on the resident's menu ticket as the entree being beef ravioli in sauce. 6. On 10/9/25 at 12:17PM a random tray ticket observation was performed of the tray line. The tray ticket was observed to state the following information: beef ravioli in sauce, however, cheese ravioli in meat sauce was observed to be served for Resident #146. Review of the menu by the surveyor on 10/9/25 at 12:18PM which was posted in the facility's kitchen revealed that beef ravioli in sauce was the planned lunchtime menu entree. All concerns were shared with RDM #55 who acknowledged understanding of the concerns.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review it was determined that the facility failed to ensure the food service department followed the menu and failed to ensure the provided menu met the requirement for the serving size of protein specified for the lunchtime meal. This was evident during a random observation of the serving tray line in the facility's kitchen and during the surveyor's review of the kitchen.Based on observation, interview, and record review it was determined that the facility failed to: 1) ensure the food service department followed the menu and failed to ensure the provided menu met the requirement for the serving size of protein specified for the lunchtime meal and 2) ensure menus and food preferences were followed according to the resident's meal ticket. This was evident for during a random observation of the serving tray line in the facility's kitchen with the potential to affect all residents receiving meals from the kitchen and 2 (Resident #12 and #170) out of 15 residents reviewed for food and nutrition The findings include: 1. During the surveyor's initial tour on 9/28/25 at 7:43AM a kitchen staff member informed the surveyor that DM #54 does all of the food ordering and that sometimes food that is different from the menu has to be served because there is not enough, such as ham and pork chops. During an interview conducted by the surveyor on 9/28/25 at 9:35AM with Resident #117 they stated to the surveyor: One day I was supposed to have chicken and they gave me pork. On 9/29/25 at approximately 1:10PM multiple surveyors observed the food serving line at which time the lunchtime meal for a resident was observed upon completion of being plated by facility staff. Observation of the ham bruschetta entrée revealed there was a very thin serving of shaved meat present on a small piece of white bread with a tomato slice which did not appear to be a 4oz serving as the menu which was posted within the kitchen was observed to indicate on it. At this time the surveyor conducted a dual observation and shared the concern with Regional Registered Dietician (RD) #12 and inquired to them as to if the meal observed was nutritionally adequate according to the planned menu, and if the daily menu was providing for nutritional adequacy. RD #12 observed and acknowledged the concern and reported to the surveyor that they would look into the concern and provide a response to the surveyor. On 9/30/25 at 11:41AM no response had been provided to the surveyor and the surveyor requested an interview of RD #12 from the facility's Administrator in Training #3. On 9/30/25 at 2:01PM the surveyor conducted an interview with RD #12 who reported to the surveyor that the contracted company the facility uses for staffing of the kitchen was responsible for the menu which is already put together for us. During the interview of RD #12 they reported to the team of surveyors that yesterday's menu was nutritionally adequate because there was meat sauce for dinner. At this time, RD #12 presented the surveyor with a menu to show the surveyor it was nutritionally adequate for the day, however, the surveyor noticed that the menu had been altered and was not the menu that was observed by the surveyor posted in the kitchen and being served on 9/29/25 which did not include meat sauce or any meat for the dinnertime meal. After the surveyor inquired as to why they had presented surveyors with a menu that had been altered, they informed surveyors that the bruschetta ham entrée was found to have only been a 2oz portion instead of a 4oz portion and so meat sauce was added. When the surveyor again inquired as to if daily nutritional (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	adequacy was met for the residents with the meals that had been served, they stated to the survey team that they would have to calculate that if the original menu was followed if it was nutritionally adequate. The surveyor noted that the initial request to RD #12 was for them to review the diet served and respond to the surveyor regarding nutritional adequacy of the provided menu and diet. On 9/30/2025 at 2:37PM the surveyor conducted an interview with DM #54 who stated: Sometimes there isn't enough meat and we have to substitute other meat for it. At this time the surveyor shared concerns with RD #54 who acknowledged and confirmed understanding of the concerns. Regional Dietary Manager #55 was present during the interview and the surveyor shared concerns with them, to which they replied: There's always enough meat. At this time, the surveyor re-confirmed with them that they were not visiting the facility in a daily capacity and also re-confirmed with them the information that was shared regarding their staff stating there was not enough. On 9/30/25 at 2:40PM the surveyor conducted an interview of [NAME] #70 who stated to the surveyor that they did not do the meat cutting which was the job of the Prep [NAME] #71. On 9/30/25 at 2:40PM the surveyor conducted an interview with Prep [NAME] #71. During the interview the surveyor inquired as to how they had portioned the ham for the bruschetta entree on 9/29/25. Prep [NAME] #71 stated to the surveyor: I just slice it thin. When the surveyor inquired as to if the kitchen had a scale to measure the ounces for the portions they stated: There's a scale if we want to weigh the ounces. On 9/30/25 at 3:07PM the surveyor shared concerns with DM #54 who acknowledged the surveyor's concerns. DM #54 reported that if s/he places the food orders and then there are fluctuations in the facility's census, that is what is causing the issue as far as not having enough meat, and once s/he places the order for the week s/he doesn't have somewhere that delivers more. On 9/30/25 at 3:29PM the surveyor shared concerns with the facility's Administrator and Director of Nursing who both acknowledged and confirmed understanding of the concerns. On 10/2/25 at 12:50PM the surveyor conducted an interview with Dietary Manager #54 who reported to the surveyor that they did not know who the person was that was responsible for ensuring nutritional adequacy of resident diets and the menu. 2. On 9/29/2025 at 12:10PM, during an interview conducted with Resident #12, the Surveyor was informed that the meal ticket, included on the meal tray, does not always match what is being served. The resident continued to say that preferred food items are sometimes not included, even though it may say it on the meal ticket. During a continued conversation with Resident #12 at 12:15PM, the lunch tray was served by Geriatric Nursing Assistant (GNA) staff. The resident and the Surveyor compared the meal tray and the meal ticket. According to the meal ticket, the resident should have received broth and there was no broth on the tray; the resident should have received ice cream and received a cream-colored pudding-like textured food instead. Resident #12 informed the Surveyor that they haven't received broth on their tray in about a week. On 10/8/2025 at 9:01AM, during an interview conducted with Dietary Manager (DM) #54, a Surveyor was informed that she was having issues with the staff responsible for ensuring the meal tickets and the meal trays match and are correct. DM #54 was aware that the residents have verbalized concern (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and that there is a problem with consistency. 3. On 10/8/2025 at 1:23PM during a dining observation in the Unit 2 dining room, the Surveyor observed 3 residents sitting at a table and 3 meal trays pushed to the side containing uneaten food. During an interview with Resident #170, the Surveyor was informed that the food was cold and unappetizing. The resident expressed the concern that there was always something wrong with the food, the meal trays, and the meal tickets. The Surveyor observed Resident #170's tray and compared what was on the meal ticket to what was actually served on the meal tray. Resident #170's meal ticket read: alternate required (entrée), French fries, coleslaw, cake w/icing, apple juice and chocolate milk. Resident #170's meal tray included a light brown, flat, oval shaped meat like food, a scoop of a creamy white, soft, mashed potato-like food, a bowl of a cooked leafy green food, a piece of cake with dark brown icing, apple juice, and chocolate milk. The meal tray failed to have the French fries or coleslaw. The resident stated that they were unsure what the meat entrée was; however, the facility served mashed potatoes and spinach for dinner the night before. On 10/9/2025 at 3:45PM during an interview with DM #54 and Regional Dietary Manager #55, the Surveyor expressed the on-going concerns with meal tickets discrepancies, actual food served, resident food preferences, and requests. DM #54 informed the Surveyor that they are aware of the concerns and were working on a resolution.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined the facility failed to ensure safe and appetizing food temperatures. This was evident during the surveyor's review of the kitchen during the facility's recertification survey. The findings include: 1.) On 10/9/25 at 11:56AM the surveyor conducted a review of the written food service temperature log with Regional Dietary Manager (RDM) #55. 10 food items were observed on the steam table which included: 1.) cheese ravioli, 2.) rice, 3.) mixed vegetables, 4.) meat sauce, 5.) cream of rice, 6.) alfredo garlic meat sauce, 7.) plain puree sauce, 8.) pureed meat, 9.) white sauce, 10.) pureed mashed potatoes. Review of the temperature log revealed that only 7 out of 10 hot food items had associated food temperatures recorded and did not identify which specific food items was temperature tested. When the surveyor shared the concern with RDM #55 they stated: I can agree with you on that, yes. When the surveyor inquired as to if it was acceptable food practice to not have food temperatures for all menu items served, RDM #55 stated No, it's not appropriate to not have temperatures recorded for each item. During observation of the tray line, the surveyor observed that milk was being temporarily stored out of the refrigerator, and the cartons were sitting in containers of ice water with some of the milk cartons resting on top of the ice. On 10/9/25 at 1:00PM the surveyor performed temperature testing of the food test tray upon all residents having been served, with RDM #55 and DM #54 which resulted in the carton of milk with a temperature testing of 48.6F. At this time the surveyor shared their concern. When the surveyor inquired to RDM #55 as to if the temperature of the milk was acceptable to them, they stated: no, not at all and further acknowledged that they were concerned regarding the temperature of the milk. On 10/9/25 at 1:47PM the surveyor shared all concerns with the facility's Administrator who acknowledged extensive process problems surrounding the kitchen. 2.) During the surveyor's initial tour of the facility's kitchen on 9/28/25 at 7:46AM the surveyor observed the plating of food in progress on the tray line at which time the indicator lights for the plate warming system which held plates within it were observed to not be lit up and the plates were cold to the touch. The surveyor conducted an interview with [NAME] #69 who reported to the surveyor that the plate warming system was broken, however, the facility had provided the kitchen with a replacement system that was in working order and showed the surveyor to a different plate warming system which was observed to not be plugged in and was not being utilized by the kitchen staff. The surveyor noted that food was being served onto cold plates and shared the concern with [NAME] #69. During an interview on 9/28/25 at 9:35AM with Resident #117 they reported to the surveyor: sometimes the food is cold, it was yesterday. On 10/9/25 at 1:47PM the surveyor shared all concerns with the facility's Administrator who acknowledged extensive process problems surrounding the kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review it was determined the facility failed to: 1) ensure sanitary practices were followed in accordance with professional standards for food service safety; 2) ensure the monitoring and oversight of food temperatures in accordance with professional standards for food service safety; 3) ensure food was stored in accordance with professional standards for food service safety; 4) ensure thorough environmental cleaning of the kitchen; 5) ensure food items were labeled and discarded appropriately, 6) ensure the transport of food in accordance with professional standards for food service safety; 7.) ensure the monitoring, oversight, sanitation and maintenance of kitchen 8.) ensure sanitary food prep surfaces were free from personal items. This was evident during observations of the kitchen and has the potential to affect all residents.The findings include:1. On 9/28/25 beginning at 7:43AM the surveyor conducted an initial tour of the facility's kitchen:On 9/28/25 at 7:43AM the surveyor observed the facility's freezer temperature log for September 2025 which was observed to not have any monitoring documented of morning freezer temperatures from September 23rd through September 28th 2025.On 9/28/25 at 7:43AM the surveyor observed that the exterior thermometer located outside of the walk-in refrigerator with duct tape present over it and was unable to be read.2. On 9/28/25 at 7:45AM the surveyor observed a plastic pitcher located underneath the coffee machine handle and spout which was catching dripping liquid. The plastic container was observed to have a thick layer of both light and dark brown film within it. The surveyor observed a pile of soiled, wet linens located underneath the coffee serving station on the kitchen floor. The coffee machine's drainage area was observed to be leaking onto the floor. 3. The hand washing sink nearest to the food serving line was observed to be unable to be easily turned off and was left running by facility staff. The three compartment sink faucet was also observed to be unable to be easily turned off and was left running by facility staff. The faucet assembly present on the three-compartment sink was observed to be leaking water into the sink.4. On 9/28/25 at 7:45AM the surveyor observed dark thick brown material present on the facility's kitchen floor underneath the food prep table.On 9/28/25 at 7:45AM the surveyor observed a rolling dish pushcart with a wooden board located on top of it which was observed to have a food chopping board screwed to it next to the food prep station. The cart was observed to be holding various items within it including rubber gloves. The surveyor observed thick black material present on the floor underneath and surrounding the push cart.5. On 9/28/25 at 7:49AM the surveyor observed caulk type material detached from the molding along the walls of the dishwashing area. The caulk type material was observed sitting within a pool of water. Dark, thick areas of debris were observed along and under the dishwashing area on the floor. The exterior surface of the dishwasher was observed to be in unclean condition with a layer of film and debris present on the exterior metal surface. A metal cord with dark debris present on it was observed to be loosely affixed to a booster heater with visible wiring present. Dish carts were observed to have food matter and brown and black debris present on their exterior and one out of two dish carts was observed with a plastic container filled with red oily food debris liquid sitting on it. [NAME] #69 reported to the surveyor that the container of red liquid had been reported to their supervisor because it had been left from the last shift.6. On 9/28/25 at 7:50AM the surveyor observed 3 carts filled with dirty trays of dishes and trash items sitting directly near the clean ice cooler with one of the carts touching the exterior surface of the clean ice cooler. The carts of dirty dishes were observed within close proximity to the clean ice scooper which was affixed to the side of the ice cooler.7. On 9/28/25 at 7:50AM the surveyor observed a stack of six plastic crates containing loaves of bread and bread rolls sitting directly on the kitchen floor's surface.On 9/28/25 at 7:51AM the surveyor observed another stack of plastic crates containing food items sitting on a rolling platform approximately 2 inches from the kitchen floor's surface within the dry storage area.On 9/28/25 at 7:51AM the surveyor observed a plastic container of sugar with the handled plastic scoop sitting (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	directly on the surface of the top of the container uncovered resting against a cardboard box.8. On 9/28/25 at 7:51AM the surveyor observed areas of sticky residue within the dry food storage area on the floor and noted that upon walking on the floor's surface it was felt to be sticky. Areas on the floor's surface were observed to be dirty with brown and black debris present.10. On 9/28/25 at 7:51 AM the surveyor observed only 1 handled scoop hung on the wall with white powder present on it above two bins, one of which contained flour and one of which contained thickener powder. No second scoop was observed to be present. The handled scoop appeared to be contained within an ice scoop type holder which allowed powder residue to fall onto the floor beneath the scooper holder.11. On 9/28/25 at 7:52AM the surveyor observed the cove molding in the dry food storage area which was separated from the wall and an area of wall damage with openings present in the dry food storage area.12. On 9/28/25 at 7:52AM the surveyor observed a rack within the facility's kitchen which was holding nozzles for the connecting of beverages which were observed to be lying directly on the floor.13. On 9/28/25 at 7:53AM The surveyor observed a juice machine within the facility's kitchen with a sprayer nozzle observed to have white debris present on it. Gray debris was observed to be present on the cords and cord coverings extending from the juice machine which was located next to a plastic container which held white powder with a handled scooper that was enclosed within the container, with the handle resting within the powder.14. On 9/28/25 at 7:58AM the surveyor observed breaded meat patties in a container with no labeling present.15. On 9/28/25 at 7:59AM the surveyor observed a plastic crate containing juice cups sitting directly on the floor of the walk-in refrigerator.16. On 9/28/25 at 8:00AM the surveyor observed an opened box of diced green peppers sitting on it's side directly on the floor's surface of the walk-in freezer which was observed to be visibly dirty with areas of dark matter present on the floor.17. On 9/28/25 at 8:00AM the surveyor observed an open bag of hash browns on the second shelf of the walk-in freezer which had no date or label present. At the time of the observation the concern was shared with [NAME] #69. After surveyor intervention, [NAME] #69 was observed throwing the bag of hash browns away into the trash can.On 9/28/25 at 8:02AM the surveyor conducted an interview with [NAME] #69 who reported to the surveyor regarding the coffee machine: That thing leaks, it leaks through the pipe down to the drain.On 9/28/25 at 8:13AM the surveyor shared concerns with [NAME] #69 who reported to the surveyor regarding the coffee machine: They fix it and every month it just goes right back to leaking.18. On 9/28/25 at 8:35 AM surveyors observed Geriatric Nursing Assistant (GNA) #73 pushing an open and uncovered sheet pan rack through the resident hallway containing resident food trays with uncovered silverware and other food items present on the food trays with the lowest resident tray observed to be approximately 4.5 inches from the hallway floor. The surveyor shared the concern with GNA #73 and GNA #59. The passing of trays utilizing the cart was observed by surveyors to continue.On 9/28/25 at 9:00AM the surveyor observed that the open uncovered sheet rack was continuing to be utilized to serve resident food trays.On 9/28/25 at 9:02AM the surveyor conducted an interview and shared concerns with the facility's Assistant Director of Nursing (ADON). During the interview the ADON reported the following information: Last I heard, some food carts were broken so these are overflow carts used when the census is high, I don't know where they are with the broken ones.19. On 9/28/25 at 10:45AM the surveyor conducted an observation of the unit 2 nourishment room which revealed a cart in which the ice cooler was sitting on with clean ice contained within it. The surveyor observed a dirty resident food tray sitting on top of the clean ice cooler. A plastic trash bag was observed hanging off the cart which contained and completely covered the scoop for the ice cooler, including the handle of the scoop. Review of the daily temperature log for the unit 2 nourishment refrigerator revealed no temperature documentation for 9/26, 9/27, and 9/28/25.On 9/28/25 at 10:48AM the surveyor conducted an observation of the unit 2 nourishment refrigerator and observed 3 plastic snack bags containing food items labeled with a use by date of 9/27/25 which were labeled: Dialysis Bag. A bag of cheese and meat slices was observed within the nourishment refrigerator and was labeled with a date of 9/23/25. A container of blueberries was observed within (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the nourishment refrigerator with no date present. A sub sandwich with torn and stained paper wrapping was observed within the nourishment refrigerator. A bag of blueberries was observed within the nourishment refrigerator which did not have identifiable labeling.On 9/28/25 at 10:53AM the surveyor shared concerns regarding the nourishment room with GNA #72 who acknowledged the surveyor's concerns.20. On 10/2/25 at 10:51AM multiple surveyors observed multiple food items including a container of peanut butter, a bottle of sauce, containers of food dipping sauces, and protein shakes stored within plastic storage bins within the facility's second floor shower room.21. On 10/9/25 at 12:15PM the surveyor observed Prep [NAME] #71 with one open disposable drink cup and an additional personal beverage cup sitting on the surface of the food prep area. At this time the surveyor shared the concern and conducted a dual observation of the concern with Regional Dietary Manager #55 who, after surveyor intervention, directed Prep [NAME] #71 to remove personal beverages from the food prep area. The surveyor conducted an interview with Prep [NAME] #71 who indicated that they had previously received food service training which included not having personal beverages in the food preparation area.22. On 10/9/25 at 12:36PM the surveyor observed Dietary Aide (DA) #72 wearing gloves and plating food on the tray line. Dietary Aide #72 was observed reaching into their pocket with their gloves on and retrieved their eyeglasses and put them onto their face. While still wearing their food service gloves, Dietary Aide #72 proceeded to then continue to go back to assembling Resident #116's plate of food and food tray and then placed it into the food cart. The surveyor shared the concern with DA #72 and RDM #55 who both acknowledged and confirmed understanding of the concern. On 10/9/25 at 1:47PM the surveyor shared all concerns with the facility's Administrator who acknowledged extensive process problems surrounding the kitchen.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment and interviews it was determined the facility failed to ensure that all required individuals participate in the Facility Assessment. Additional the facility failed to document, complete and accurately reflect Facility Assessment processes regarding the facility's physical environment, equipment, and other physical plant needs that are necessary to care for its population as well as an evaluation of the facility building maintenance capital improvements, or structures. The findings include the following: During review of the Facility Assessment and interview on 10/08/2025 at 1:00 PM revealed there was no Direct Care Representative involved in completing the Facility assessment dated [DATE]. The Administrator staff #1 and/or staff # 16 were unable to provide or show surveyor that the facility's process to ensure adequate supplies, appropriate maintenance and replacement needs/services by way of plant operational review, established preventative maintenance processes and administrative rounding was being completed and or effective. Based on the volume of facility disrepair, it was evident that regular preventive maintenance was not occurring. Further review revealed that the Facility Assessment did not include an evaluation of building maintenance capital improvements or structures and stated that any capital facility needs would be addressed through the capital budget.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on observation, interview and record review it was determined the facility failed to ensure the outside resources utilized for delivery of food and nutrition services to the facility's residents followed professional standards. This was evident for 2 out of 2 contracted companies utilized by the facility for the delivery of food and nutrition services during the facility's recertification survey and has the potential to affect all residents of the facility. The findings include: 1. On 9/30/25 at 3:07PM in response to the surveyor's request for evidence of consultation occurring between the outside contracted dietician services and the outside contracted food and nutrition services which staffed and oversaw the kitchen, Dietary Manager #54 provided the surveyor with the following documentation of correspondence between the two outside contracted companies the facility utilizes for delivery of food and nutrition services for the residents of the facility: a.) Documentation dated 8/12/25 at 2:37PM from RD #13 to DM#54: When was the last time a diet audit was completed? I was able to gain access to tray card and I have noticed a lot of incorrect diets, missing fluid restrictions, etc. It really needs to be completed monthly. Do you need help completing one? Let me know! Thank you, b.) Documentation dated 8/13/25 at 8:50AM from DM #54 to RD#13: I have not done it yet, c.) Documentation dated 8/13/25 at 8:51AM from DM #54 to RD#13: I do not have access to PCC [facility electronic clinical software system]. I did but when company changed I no longer do, d.) Documentation dated 8/13/25 at 8:55AM from RD#13 to DM #54: I'm sure the building can get you access. If not, I can send you the diet and supplement list. Just let me know.e.) Documentation dated 8/13/25 at 11:30AM from DM #54 to RD #13: Yes, please do. f.) Documentation from 8/13/25 at 11:50AM which included an attachment labeled elkton diets.pdf from RD# 13 to DM #54: Here you go! g.) Documentation dated 9/9/25 at 9:45AM from Renal Dietician #75 relaying their concern to the facility regarding Resident #14 : I was speaking with (Resident #14) this morning. [S/he] is very unhappy because [s/he] is supposed to be getting double portions, and [s/he] still complains [s/he] isn't. [S/he] reports [s/he] is going to bed hungry at nights.h.) Documentation dated 9/10/25 at 10:25AM from DM #54 to RD #13 and Renal Dietician #75: Will do.2. During observation rounds on 10/08/2025 at 8:15AM Resident #172 was found lying in bed with a food tray in front of him/her eating the breakfast that was provided by the facility. The tray was found to have a paper meal ticket with the following printed on it: Resident #172 name and room number, current unit number, 10/08/2025, Breakfast, Regular- Diabetic, Thin liquids, 6oz Hot Cereal, 2@ Waffles, 1-each Diet Syrup & Margarine, 2@ Breakfast Sausage Links, Orange Juice Cup - 4oz, Milk 2% - 8oz and Coffee - 8oz. The paper meal ticket was also noted to have on it; Tray Notes, Instructions and Dislikes which had no information listed. The tray was observed to not have hot cereal but 1- 0.75oz container of Tootie Fruities cold cereal, a 1-1.5oz container of Lucky regular Table Syrup and no coffee. All other items were observed on the breakfast tray as listed.During an interview on 10/08/2025 at 8:48AM staff #44 stated, Yes and confirmed that resident #172 meal ticket. Staff #44 further stated, Resident #172 should not be getting regular syrup or sugary cold cereal like that, but that is what the kitchen sent [him/her].Review of Resident #172's medical record on 10/08/2025 at 9:30AM revealed a diet order dated 04/22/2025 stating Diabetic diet regular texture, Thin Liquids consistency, double protein and an active diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. 3. During an interview on 10/08/2025 at approximately 9:00AM Resident #52 stated, I am not getting the correct diet, they send me food all the time that I cannot eat or do not like and they give me things to drink that I cannot drink. I am not getting the right food, too many fluids or not enough when I am supposed to be watching my fluid intake.During an interview and review of facility documents on 10/08/2025 at approximately 9:05AM at request, this surveyor was provided by the Dietary Manager staff #54, the paper meal ticket that the kitchen used for breakfast and was using to prepare remaining daily meal trays for the Resident #52 for 10/08/2025. The paper meal ticket revealed the following: Resident #52 (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	name and room number, current unit number, 10/08/2025, Breakfast, Regular, Thin liquids, 6oz Hot Cereal, 2@ Waffles, 1-each Syrup & Margarine, 2@ Breakfast Sausage Links, Orange Juice Cup - 4oz, Milk 2% - 8oz and Coffee 8oz. The paper meal ticket was also noted to have on it; Tray Notes and Instructions which had no information listed and Dislikes: which had the food Pork listed. There was no documentation noting that there was a substitute for the Resident #52 dislike of pork.A second paper meal ticket labeled Lunch, revealed for Resident #52 to be served a Regular Diet, Thin liquids, 4oz of Beer Battered Fish, 4oz of Coleslaw, 1-2x2 Cake with Icing, no Tray notes or Instructions and Dislikes: Pork, Apple Juice - 4oz. A third paper meal ticket labeled Dinner, revealed for resident #52 to be served a Regular Diet, Thin liquids, 1 Cheeseburger on a bun, 4oz of Potato Salad, 4oz of Broccoli Cuts, Chilled peaches, no Tray notes or Instructions and Dislikes: Pork, Cranberry Juice Cup - 4oz. When reviewing the Resident #52 meal tickets for the day with staff #54, who stated, We use the paper meal ticket to plate the residents food, the last person on the meal tray line checks that the resident is trayed the proper food against what is on the resident's meal ticket, and we have been having some problems with consistency of correct food being served to the residents.Review of resident #52 medical record on 10/08/2025 at 9:35AM revealed a diet order dated 05/19/2025 stating Renal Diabetic Diet regular texture, Thin Liquids consistency, 1500ml/day fluid restrictions: double protein and an active diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified and End Stage Renal Disease. Resident #52 was also noted to be on Dialysis. During an interview on 10/08/2025 at approximately 9:50AM the Nursing Home Administrator staff #1 and Director of Nursing staff #2 were shown and made aware of the concerns with the discrepancies of the residents prescribed diets verses the diets listed on the meal tickets, as well as the accuracy of what is being placed on residents trays verses the meal tickets being used by the Dietary staff. Staff #1 stated that they would look into the concerns and talk with the Regional Manager staff #55 overlooking the Dietary Department to fix the problems.4. On 10/9/25 at 12:10PM Regional Dietary Manager (RDM) #55 reported to the surveyor and showed them on the steam table, that cheese ravioli and meat sauce was being served for the lunchtime entree. On 10/9/25 at 12:10PM the surveyor observed the tray ticket of Resident #70 at random which was observed to state: no cheese, however, the resident was prepared a tray of food which was observed to be cheese ravioli and meat sauce although the menu entree item was listed on the resident's menu ticket as the entree being beef ravioli in sauce. 5. On 10/9/25 at 12:17PM a random tray ticket observation was performed of the tray line. The tray ticket was observed to state the following information: beef ravioli in sauce, however, cheese ravioli in meat sauce was observed to be served for Resident #146. Review of the menu by the surveyor on 10/9/25 at 12:18PM which was posted in the facility's kitchen revealed that beef ravioli in sauce was the planned lunchtime menu entree. All concerns were shared with RDM #55 who acknowledged understanding of the concerns. On 10/9/25 at 1:47PM the surveyor shared all concerns with the facility's Administrator who acknowledged extensive process problems surrounding the kitchen. All concerns were shared with the facility Administrator and other facility staff present during the facility's exit conference on 10/9/25. Refer to F800, F801, F803, F804, F806, F812, F908.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview it was determined that the facility failed to ensure the dishwashing system was maintained in safe operating condition. This was evident for 1 out of 1 dishwasher present within the facility's kitchen.The findings include:On 9/28/25 at 7:49AM the surveyor observed a large area of pooling water on the floor in the dishwashing area and additionally observed a plastic bucket which was situated under one of the dishwasher's mechanical components which was observed to be catching the dripping of water and was approximately 80% full of cloudy liquid. The surveyor observed an empty plastic jug of sodium hypochlorite chemical attached to the dishwashing machine system which was operating in chemical sanitization mode.On 9/28/25 at 7:49AM the surveyor observed the dish machine's manufacturer guidelines as outlined on the machine's placard which included the following information regarding chemical sanitization: wash tank minimum temperature: 140F and sanitizer required 50ppm available chlorine.On 9/28/25 at 8:02AM the surveyor conducted a dual observation of the dish machine and conducted an interview with [NAME] #69 who reported regarding the dish machine: It just leaks. When the surveyor inquired to [NAME] #69 as to how long the dish machine had been leaking, they stated to the surveyor that it had been leaking for two months.On 9/28/25 at 8:13AM the concern was shared with [NAME] #69 who acknowledged and confirmed understanding of the concern.On 9/28/25 at 11:20 AM the surveyor conducted a dual observation with the facility's Administrator of the dish machine in operation at which time the hypochlorite solution was again observed to be empty and the wash temperature was observed to be 134F. At this time, the surveyor shared their concern with the Administrator.On 9/28/25 at 11:24AM the facility Administrator provided the dish machine temperature log in response to the surveyor's request. Review of the dish machine temperature log revealed the following information: notify supervisor immediately if wash temperature is below 120F and or sanitizer ppm is not within acceptable range of 50-100. Further review of the log revealed that on approximately 6 occasions during September 2025 the ppm was logged as being above the listed acceptable range and no documentation was present on the form which had a column titled: action taken if out of range.On 10/9/25 at 11:51AM the surveyor conducted an interview with Dietary Manager (DM) #54 who reported to the surveyor that the dish machine had been leaking for several months. DM #54 confirmed with the surveyor that the dish machine was in chemical sanitization mode utilizing the hypochlorite solution chemical, and if the chemical was not present, the machine would not be effectively sanitizing the dishes. DM #54 additionally informed the surveyor that they do not pay attention to the rinse temperatures of the machine.On 10/9/25 at 1:47PM the surveyor again shared concerns with the facility Administrator at which time the Administrator informed the survey team that the dish washer will be replaced with a new piece of equipment.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, it was determined that the facility failed to ensure residents' right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This was evident for 7 (Resident #58, #143, #78, #12, #142, #180, #147) residents out of 14 investigated during the the survey.The findings include: 1. On 09/29/2025 at 12:35 PM during observation and interview, Resident #58 shared several concerns: my care plan meetings are at bedside, attended only by the social worker, I receive a care plan report and grievance form, but there are no other staff members to discuss my care or multiple concerns. There is no support for discharge or transfer to return to my home state where I feel I can get access to more community resources. I have missed appointments for over a year due to my lost wheelchair which could fit in the cab for transport, but the current replacement wheelchair is larger and unable to fit in with the only cab service that is offered by the facility. I was fitted for a power wheelchair and told I was approved but never received it. I have asked about my money no longer going into my personal account since about April of this year. When I called Social Security, I was told that a facility doctor signed a statement that I cannot handle my finances anymore, no one will give me information. I still have not received statements or funds since this change and have requested money from the facility. I have no money to obtain my lost documents (birth certificate and social security card) and to get a lawyer. When I asked for help from the Social Worker, they just give me a grievance form, but nothing is ever done; I feel like the only way out for me is if I die. On 10/07/2025 at 9:49 AM during record reviews and interviews regarding Resident #58 concerns of missed appointments related to transportation, it revealed in the Front Desk Appointment log, Resident #58 missed the following appointments on 7/19/24, 1/23/25 and 8/21/25 due to rescheduled W/C wouldn't fit in taxi. During interview with Unit Clerk staff 76, Surveyor asked about missed appointments due to transportation or alternate forms of transportation; Staff #76 states we only are allowed to schedule with Friendly Taxi service and that company cannot fit the resident's large wheelchair and the physician offices that are scheduled cannot accommodate alternate stretcher transport, so I just reschedule the appointments. On 10/07/2025 at 9:59 AM during an interview with Director of Rehab Services staff #30 regarding Resident #58's wheelchair, this Surveyor was told I did dispense Resident #58 a larger wheelchair (28in.) when their personal wheelchair was lost, and then registered and obtained approval for the power wheelchair, however, once the facility was billed for the wheelchair, I no longer have control when the bill will be paid for the resident to receive the wheelchair. Staff #30 provided an Email communication dated 7/10/2025 to 9/29/2025. This communication indicated that Resident #58 was recommended for the Freedom Mobility Power Wheelchair program, met the requirements, was cleared through the loaner screening process to be able to properly handle the power wheelchair, and the final bill received at the facility, but remains unpaid at the time of the survey. On 10/07/2025 at 10:19 AM during record reviews and interviews regarding concerns for incompetence and resident funds, it revealed a BIMS Interview and Staff Assessment, dated 09/19/2024, with a Score of 15, indicating the resident is cognitively intact. The three Physician (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certification Related to Medical Condition, Decision Making, and Treatment Limitations forms, dated 05/19/2022, 10/15/2023, and 6/5/2025 all indicate via the Certification Regarding Decision Making Capacity, that Resident #58 has adequate decision making capacity (including decisions about life-sustaining treatments). Of note, the last certification was completed by Resident #58 current physician (Physician #30). However, the facility filed form SSA-787, the Medical Source Opinion of Patient's Capability to Manage Benefits, the process used to make the facility Representative Payee, completed by Physician #30, citing Resident not capable of handling funds due to their medical condition." dated 3/17/25. Subsequently, the facility received a favorable decision letter dated May 7, 2025 assigning the facility as Representative Payee and that effective on or about April 30, 2025, Resident #58 direct deposit information was changed. Of note, there were no progress notes about the change of decision-making ability regarding Resident #58 around the time of the filing of the changes to Social Security and no communication provided to the resident about the redirecting of their personal funds now to the facility made on their behalf. During an interview with Business Office Manager staff #51, Surveyor asked why the resident was not informed of the Resident Payee request and no statements or funds received until Surveyor intervention and Staff #51 stated I am new, but the resident had an outstanding unpaid bill of over $40,000 and that was why the Resident Payee process was started. Because resident had SSA-787 form on file the facility is the Representative Payee, I do not give them statements. When I was informed that the resident wanted funds, I did arrange for the resident to get their allowance amount just last week, I sent the receptionist to this resident to give them money, that is our process. On 10/07/2025 at 12:06 PM during record reviews regarding resident concern for lack of Social Worker support for discharge planning to return to their home state for Long Term Care, it revealed Resident #58 demonstrated frustrations and no documents related to actual attempts. Discharge Planning Notes, dated 09/01/2025 and 09/08/2025, stated the resident has frustration and anger about (their) stay at this facility and, attempts have been made for transfer but have been unsuccessful. Additionally, Resident #58 Care Plan Report, Created on 06/06/2025, notes the resident is expected to remain in the facility long term and has no plans to discharge at this time. Goal: the resident/resident representative will have their needs met thru the review period. Interventions: assess for the resident's preference to return to community and refer if needed; and review and update discharge plans with the resident when needed. On 10/09/2025 at 9:19 AM during interview with Director of Social Services Staff #36, this Surveyor asked about Resident #58 various concerns. Staff #36 recalled an attempt to help Resident #58 to recover their lost documents, (Birth Certificate, Social Security Card) online, and stated resident was unwilling to proceed because of the money and always says (they) don't have money because facility is taking (my) money. When Surveyor asked if the resident concern about losing access to their personal funds was investigated, Staff #36 further stated I spoke with the old Business Office Manager regarding Resident #58 funds and was told funds are now going to (their) care. Staff #36 shared that attempts were made to explain this to the resident. This Surveyor asked if any documentation related to this follow-up was provided to the resident and Staff #36 stated No. 2. On 9/28/2025 at 9:35AM, the Surveyor observed Geriatric Nursing Assistant (GNA) #4 enter room [ROOM NUMBER], where Resident #143 and #78 reside, without knocking or asking permission to enter prior to entering the residents' room. On 9/29/2025 at 12:21PM, the Surveyor observed GNA #53 enter room [ROOM NUMBER], where Resident #12 and Resident #142 reside, to deliver a lunch tray to Resident #142. GNA #53 did not (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knock or ask permission to enter prior to entering the residents' room. On 10/7/2025 at 12:10PM, an interview with Resident #39 revealed that multiple residents have complained that the nursing staff are not knocking or announcing themselves when they enter the room. This concern was reported to administrative staff; however, the problem still exists. On 10/7/2025 at approximately 3:50PM, during an interview with Resident #12 and #142, the Surveyor observed a GNA enter the residents' room without knocking or asking permission to enter. The GNA took a green pack of adult briefs out of a cupboard, located next to the resident's closet, and then turned around and walked out of the room without acknowledging the residents or the Surveyor. Resident #142 stated that some staff do not knock or ask permission to enter prior to entering the room. During an interview with the Administrator in Training (AIT) #3 on 10/9/2025 at 8:20AM, the Surveyor expressed the concern of multiple observations of nursing staff entering residents room and failing to knock or request permission to enter prior to entering the residents rooms. The Surveyor also expressed the concern that residents have complained about it and reported it to administrative staff and the problem has not been resolved. AIT #3 informed the Surveyor that staff were educated on knocking and announcing themselves prior to entering resident rooms. The Surveyor confirmed that this was a current problem. 3. On 9/28/25 at 9:34AM the surveyor conducted an interview of Resident #180 who expressed their concern to the surveyor: I don't have any clothes, laundry is closed on the weekend, go look, this is day four, it feels like a slob, I have clothes, but they aren't here. Observation of Resident #180's room by the surveyor revealed there was no clothing within the resident's room with the exception of the outfit the resident was wearing that they had been sleeping in. On 9/28/25 at the surveyor observed Resident #147 wearing a hospital gown and conducted an interview of Resident #147 who reported to the surveyor that they also did not have any clothes and stated: laundry staff have to be with their family on the weekend, I like to be dressed I don't want to wear a gown, I didn't tell staff. Resident #147 reported to the surveyor that Resident #180's clothing went to laundry, but they don't do it on the weekend. During an interview on 10/2/25 at 12:17 PM conducted by the surveyor, Director of Housekeeping (DH) #15 reported that the facility was short handed with staffing in laundry for the weekend personals laundry position. DH #15 confirmed with the surveyor that two laundry personnel were needed to perform the weekend laundry tasks, with one assigned to linens and one assigned to personals and the position for personals had been open for months and there was difficulty with filling the position. DH #15 confirmed with the surveyor that they had received concerns regarding that on weekends residents did not have their laundry. DH #15 reported that the unfilled laundry staff position has extended the wait time for laundry to be returned to residents. The surveyor shared concerns with DH #15 who acknowledged and confirmed understanding of the concerns. On 10/2/25 at 12:42PM the surveyor shared concerns with Administrator in Training #3 who acknowledged and confirmed understanding of the surveyor's concern. On 10/2/25 at 12:48PM the surveyor conducted an interview with DH #15 who reported to the surveyor that Resident #180 had no clothing and they had previously been given some clothing, however, she had no record of laundry having tagged the items that had been previously given to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview with residents and staff, it was determined that the facility failed to: 1) maintain all smoking paraphernalia for residents who require supervision with smoking and failed to ensure smoking assessments were reviewed and revised according to the residents' current condition; 2) provide an environment that is free from accident hazards over which the facility has control and provides supervision to each resident to prevent avoidable accidents; 3) adequately assess, monitor, and implement facility smoking policy and procedures for residents that smoke. This was evident for 8 (Resident #33, #119, #55, #4, #45, #42, #2, #37) out of 40 residents reviewed for smoking had the potential to affect all residents who smoke. The findings include: 1. On 10/6/2025 at 10:00AM, during an interview with the Director of Nursing (DON) in the presence of the Nursing Home Administrator (NHA) and the Administrator in Training (AIT), the Surveyor was informed that staff can take the residents who require supervision outside to designated smoking areas at 10AM, 2PM, and 7PM. The staff or the residents must retrieve their smoking paraphernalia from the nursing staff and return it back to be locked away. Independent smokers can keep their own smoking paraphernalia. On 10/6/2025 at 10:05AM, a review of the facility's Smokers List revealed that Resident #33 needed supervision while smoking. A review of Resident #33's electronic medical record on 10/6/2025 at 10:41AM revealed a Smoking Safety Screen assessment completed on 6/18/2025 with a score of 10, indicating the resident needed supervision while smoking. The Surveyor reviewed a care plan created on 1/14/2025 with revisions on 6/23/2025 with a focus resident prefers to smoke cigarettes, a goal the resident will smoke safely thru the review period with revisions on 4/28/2025, and an intervention supervise with smoking created on 4/24/2025. During an interview/observation with Resident #33 on 10/6/2025 at 11:00AM, the resident informed the Surveyor that they smoke and need supervision during the smoking sessions. The resident also informed the Surveyor that they keep the smoking paraphernalia in their room in a pocket of their clothing. On 10/6/2025 at 11:30AM, during a review of the facility's Patient Smoking policy #7, the Surveyor validated that the center will maintain all smoking paraphernalia for [residents] who require supervision with smoking. On 10/6/2025 at 1:23PM, during an interview with the DON, the Surveyor expressed the concern that Resident #33 required supervision while smoking and was observed with their smoking paraphernalia in the room. 2. On 10/6/2025 at 10:05AM, a review of the facility's Smokers List revealed that Resident #119 needed supervision while smoking. On 10/6/2025 at 10:26AM, during an interview with Resident #119, a Surveyor observed a pack of cigarettes in the resident's nightstand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/6/2025 at 12:40PM, a review of Resident #119's electronic medical record revealed a Smoking Safety Screen assessment completed on 8/13/2025 with a score of 25, which indicates the resident requires supervision while smoking. The Surveyor reviewed a care plan created on 7/8/2025 with a focus the resident prefers to smoke cigarettes, a goal the resident will smoke safely thru the review period, and an intervention supervise with smoking. On 10/6/2025 at 1:23PM, during an interview with the DON, the Surveyor expressed the concern that Resident #119 required supervision while smoking and was observed with their smoking paraphernalia at the bedside. On 10/7/2025 at 9:22AM, the Surveyor observed a pack of cigarettes on top of Resident #119's over the bed table. 3. On 9/29/2025 at 10:30AM, during an interview with Resident #4, the resident stated that they can smoke independently in designated areas of the facility. The Surveyor observed 2 packs of cigarettes sitting on the bedside table. On 10/1/2025 at 12:50PM, the review of the facility's Smokers List revealed Resident #4 was an independent smoker. On 10/1/2025 at 1:15PM, during an interview conducted with the Director of Nursing (DON), the Surveyor was informed smoking assessments are completed during the admission process and quarterly. The facilities smoking policy will be reviewed with resident and/or resident's family and the Patient Smoking Acknowledgement form will be signed by resident and facility staff. Based on the assessment findings, the resident would either be considered an independent smoker or a supervised smoker. Independent smokers can smoke at any time in designated areas. Supervised smokers can smoke in designated areas at 10AM, 2PM, and 7PM with assigned staff supervision. Those residents who need supervision when smoking cannot maintain possession of smoking paraphernalia to include cigarettes, lighters, and matches. The nurse should keep the supervised resident's smoking paraphernalia locked up and should ensure that it is returned after their smoking sessions. On 10/6/2025 at 9:45AM, a review of Resident #4's electronic medical record revealed a Smoking Safety Screen assessment completed on 7/14/2025 with a score of 10. Scores of 0-4 indicate the resident may smoke unsupervised and scores 5 or greater indicate the resident requires supervision with smoking. Further review revealed a care plan created on 7/14/2025 with focus the resident prefers to smoke, a goal the resident will smoke safely thru the review period, and an intervention to supervise with smoking. On 10/6/2025 at 10:15AM, the Surveyor conducted an interview with Unit Manager (UM) #67. During the interview, UM #67 informed the Surveyor that smoking assessments are completed on admission, quarterly, and as needed. Residents can progress from a supervised smoker to an independent smoker. A nurse would have to directly observe the resident during a smoking session and complete an updated smoking assessment to determine that they no longer require supervision with smoking. The care plan should then be updated to reflect the independent smoking status in the medical record. UM #67 continued to inform the Surveyor that Resident #4 is an independent smoker. The resident needed supervision when they were first admitted to the facility due to their medical condition but since then had been evaluated and can smoke independently. The Surveyor expressed the concern that the facility failed to update the resident's Smoking Safety Screen assessment and care plan to reflect the resident was an independent smoker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 10/6/2025 at 10:34AM, a review of the facility's Smokers List revealed that Resident #55 was an independent smoker. A review of the resident's electronic medical record revealed a Smoking Safety Screen assessment completed on 6/23/2025 which indicated the resident did not smoke. The Surveyor reviewed a care plan created on 6/16/2025 with a focus resident refuses nicotine patch, the resident prefers to smoke cigarettes, a goal the resident will smoke safely thru the review period, and an intervention may smoke independently. On 10/6/2025 at 1:23PM, during an interview with the DON, the Surveyor expressed the concern that Resident #55's Smoking Safety Screen assessment completed on 6/23/2025 failed to indicate that the resident was a smoker and the resident was care planned for smoking on 6/16/2025. On 10/7/2025 at 12:56PM, the AIT provided the Surveyors with an updated smokers list as of 10/6/2025 at 5PM. According to the updated list, Residents #33 and #119 were still supervised smokers and Residents #4 and #55 were still independent smokers. 5. Review of facility documentation on 09/28/2025 at 10:45 AM revealed a facility Smokers List dated 09/27/2025 with Resident #45 listed as a smoker that required supervision. During multiple observations and interviews, on 09/29/2025 at 10:36 AM and 09/30/2025 at 11:15 AM, Resident #45 was lying in bed with bedside table adjacent to resident bed. Surveyor observed on the bedside table a vape pen box-like handheld device, which was approximately a 2 inch purple box with yellow writing on it and a mouthpiece. The Surveyor asked the resident what the device was; the resident replied, it is my Vape Pen. On 10/06/2025 at 10:29 AM during a follow-up observation and interview, Resident #45 was in bed and the vape pen box-like handheld device was now observed in the resident's left hand. Surveyor asked what was in resident hand; resident replied, it is my Vape Pen, I like it in my hand as something to grab on to. Surveyor asked resident when the last use was of the vape pen and where; the resident replied, my last use was Friday (10/3/25) outside, and occasionally I use while in bed. This Surveyor then asked if the resident used the vape pen today; Resident #45 stated yes. 6. On 10/06/2025 10:35 AM during observation and interviews, Resident #42 was in bed with 3 boxes of cigarettes noted to be Virginia Slims 120's in the bedside table 1st drawer that was slightly opened and clearly visible. On 10/6/2025 at 12:51 PM during Resident #42's record review, it revealed a facility Smoking Safety Screen, dated 7/10/2025 stated Resident #42 scored a 15. A score of 15 indicates that Resident #42 required supervision with smoking. The Facility Care Plan Report smoking plan created on 11/24/2024 and revised on 4/22/2025 indicated Resident #42 prefered to smoke cigarettes with an intervention to supervise with smoking created on 7/10/2025. The facility Policies and procedures stated in procedure item 7, the center will maintain all smoking paraphernalia for patients who require supervision with smoking. 7. On 10/6/2025 at 12:52 PM during Resident #45's record review, it revealed a facility smoking safety screen, dated 4/22/2025 stated Resident #45 scored a 10. A score of 10 indicates that Resident #45 required supervision with smoking. The Facility Care Plan Report smoking plans were created on 4/21/2025 and 4/22/2025 indicating Resident #45 preferences to use a vape pen. Despite the smoking assessment scoring Resident #45 at 10, the interventions for both care plans did not list the necessity for supervision with smoking. The facility policies and procedures states in procedure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	item 1 reads that smoking references any device/item, as well as any electronic delivery systems (vape pens); items 6 reads if supervision is deemed necessary, the patient will be supervised by staff; and items 7 reads the center will maintain all smoking paraphernalia for patients who require supervision with smoking. On 10/06/2025 at 1:00 PM during interview with the Director of Nursing staff #2 was made aware of Residents #45 and #42 having smoking paraphernalia at bedside. Additionally, this Surveyor notified Staff #2 of Resident #45 admission of using the vape pen while in bed. Staff #2 stated, I will address that right away. On 10/7/2025 at 1:35 PM during record review of Resident #45, after surveyor intervention, revealed in Progress Notes, a Health Status Note, dated 10/6/2025 18:00: Note Text: Staff removed vape materials from residents room. [Resident #45] is totally dependent to smoke. Will need to smoke on supervised smoking times outside. 8. During observation rounds and interview on 09/28/2025 at approximately 8:27AM Resident #2 was found lying in bed wearing oxygen at 3 liters via nasal cannula and 2 red and white full packs of cigarettes as well as a light blue lighter were observed on his/her bedside table. Resident #2 stated, I have not gone out today to smoke and if I did, I would not wear my oxygen. I would take it off first before I go outside to smoke. Review of facility documentation on 09/28/2025 at 10:45 AM revealed a facility Smokers List dated 09/27/2025 with Resident #2 listed as a smoker that required supervision. Review of Resident #2's medical record on 09/28/2025 at 10:50 AM revealed a smoking assessment dated [DATE] stating that resident #2 scored a 0. A score of 0 indicates that a resident #2 may smoke unsupervised. Further review revealed an order dated 06/17/2025 for Oxygen Therapy – Oxygen at 3 liters per minute via nasal cannula every shift. During interview on 09/28/2025 at approximately 11:10 AM the Director of Nursing staff #2 stated, All residents who smoke and are on oxygen should be supervised. Any resident that requires supervision should not have any smoking paraphernalia in their possession or rooms. Resident #2 smoking assessment needs to be redone. Staff #2 stated, Yes, the dated 06/23/2025 smoking assessment stating that resident #2 scored a 0 was the current smoking assessment the facility would be going by as of 09/28/2025 for the status of Resident #2 smoking. Review of resident #2 medical record on 09/29/2025 at 8:30 AM revealed a facility Smoking Assessment, completed after surveyor intervention, dated 09/28/2025 stating that Resident #2 scored a 5. A score of 5 indicates that Resident #2 requires supervision with smoking. During observation rounds and interview on 10/06/2025 at 9:58 AM resident #2 was found wearing Oxygen 3 liters via nasal cannula with 1 pack of full red and white cigarettes and a light blue lighter on his/her bedside table. Staff # 39 verified to the surveyor observation of smoking paraphernalia on Resident #2 bedside as well as resident #2 being on Oxygen. During interview on 10/06/2025 at 10:03 AM the Director of Nursing staff #2 was made aware by this surveyor of Resident #2 still having smoking paraphernalia at bedside. Staff #2 stated, I will address that right away. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 10/06/2025 at 11:00 AM a review of the electronic medical record revealed that Resident # 37 had a smoking screening assessment completed 06/23/2025 which identified the resident as a smoker without supervision. Resident # 37 was listed on the facility's 09/27/25 smoking list as requiring supervision and no update to the care plan was found by the surveyor. Based on the review of the medical record the resident would have required the additional protection while smoking like an apron because of the physical limitations with his/her hands which was present when the June 2025 smoking assessment was completed. After the interview with the Director of Nursing (DON) on 10/06/2025, the DON provided an updated smoking list of residents on 10/7/2025. After surveyor inquiry, Resident # 37 was listed as requiring supervision and an apron on the updated smoking list and the resident's smoking assessment had been updated to reflect the supervision needed with an apron while smoking.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to: 1) ensure secure storage of medications 2) appropriately label and store drugs and biologicals in accordance with currently accepted professional principles (within medication rooms, carts, boxes, refrigerators). This was evident for 2 out of 2 random observations of the facility's second floor supply room, 1 out of 1 shower room on Unit 1, second floor, 1 of 3 medication carts and 1 of 1 Medication refrigerators on Station 2 investigated during the facility's survey.The findings include: 1.) During the surveyor's initial tour of the facility on [DATE] at 8:40 AM the surveyor observed the second-floor biohazard soiled utility room door visibly ajar at which time the surveyor was also able to freely access the 2nd floor supply room. On [DATE] at 8:42 AM the surveyor observed multiple freely accessible boxes and bags of Apomorphine Hydrochloride Injection medication and boxes of needles present within the freely accessible unlocked supply room. On [DATE] at 8:47AM Registered Nurse (RN) #39 was observed entering the supply room at which time the surveyor shared the concern and conducted a dual observation of the concern with them. RN #39 confirmed with the surveyor that medication should not be store in the supply room. On [DATE] at 8:50AM Geriatric Nursing Assistant (GNA) #59 was observed freely entering the supply room at which time the surveyor conducted an interview with them. During the interview, GNA #59 reported to the surveyor that they did not need a code to enter the supply room and additionally reported that the lock on the supply room door had been broken for approximately two to two and a half years. On [DATE] at 8:53AM the surveyor conducted and performed a dual observation of the concern with the facility's Assistant Director of Nursing (ADON). After surveyor intervention, the ADON reported the following regarding the freely accessible medications: I'm going to go put it in the med room behind the locked door. The ADON was then observed by the surveyor instructing GNA #59 to submit a maintenance ticket because the supply room door lock was broken. The surveyor observed the ADON removing the medication from the supply room and placing it into the medication room located behind the 2nd floor nurse's station. 2.) On [DATE] at 10:36 AM surveyors observed the following medications in an unlocked treatment cart located within a freely accessible unlocked key padded storage supply room on floor two of the facility accessible from the resident hallway: 1.) Lidocaine ointment, 2.) Clobetasol topical solution, 3.) Clotrimazole, 4.) Santyl, 5.) Calcipotriene, 6.) Tacrolimus, and 7.) Triamcinolone, among other various medications. At this time, the Director of Housekeeping #15 was observed freely entering the supply room. At this time, surveyors observed the supply room unlocked door mechanism with the facility's Director of Maintenance #16 who reported staff took the mechanism out, they're doing it for convenience. On [DATE] at approximately 10:40AM the surveyor requested and performed a dual observation of the concern with Licensed Practical Nurse #37 who after surveyor intervention, was observed pushing (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the lock button to the cart inward in order to lock the treatment cart drawers. At this time the surveyor conducted an interview with LPN #37 who confirmed with the surveyor that all staff have access to the supply room. On [DATE] at 10:44AM the surveyor shared the concern with the Facilities Assistant Director of Nursing who acknowledged and confirmed understanding of the surveyor's concern. 3.) On [DATE] at 10:55AM multiple surveyors observed fluticasone nasal spray not labeled with any resident information and present in resident belongings observed to be stored in the facility's second floor unlocked shower room. On [DATE] at 10:55AM the surveyor shared the concern and conducted a dual observation of the concern with the facility's Administrator who observed, acknowledged, and confirmed understanding of the surveyor's concern. On [DATE] at 11:00AM the surveyor shared the concern with the facility's Assistant Director of Nursing who stated: Okay. 4.) On [DATE] at 8:02 AM during medication administration for Resident #27, this Surveyor observed at Station 2 Hall 1 medication cart, LPN staff #21 dispensed insulin to Resident #27 from an unlabeled Insulin Aspart Injection FlexPen, Exp 2027-10-31, Lot RZFSM68. When asked about the non-labeled medication; LPN staff #21 replied, 'the label fell off, but this is the only resident on this FlexPen medication'. Surveyor then asked what the facility expectation with the non-labeled medication and LPN staff #21 replied 'we should have requested another labeled FlexPen from pharmacy for the resident. 5.) On [DATE] at 8:24 AM during medication administration at Station 2 Hall 1 medication cart, Surveyor observed LPN staff #21 use Blood Glucose test strips from the bottle that read 'EvenCare Blood Glucose Test Strip, Manufacture Exp (17): 2026-12-18, Lot (10) 16825033006'; this bottle did not have a facility open or discard date visible on the bottle. This Surveyor asked about facility policies and expectations for labeling the Blood Glucose test strips bottle once opened; LPN staff #21 replied, 'the bottle should be labeled with the open date and then discarded per protocol or per manufacture date.' 6.) On [DATE] at 8:32 AM during Medication Room storage review and interview RN Unit Manager of Station 2 staff #23, it revealed the following: 6a. The 'Temperature Log for Refrigerator and Freezer had Fahrenheit' spaces for the temperature to be monitored twice daily at AM and PM was blank for Day of Month 1 PM and Day of Month 2 AM slots at time of observation. Surveyor asked staff #23 about the 2 blank slots and the staff expectation; staff #23 stated 'I am relatively new, but I was told it is supposed to be completed by Station 2 Hall 2 Nurse and listed as an assignment on the Unit Board. Of note, the nurse covering Station 2 Hall 2 for this day was identified as LPN staff #24. Additionally, this Surveyor observed the Unit Board on Station 2, there was no indication of 'check Temperature Logs' as an assignment visibly noted anywhere on the board. 6b. The sink area is inaccessible due to clutter of storage bins sitting across the sink, multiple medication deliveries atop this storage bin, and multiuse items such as saline syringe boxes and empty return pharmacy bags within the splash range of the sink area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6c. Within the top left drawer just below the sink, there was an expired 'Secondary Medication Set', Exp (17) 2024-12-00, Lot (10) SR23A11001. Also, there was a bag of opened activated charcoal, labeled 'DETERRA drug deactivation system', this bag did not have a facility open or discard date. 6d. There was a bedside table and medication cart within the medication room; the cart was being used for overflow medications per staff #23. Both the bedside table and the medication cart were filled on top with medication card packs of different residents. During the interview, Surveyor asked RN Unit Manager staff #23 why there were so many unused medication card packs on top of the bedside table and medication cart; staff #23 replied 'these are the return medications usually awaiting pharmacy pickup.' On [DATE] at 9:50 AM during interview with LPN staff #24, Surveyor asked about the completion of the Temperature Log by the Station 2 Hall 2 staff as per RN Unit Manager staff #23; staff #24 stated 'that is not the day staff responsibility, night staff checks the Temperature Log.' On [DATE] at 12:15 PM during interview with Director of Nursing staff #2 and Quality Improvement/Infection Prevention Nurse staff #22, this Surveyor discussed the findings of the non-labeled insulin FlexPen in the medication cart; the failure to properly label multiuse glucose test strip bottles after opening, the failure to maintain an organized medication room; the monitoring of expiration dates on multiuse medications; and the overflow of returned medications not returned to pharmacy.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure a resident receiving a therapeutic mechanically altered diet was given food in the correct consistency based on the physician's order. This was evident for 1 (Resident #100) out of 2 residents observed for accuracy of meal tickets during the revisit survey.The findings include:On 12/18/2025 at 9:00AM, during a tour of the 2nd floor nursing unit, the Surveyor observed Resident #100 sitting in a chair with their breakfast on the bedside table in front of them. During an interview conducted with the resident, the Surveyor was informed that the resident drank some of the supplement shake and was not interested in what was served on their tray. The resident's breakfast tray contained uneaten hot cereal, scrambled eggs, and slice of toast cut in half with margarine. The Surveyor reviewed Resident #100's meal ticket and noted that the tray was to include hot cereal, scrambled eggs (fork mashable), toast (pureed) and jelly and margarine.On 12/18/2025 at 9:18AM, during an interview with Licensed Practical Nurse #10, the Surveyor expressed the concern that Resident #100's meal ticket stated Mech Altered-Regular diet and pureed toast, and the resident received regular toast on their breakfast tray. LPN #10 and the Surveyor observed Resident #100's tray and confirmed the Surveyor's findings. LPN #10 stated they would review the physician's diet order.On 12/18/2025 at 9:45AM during a review of Resident #100's electronic medical record, the Surveyor discovered a physician's order for a regular diet, dysphagia, mechanically altered texture, thin liquid consistency.During an interview conducted with Registered Dietician (RD) #8 on 12/18/2025 at 12:50PM, the Surveyor was informed that Resident #100 was on a mechanically altered diet and that their diet order had not been changed as far as they were concerned. The resident should not have had regular toast on their tray; the toast should have been pureed according to the diet order.During an interview conducted with the Director of Rehab (DOR) #11 on 12/18/2025 at 1:10PM, the Surveyor was informed that there was no upgrades made to the resident's diet. According to the Speech Language Pathologist's notes, the resident was to remain on a mechanically altered diet due to dysphagia.During an interview conducted with the Regional Dietary Manager on 12/18/2025 at 1:18PM in the presence of the Director of Nursing (DON), the Surveyor expressed the concern that Resident #100 has a physician's order for a regular diet, dysphagia, mechanically altered texture, thin liquid consistency diet and the meal ticket on the breakfast tray noted toast (pureed); however, the resident received regular toast on their tray. Regional Dietary Manager stated that they would look into the Surveyor's concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined that the facility staff failed to implement appropriate infection prevention and control practices. This was evident in observation by surveyors during the environmental tour of the facility including the laundry room, 2 out of 2 hand washing sinks observed by the surveyor on floor 2 of the facility and 5 (#27, #52, #142, and #104, #3) out of 38 residents reviewing during the survey.The findings include:1. On 10/02/2025 at 7:58 AM during medication administration observation of resident #27, LPN staff #21 observed donning and doffing gloves and failing to perform hand hygiene after completing point-of-care testing of fingerstick or administering insulin pen medications. Additionally, staff #21 returned the point-of-care device (glucometer) to the medication cart without cleaning the device. Of note, this was the only glucometer observed in the medication cart.2. On 10/02/2025 at 8:18 AM during medication administration observation of resident #52, this Surveyor observed LPN staff #21 access the resident medication profile to begin and then retrieve the non-cleaned glucometer from the medication cart. After Surveyor intervention, stating the glucometer was returned to draw without cleaning after the last resident use; LPN staff #21 then cleaned glucometer prior to use with resident #52.On 10/02/2025 at 8:22 AM during interview with Quality Improvement/Infection Prevention Nurse staff #22, this surveyor notified QI/IP Nurse of the failure of LPN staff #21 to perform hand hygiene and cleaning of point-of-care testing equipment between residents. Staff #22 stated ?the staff was just in-serviced on this and asked staff #21 were you recently in-serviced, staff #21 replied, yes.3. On 10/02/2025 at 9:55 AM prior to starting medication administration observation, this surveyor observed LPN staff #24, enter resident #142 room and proceed to adjust the O2 Nasal cannula. Staff #24 exited resident room without performing hand hygiene.On 10/02/2025 at 9:57 AM Staff #24 then proceeded to medication cart to begin medication administration for resident #104 and no hand hygiene performed, despite previously assisting another resident with adjusting their nasal cannula without gloves or performing hand hygiene afterwards.On 10/02/2025 at 10:35 AM during interview with Director of Nursing staff #2 and Clinical Regional Nurse staff #43, this surveyor discussed concerns of Infection Prevention and Control practices during medication administration, specifically failure to perform hand hygiene between resident interactions and when donning and doffing gloves, and cleaning of point-of-care testing devices between resident use.On 10/02/2025 at 12:15 PM during interview with Director of Nursing staff #2 and Quality Improvement/Infection Prevention Nurse staff #22, this Surveyor again discussed the failure to perform hand hygiene between residents and glove usage; failure to clean point-of-care device glucometer prior to returning to medication cart and next resident use; and no gloves or disposable wipes visibly available for staff use to maintain infection prevention and control.4. On 9/29/2025 at 11:09AM, during a tour of Unit 2, the Surveyor observed admission Assistant (AA) #65 grab linen off a linen cart in the hallway and drop a couple pieces on the floor. AA #65 picked the linen up off the floor, placed majority of it on top of the linen cart, and some in a soiled linen bin in the hallway. AA #65 gathered more linen from the linen cart, grabbed the linen from the top of the linen cart, and proceeded into room [ROOM NUMBER] and made the bed by the window. The Surveyor made AA #65 aware of their observation.On 9/30/2025 at 8:25AM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that AA #65 dropped linen on the hallway floor on Unit 2 and used that linen to make a bed in room [ROOM NUMBER].On 10/1/2025 at 1:00PM, the DON informed the Surveyor that AA #65 was immediately educated regarding the proper way to handle linen and the Staff Educator #29 started to educate all staff. 5. On 10/2/2025 at 10:27AM, during environmental rounds with Director of Laundry (DOL) #15, the Surveyor observed the laundry processing room. The laundry chute was backed up and full of dirty, loose clothing and linen, and clear bags of clothing and linen that were not closed before tossing into the chute. DOL #15 confirmed the Surveyor's findings. The laundry chute should not be backed up and the laundry should (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be in securely tied clear bags when they are tossed down the chute.6. On 10/2/2025 at 10:20AM, during an observation of the clean linen room, the Surveyor observed Laundry Assistant (LA) #63 while folding linen, allowing the linen to touch their uniform.On 10/8/2025 at 11:54AM, the Surveyor observed LA #63 folding a blanket as the blanket touched their uniform and the floor. LA #63 placed the blanket on the bottom row of the clean linen cart. LA #63 proceeded to fold another blanket in the same manner. The Surveyor asked LA #63 if clean linen should touch the uniform or the floor and the Surveyor was informed that clean linen should not touch their uniform or the floor. The Surveyor confirmed that the last two blankets that LA #63 folded were now contaminated.During an interview with DOL #15 on 10/8/2025 at 12:00PM, the Surveyor expressed the concern that LA #63 was observed on 2 different occasions while folding linen and failed to handle the linen in a way to prevent it from touching their uniform or the floor. The Surveyor was informed that LA #63 will receive education on the proper way to handle clean linen.7. On 10/1/25 at 9:05AM the surveyor observed Resident #3's heel with a gauze dressing in place, laying directly against the mattress. At this time, the surveyor conducted an interview with Resident #3 who reported to the surveyor that they had needed another (pressure relieving) boot because there was drainage in the boot's pad. During the observation and interview, the resident's IV therapy pump was alarming due to completion of IV antibiotic therapy at which time Licensed Practical Nurse (LPN) #56 was observed entering the room and performing hand sanitization and applied gloves, however, did not apply a gown. LPN #56 handled the resident's uncapped PICC (peripherally inserted central catheter) line and disconnected it from the IV pump, no swab caps (alcohol infused caps used to prevent infection) were present or applied.During continuation of the interview with Resident #3 they expressed they were concerned about their uncapped PICC line connectors dragging along the counter when getting ready for the day in the morning, and were concerned for it getting into their food tray while eating and informed the surveyor that they were educated at the hospital that caps needed to be kept on it, but there were none. Resident #3 showed the surveyor the uncapped lines dangling close to their food tray contents and the surface of their overbed table. The surveyor observed Resident #3 with no date or time on their PICC dressing. During the interview with Resident #3 they expressed that dressing changes were not occurring at the frequency they were supposed to occur due to there not being enough nursing staff available to perform the dressing changes. Resident #3 reported that on 9/29/25 at 12:23PM (after surveyors entered the building on 9/28/25) they observed enhanced barrier precaution signage had been placed on their room door for the first time.On 10/1/25 at 9:25AM the surveyor observed the resident's pressure relieving boot sitting on top of a plastic basin on the floor. The surface material of the resident's pressure relieving boot was observed to be saturated with crusted areas of brown, black, and red colored matter present on the area where the resident's wound area would make contact with the boot if applied. The surveyor observed Resident #3's PICC line dressing again with no date or time on it to indicate when it had last been changed, and there were no swab caps present on the connectors.On 10/1/25 at 9:33AM the surveyor requested and conducted a dual observation of the concerns with the facility's ADON and Resident #3 at which time the ADON observed, acknowledged, and confirmed understanding of the surveyor's concerns. On 10/1/25 at 9:43AM the surveyor conducted an interview with the ADON who, after surveyor intervention, reported to the surveyor that the resident would receive another boot today and the current one may get laundered or thrown away, and reported that Resident #3's dressing change would be performed now. The ADON confirmed with the surveyor that Resident #3 was ordered enhanced barrier precautions and their expectation was for staff to wear a gown when managing the resident's PICC line.On 10/1/25 at 9:44AM the surveyor conducted an interview of LPN #56 who was able to appropriately describe personal protective equipment that should be used for the resident on enhanced barrier precautions. LPN #56 expressed to the surveyor regarding their disconnection of Resident #3's IV therapy: I should've had a gown on.On 10/3/25 at 12:00PM the surveyor conducted an interview with the facility's Assistant Director of Nursing (ADON) who reported the following information: The boot (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was replaced that day, the old one was sent to laundry and the new one was put in [his/her] room, [s/he] is using it, and that Resident #3's dressing had been changed immediately by the nurse on 10/1/25.On 10/3/25 at 2:13PM the surveyor conducted an interview of the ADON who confirmed: Yes, (Resident #3) does use the boot. On 10/6/25 at 3:18PM the surveyor shared the concerns with the Director of Nursing who acknowledged and confirmed understanding of the concerns and reported that nursing staff should have identified the boot when they went into the room. On 10/9/25 at 2:52PM the surveyor conducted an interview with the ADON who reported that the resident's wound had been present since at least the date of 5/20/25.8. On 10/2/25 at 10:17AM during a multi-surveyor tour of the facility's laundry room, 2 out of 2 ceiling vents were observed to be missing their coverings and had a layer of grey debris present on them. Uncovered laundered personal resident laundry was observed to be sitting below one of the ceiling vents, and uncovered laundered resident linen was observed to be sitting below the second ceiling vent. On 10/2/25 at 10:20AM surveyors shared concerns with and conducted an interview of Director of Maintenance #16 who reported to surveyors that the vents did have a cover, however laundry staff take them down because it cools them off.On 10/2/25 at 10:25AM during a multi-surveyor tour of the facility's laundry room, unbagged soiled laundry was observed overflowing from the laundry chute located on the wall. On 10/2/25 at 10:28AM surveyors conducted an interview with the Director of Housekeeping #15 who observed surveyor concerns and stated regarding the unbagged soiled laundry in the chute: It's supposed to be in bags. 9. On 9/29/25 at 10:00AM the surveyor observed when they went to wash their hands in the sink located inside of the floor 2 assisted bathing room bathroom, that there was no hand soap available. When the surveyor searched and located another sink within the floor 2 community area, that sink was observed to have a hand soap dispenser which was nearly empty and unable to dispense out hand soap for hand washing. On 9/29/25 at 10:03AM the surveyor had to go seek out facility staff in order to locate hand soap for hand washing, at which time the Director of Housekeeping (DH) #15 was observed in the floor 2 hallway. At this time the surveyor conducted an interview with DH #15 who observed the concern with the surveyor and reported the following information: There is a red electronic light to access the storage supply closet and we couldn't get in, it was broken so maintenance is fixing it so we can bring the hand soap.On 10/2/25 at 10:52AM multiple surveyors observed during a shared observation with the facility's Director of Maintenance #16, Director of Housekeeping #15, and Administrator, that the floor 2 assisted bathing room bathroom had no hand soap available for hand washing. 10. On 10/2/25 at 10:13AM multiple surveyors observed respiratory supplies including tracheostomy collars and oxygen masks with tubing stored approximately 2 inches from the floor's surface. The flooring surface was observed to be visibly dirty with areas of white and brown matter present. The concern was shared at this time during a shared observation with the facility's Director of Housekeeping #15, Director of Maintenance #16, and Administrator.On 10/6/25 at 11:00AM the surveyor observed the respiratory supplies continued to be stored approximately 2 inches from the floor's surface with the flooring surface observed to be again, visibly dirty with areas of white and brown matter present.Surveyor concerns were again reviewed with the facility Administrator and other staff during the exit conference on 10/9/25. Based on observations, interviews and record reviews, it was determined that the facility staff failed to implement appropriate infection prevention and control practices. This was evident in observation by surveyors during the environmental tour of the facility including the laundry room, 2 out of 2 hand washing sinks observed by the surveyor on floor 2 of the facility and 5 (#27, #52, #142, and #104, #3) out of 38 residents reviewing during the survey. The findings include: 1. On 10/02/2025 at 7:58 AM during medication administration observation of resident #27, LPN staff #21 observed donning and doffing gloves and failing to perform hand hygiene after completing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	point-of-care testing of fingerstick or administering insulin pen medications. Additionally, staff #21 returned the point-of-care device (glucometer) to the medication cart without cleaning the device. Of note, this was the only glucometer observed in the medication cart. 2. On 10/02/2025 at 8:18 AM during medication administration observation of resident #52, this Surveyor observed LPN staff #21 access the resident medication profile to begin and then retrieve the non-cleaned glucometer from the medication cart. After Surveyor intervention, stating the glucometer was returned to draw without cleaning after the last resident use; LPN staff #21 then cleaned glucometer prior to use with resident #52. On 10/02/2025 at 8:22 AM during interview with Quality Improvement/Infection Prevention Nurse staff #22, this surveyor notified QI/IP Nurse of the failure of LPN staff #21 to perform hand hygiene and cleaning of point-of-care testing equipment between residents. Staff #22 stated 'the staff was just in-serviced on this and asked staff #21 were you recently in-serviced, staff #21 replied, yes. 3. On 10/02/2025 at 9:55 AM prior to starting medication administration observation, this surveyor observed LPN staff #24, enter resident #142 room and proceed to adjust the O2 Nasal cannula. Staff #24 exited resident room without performing hand hygiene. On 10/02/2025 at 9:57 AM Staff #24 then proceeded to medication cart to begin medication administration for resident #104 and no hand hygiene performed, despite previously assisting another resident with adjusting their nasal cannula without gloves or performing hand hygiene afterwards. On 10/02/2025 at 10:35 AM during interview with Director of Nursing staff #2 and Clinical Regional Nurse staff #43, this surveyor discussed concerns of Infection Prevention and Control practices during medication administration, specifically failure to perform hand hygiene between resident interactions and when donning and doffing gloves, and cleaning of point-of-care testing devices between resident use. On 10/02/2025 at 12:15 PM during interview with Director of Nursing staff #2 and Quality Improvement/Infection Prevention Nurse staff #22, this Surveyor again discussed the failure to perform hand hygiene between residents and glove usage; failure to clean point-of-care device glucometer prior to returning to medication cart and next resident use; and no gloves or disposable wipes visibly available for staff use to maintain infection prevention and control. 4. On 9/29/2025 at 11:09AM, during a tour of Unit 2, the Surveyor observed admission Assistant (AA) #65 grab linen off a linen cart in the hallway and drop a couple pieces on the floor. AA #65 picked the linen up off the floor, placed majority of it on top of the linen cart, and some in a soiled linen bin in the hallway. AA #65 gathered more linen from the linen cart, grabbed the linen from the top of the linen cart, and proceeded into room [ROOM NUMBER] and made the bed by the window. The Surveyor made AA #65 aware of their observation. On 9/30/2025 at 8:25AM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that AA #65 dropped linen on the hallway floor on Unit 2 and used that linen to make a bed in room [ROOM NUMBER]. On 10/1/2025 at 1:00PM, the DON informed the Surveyor that AA #65 was immediately educated regarding the proper way to handle linen and the Staff Educator #29 started to educate all staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 10/2/2025 at 10:27AM, during environmental rounds with Director of Laundry (DOL) #15, the Surveyor observed the laundry processing room. The laundry chute was backed up and full of dirty, loose clothing and linen, and clear bags of clothing and linen that were not closed before tossing into the chute. DOL #15 confirmed the Surveyor's findings. The laundry chute should not be backed up and the laundry should be in securely tied clear bags when they are tossed down the chute. 6. On 10/2/2025 at 10:20AM, during an observation of the clean linen room, the Surveyor observed Laundry Assistant (LA) #63 while folding linen, allowing the linen to touch their uniform. On 10/8/2025 at 11:54AM, the Surveyor observed LA #63 folding a blanket as the blanket touched their uniform and the floor. LA #63 placed the blanket on the bottom row of the clean linen cart. LA #63 proceeded to fold another blanket in the same manner. The Surveyor asked LA #63 if clean linen should touch the uniform or the floor and the Surveyor was informed that clean linen should not touch their uniform or the floor. The Surveyor confirmed that the last two blankets that LA #63 folded were now contaminated. During an interview with DOL #15 on 10/8/2025 at 12:00PM, the Surveyor expressed the concern that LA #63 was observed on 2 different occasions while folding linen and failed to handle the linen in a way to prevent it from touching their uniform or the floor. The Surveyor was informed that LA #63 will receive education on the proper way to handle clean linen. 7. On 10/1/25 at 9:05AM the surveyor observed Resident #3's heel with a gauze dressing in place, laying directly against the mattress. At this time, the surveyor conducted an interview with Resident #3 who reported to the surveyor that they had needed another (pressure relieving) boot because there was drainage in the boot's pad. During the observation and interview, the resident's IV therapy pump was alarming due to completion of IV antibiotic therapy at which time Licensed Practical Nurse (LPN) #56 was observed entering the room and performing hand sanitization and applied gloves, however, did not apply a gown. LPN #56 handled the resident's uncapped PICC (peripherally inserted central catheter) line and disconnected it from the IV pump, no swab caps (alcohol infused caps used to prevent infection) were present or applied. During continuation of the interview with Resident #3 they expressed they were concerned about their uncapped PICC line connectors dragging along the counter when getting ready for the day in the morning, and were concerned for it getting into their food tray while eating and informed the surveyor that they were educated at the hospital that caps needed to be kept on it, but there were none. Resident #3 showed the surveyor the uncapped lines dangling close to their food tray contents and the surface of their overbed table. The surveyor observed Resident #3 with no date or time on their PICC dressing. During the interview with Resident #3 they expressed that dressing changes were not occurring at the frequency they were supposed to occur due to there not being enough nursing staff available to perform the dressing changes. Resident #3 reported that on 9/29/25 at 12:23PM (after surveyors entered the building on 9/28/25) they observed enhanced barrier precaution signage had been placed on their room door for the first time. On 10/1/25 at 9:25AM the surveyor observed the resident's pressure relieving boot sitting on top of a plastic basin on the floor. The surface material of the resident's pressure relieving boot was observed to be saturated with crusted areas of brown, black, and red colored matter present on the area where the resident's wound area would make contact with the boot if applied. The surveyor observed Resident #3's PICC line dressing again with no date or time on it to indicate when it had last been changed, and there were no swab caps present on the connectors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/25 at 9:33AM the surveyor requested and conducted a dual observation of the concerns with the facility's ADON and Resident #3 at which time the ADON observed, acknowledged, and confirmed understanding of the surveyor's concerns. On 10/1/25 at 9:43AM the surveyor conducted an interview with the ADON who, after surveyor intervention, reported to the surveyor that the resident would receive another boot today and the current one may get laundered or thrown away, and reported that Resident #3's dressing change would be performed now. The ADON confirmed with the surveyor that Resident #3 was ordered enhanced barrier precautions and their expectation was for staff to wear a gown when managing the resident's PICC line. On 10/1/25 at 9:44AM the surveyor conducted an interview of LPN #56 who was able to appropriately describe personal protective equipment that should be used for the resident on enhanced barrier precautions. LPN #56 expressed to the surveyor regarding their disconnection of Resident #3's IV therapy: I should've had a gown on. On 10/3/25 at 12:00PM the surveyor conducted an interview with the facility's Assistant Director of Nursing (ADON) who reported the following information: The boot was replaced that day, the old one was sent to laundry and the new one was put in [his/her] room, [s/he] is using it, and that Resident #3's dressing had been changed immediately by the nurse on 10/1/25. On 10/3/25 at 2:13PM the surveyor conducted an interview of the ADON who confirmed: Yes, (Resident #3) does use the boot. On 10/6/25 at 3:18PM the surveyor shared the concerns with the Director of Nursing who acknowledged and confirmed understanding of the concerns and reported that nursing staff should have identified the boot when they went into the room. On 10/9/25 at 2:52PM the surveyor conducted an interview with the ADON who reported that the resident's wound had been present since at least the date of 5/20/25. 8. On 10/2/25 at 10:17AM during a multi-surveyor tour of the facility's laundry room, 2 out of 2 ceiling vents were observed to be missing their coverings and had a layer of grey debris present on them. Uncovered laundered personal resident laundry was observed to be sitting below one of the ceiling vents, and uncovered laundered resident linen was observed to be sitting below the second ceiling vent. On 10/2/25 at 10:20AM surveyors shared concerns with and conducted an interview of Director of Maintenance #16 who reported to surveyors that the vents did have a cover, however laundry staff take them down because it cools them off. On 10/2/25 at 10:25AM during a multi-surveyor tour of the facility's laundry room, unbagged soiled laundry was observed overflowing from the laundry chute located on the wall. On 10/2/25 at 10:28AM surveyors conducted an interview with the Director of Housekeeping #15 who observed surveyor concerns and stated regarding the unbagged soiled laundry in the chute: It's supposed to be in bags. 9. On 9/29/25 at 10:00AM the surveyor observed when they went to wash their hands in the sink (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	located inside of the floor 2 assisted bathing room bathroom, that there was no hand soap available. When the surveyor searched and located another sink within the floor 2 community area, that sink was observed to have a hand soap dispenser which was nearly empty and unable to dispense out hand soap for hand washing. On 9/29/25 at 10:03AM the surveyor had to go seek out facility staff in order to locate hand soap for hand washing, at which time the Director of Housekeeping (DH) #15 was observed in the floor 2 hallway. At this time the surveyor conducted an interview with DH #15 who observed the concern with the surveyor and reported the following information: There is a red electronic light to access the storage supply closet and we couldn't get in, it was broken so maintenance is fixing it so we can bring the hand soap. On 10/2/25 at 10:52AM multiple surveyors observed during a shared observation with the facility's Director of Maintenance #16, Director of Housekeeping #15, and Administrator, that the floor 2 assisted bathing room bathroom had no hand soap available for hand washing. 10. On 10/2/25 at 10:13AM multiple surveyors observed respiratory supplies including tracheostomy collars and oxygen masks with tubing stored approximately 2 inches from the floor's surface. The flooring surface was observed to be visibly dirty with areas of white and brown matter present. The concern was shared at this time during a shared observation with the facility's Director of Housekeeping #15, Director of Maintenance #16, and Administrator. On 10/6/25 at 11:00AM the surveyor observed the respiratory supplies continued to be stored approximately 2 inches from the floor's surface with the flooring surface observed to be again, visibly dirty with areas of white and brown matter present. Surveyor concerns were again reviewed with the facility Administrator and other staff during the exit conference on 10/9/25.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview it was determined the facility failed to ensure a safe functional environment. This was evident during 1 out of 1 multi-surveyor observation conducted of the facility's exterior grounds. The findings include: On 9/30/25 at 12:19PM surveyors observed the exterior vent for the laundry room with several inches of grey matter present covering the vent. Overgrown weeds were observed in an area surrounding the facility's generator equipment.On 9/30/25 at 12:20PM surveyors observed from the exterior of the building, an area of ceiling disrepair with peeling paint present extending several feet across the ceiling located within the facility's laundry room.On 9/30/25 at 12:20PM surveyors observed an exterior gutter near the laundry room which was filled with leaves and debris.On 9/30/25 at 12:23PM surveyors observed an area near to the resident dining hall which was observed to have an emergency fire blanket located on the wall with approximately 15 cigarette butts sitting on top of it. At this time surveyors shared the concern with Director of Housekeeping #15 who observed the concern and stated: Okay, I'll get that cleaned up.The area near the dining hall was observed to have two carts situated on their side, a piece of broken furniture, a nightstand, a geriatric chair and a table which was upside down, and four mattresses. On 9/30/25 at 12:40PM surveyors observed the exterior of the building and shared concerns with Regional Director of Operations #62 and Regional [NAME] President of Operations #61, who stated to surveyors: I'm going in to tell the Administrator now and we are going to get this cleaned up.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff and residents, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests. This was evident for 2 out of 3 nursing units observed during the annual survey.The findings include: During observation rounds of Unit 1 on 09/28/2025 at 8:55 AM resident #16 room was observed to have 11 black insects flying around near and on resident #16 head, bed and privacy curtain. During an interview on 09/28/2025 at 8:56 AM resident #16 stated, there are flies flying around my head, landing on my food, all over my bed and just everywhere. During an interview on 09/28/2025 at approximately 11:00 AM the Nursing Home Administrator staff #1 was made aware of the observation of insects in resident #16 room. Staff #1 stated that the problem would be addressed. During observation rounds of Unit 1 on 09/30/2025 at 10:00 AM resident #16 room was noted to have 5 black insects flying around near and on resident #16 bed and privacy curtain. During an interview on 09/30/2025 at approximately 10:20 AM staff #16 was made aware of the observation of insects in resident #16's room and stated, the pest control company can come in and if the flies are still a problem, then they can come in and spray the room. On 9/28/2025 at 7:50AM, during a tour of Unit 2, the Surveyor observed flies and gnats in the hallway. On 9/28/2025 at 9:55AM, during an interview with resident #155 on Unit 1, the Surveyor was informed that the facility issues with flies and gnats in the building. On 9/28/2025 at 10:08AM, during a continued tour of Unit 1, the Surveyor observed flies in room [ROOM NUMBER]. During a tour of the shower room on Unit 1 on 9/29/2025 at 10:45AM, the Surveyor observed flies inside the bathroom. On 9/29/2025 at 12:30PM, during an observation of room [ROOM NUMBER] on Unit 2, the Surveyor observed a trail of ants crawling from the baseboard underneath the window to a yellow food like particle on the ground by the bed. Geriatric Nursing Assistant (GNA) #68 and Unit Manager (UM) #23 confirmed the Surveyor findings. UM #23 stated that she would let the maintenance department know about the ants in room [ROOM NUMBER]. During environmental rounds with the Director of Maintenance (DOM) #16, Director of Housekeeping (DOH) #15, the Nursing Home Administrator (NHA), and Administrator in Training (AIT) #3 on 10/2/2025 at 10:30AM, the Surveyor expressed the concerns regarding gnats, flies, and ants within the facility. DOM #16 stated that a pest control company visits the facility weekly and will make sure they look into the pest concerns.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure reasonable clinical and safety restrictions of the facility's policies, procedures or practices that protect the health and security of all residents and staff by allowing an unvaccinated animal into the controlled environment. This was evident for 1 (#115) resident out of 9 residents investigated during the facility's annual survey.The findings include:On 09/29/2025 at 10:00 AM Surveyors observed a dog in the 1st floor-Dining Room brought in by family; the dog was later identified as belonging to resident #115 and comes for weekly visits.On 09/29/2025 at 10:30 AM during interview with Director of Recreational Therapy staff #10, Surveyor asked about facility Policy & Procedures (P&P) for resident pet visitations on site, pet vaccination records, and front desk check-in process for resident pets. Staff #10 provided the facility P&P and stated that per our policy, all animals, both service animals used for therapy and resident animals are to have vaccination records on file. Staff #10 stated I will follow-up with the Survey team for this resident animal vaccination information.On 09/30/2025 at 8:39 AM during interview with Director of Nursing staff #2, Nursing Home Administrator staff #1, and Administrator in Training staff #3, Surveyor shared concerns of resident #115 personal pet (dog) permitted in Dining Room and awaiting confirmation of vaccination record on file from staff #10.On 09/30/2025 at 3:06 PM during follow-up interview, staff #10 stated, there are no vaccination records on file for resident #115 dog, the facility will need to get it from the family.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, it was determined that the facility failed to ensure that a current copy of a resident's advance directive was in the resident's medical record. This was evident for 1 (#58) resident out of 9 residents investigated for Advance Directives during the facility's annual survey.The findings include:On [DATE] at 9:03 AM during record review it revealed Resident #58 Code Status:(Advance Directives) as CPR (Full Code) via hyperlink to the document. However, once the hyperlink for Advance Directive was selected, it revealed Resident #58 had two 5 Wishes forms with a DNR preference, dated [DATE] and [DATE] on file. Per the Nursing Home H&P Note signed by Physician staff #52, notes in the ?Advance Directives' section stated The patient has the capacity to make decisions and requests full code including tube feeding, blood transfusion except dialysis. Additionally, there was a history of 5 Maryland Orders for Life Sustaining Treatment (MOLST) forms completed: the most current done on [DATE] and reflects Attempt CPR; and 4 voided MOLST forms as follows: [DATE]-DNR/I; [DATE]-DNR/[NAME] Cr; [DATE]-Attempt CPR; [DATE]-DNR/I.On [DATE] at 2:22 PM during interview with Clinical Regional Nurse staff #43, this Surveyor shared concerns of the active 5 Wishes form that reflects DNR status (2018) and an active MOLST form that reflects Full Code, dated [DATE].On [DATE] on 12:45 PM during interview with Director of Social Services staff #36 the conflicting Advance Directives and end of life orders within the medical record, this Surveyor asked how Advanced Directives are discussed and offered if requested and staff #36 stated during admission, however the resident came prior to my arrival. Staff #36 further shared that charts are audited for Advance Directives and updated as needed; but it was unclear if Resident #58 chart was ever audited for Advance Directives.On [DATE] at 10:00 AM during an interview status post Surveyor intervention, Director of Nursing staff #2, states after provider discussion with Resident #58, the Advance Directives were changed to Full Code status effective [DATE]. Additionally, the resident 5 Wishes Aging with Dignity packet on file has been voided in the medical record and voided copy provided to survey team.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of medical records, administrative records, interviews, and observations it was determined the facility failed to protect a resident from physical abuse perpetrated by a facility employee. This was evident for 1 (#143) out of 8 residents reviewed for abuse during the recertification survey.The findings include:On 09/28/2025 at 09:30 AM the surveyor observed the Resident #143 in the hallway of the second floor in a wheelchair. The resident denied any remembrance of an employee being physically abusive towards him/her. On 09/28/2025 at 1:00 PM the surveyor reviewed intake #2578157 and the complaint #2578168 related to resident #143. The facility report was directly related to the complaint.On 10/07/25 at 08:15 AM the surveyor continued the review of the resident's hard copy facility incident report. The review revealed that the facility had found the perpetrator (GNA #40) physical abused Resident # 143. The physical abuse consisted of the GNA #40 being observed slapping the resident on the right cheek while attempting to get Resident #143 off the elevator. A staff #41, from the laundry department witnessed the encounter between Resident #143 and GNA # 40. The resident was struck on the right side of the face. However, the hospital staff stated the resident #143 reported being hit on left side of the face by a staff member while at the nursing home facility. The resident was ordered to be taken to the hospital for CT scan of the head on the same evening of the incident. The CT scan completed on 08/01/25 was negative. Resident #143 returned to the facility on [DATE]. On 10/07/2025 at 09:40 AM the hard copy of the entire facility incident report was provided to the surveyor. The initial report stated: Allegation: physical abuse and stated the facility became aware of the incident on 07/31/2025 at 08:15 PM the assistant administrator was notified at 8:27 PM on 07/31/2025. The alleged perpetrator was GNA #40. The individual who made the witnessed allegation was laundry assistant #41. The laundry assistant #41 was contacted by the surveyor by telephone and verified/confirmed the physical assault incident described in the facility report. The final investigation of the facility incident report confirmed that resident #143 had been physically assaulted by GNA #40. GNA#40 was terminated on 08/07/25 and reported to the Maryland Board of Nursing. On 10/07/2025 the surveyor reviewed the results of the facility report investigation and the complaint with the DON.On 10/09/2025 the facility administrator and DON were advised of the deficiency related to resident abuse during the exit conference.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record reviews it was determined that the facility failed to: 1) provide the resident representative with written notification of transfer to the hospital and written notification of the facility's bed hold policy upon transfer to the hospital, and ensure the local Ombudsman was notified timely, on a monthly basis, of a facility-initiated transfer to the hospital; 2) ensure the documentation of the clinical circumstances related to the return of the resident to the hospital as part of the transfer process. This was evident for 3 (Resident #153, #5 and #174) out of 7 residents reviewed for hospitalization during the survey.The findings include: 1. Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. On 10/1/2025 at 10:38AM, a review of Resident #153's electronic medical record revealed the resident was transferred to the hospital on 9/8/2025 and 9/29/2025. On 10/3/2025 at 10:45AM, a review of Resident #153's electronic and paper medical record failed to reveal documentation to verify Resident #153's resident representative had been provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 9/8/2025 and 9/29/2025. There was also no documentation that the local Ombudsman was informed of the resident's hospital transfers on 9/8/2025 and 9/29/2025. On 10/3/2025 at 12:25PM, after an interview with the Assistant Director of Nursing (ADON) #32, the Surveyor requested documentation to verify Resident #153's resident representative had been provided with written notification of the transfers to the hospital and the facility's bed hold policy upon transfer to the hospital, and that the local Ombudsman was notified regarding the transfers to the hospital on 9/8/2025 and 9/29/2025. On 10/6/2025 at 12:17PM, the Director of Nursing (DON) informed the Surveyors that the admissions department sends out notification of transfer to the resident representative for hospital transfers and the social services department sends monthly emails to the local Ombudsman regarding discharges, admissions, and transfers to the hospital. The Surveyor requested documentation to verify written notification was sent to the resident representative and the Ombudsman for Resident #153's transfers to the hospital in September 2025. During an interview conducted with the Administrator in Training (AIT) #3 on 10/9/2025 at 8:30AM, the Surveyor expressed the concern that the facility failed to provide the requested documentation. On 10/9/2025 at 9:20AM, AIT #3 informed the Surveyor that the facility could not provide documentation to verify the resident representative was notified in writing for the transfers to the hospital on 9/8/2025 and 9/29/2025 and the facility's bed hold policy at the time of those transfers. The Surveyor was provided with a copy of emails from the Corporate Regional Social Worker #35 to the local Ombudsman notifying them of the facility's August and September 2025 transfers and discharges. A review of the documents revealed that the emails were sent on 10/7/2025, after Surveyor intervention. Further review of the email documents revealed that Resident #153 was on the list of notifications for 9/8/2025 but not 9/29/2025. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 10/1/2025 at 11:15AM, a review of Resident #5's electronic medical record revealed that the resident was transferred to the hospital on 8/23/2025 and on 8/29/2025. On 10/1/2025 at 11:25AM, a review of Resident #5's electronic medical record failed to reveal documentation to verify the local Ombudsman was notified of the transfers to the hospital on 8/23/2025 and 8/29/2025. On 10/3/2025 at 12:25PM, after an interview with the Assistant Director of Nursing (ADON) #32, the Surveyor requested documentation to verify the local Ombudsman was notified of Resident #5's transfers to the hospital in August 2025. On 10/6/2025 at 12:17PM, the Director of Nursing (DON) informed the Surveyors that the social services department sends monthly emails to the local Ombudsman regarding discharges, admissions, and transfers to the hospital. The Surveyor requested documentation to verify notification of Resident #5's transfers to the hospital in August 2025. During an interview conducted with the Administrator in Training (AIT) #3 on 10/9/2025 at 8:30AM, the Surveyor expressed the concern that the facility failed to provide the requested documentation. On 10/9/2025 at 9:20AM, the Surveyor was provided with a copy of emails from the Corporate Regional Social Worker #35 to the local Ombudsman notifying them of the facility's August and September 2025 transfers and discharges. A review of the documents revealed that the emails were sent on 10/7/2025, after Surveyor intervention. Further review of the email documents revealed that Resident #5 was on the list of notifications for August 2025. 3. On 10/02/2025 at 12:40 PM the surveyor interviewed the DON regarding the admission of Resident #174. The resident was admitted from the hospital on [DATE] and then discharged back to the hospital on [DATE]. The DON stated that the resident was not an appropriate admission for the facility because the resident required 1:1 service for the remainder of his/her life which the facility stated that they would not be able to provide for an extended period. The DON stated the hospital was notified by the facility that they were unable to manage the resident and that the resident was being returned to the hospital. The surveyor was unable to find any facility clinical documentation in the electronic medical record addressing the above stated reasoning for resident's discharge on [DATE] to the hospital. The surveyor requested the DON to provide hard copy documentation of discharge process for this resident. On 10/02/2025 at 1:00 PM the DON provided copies of the SNF/NF to Hospital transfer form related to this resident's return to the hospital on [DATE]. The DON stated that there was no transfer progress note written by nursing related to the transfer. The notice of transfer was documented within the Interact 4.0 electronic transfer form that the resident representative was notified of the transfer of Resident # 174's hospital admission. The DON could not provide the surveyor with any documentation of the Ombudsman notification of Resident #174's discharge to the hospital. On 10/02/2025 1:10 PM Resident #174 a review of the electronic medical failed to reveal any documentation that the hospital was notified of pending transfer. The documentation revealed that a LPN #60 wrote that the hospital did not answer when called on 09/04/25 at 20:00 PM and there was no answer, and this was documented under Section E. Key contacts: Interact Report Details: LPN #60. On 10/02/2025 at 2:45 PM the surveyor discussed the admission and discharge of the resident # 174 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the DON. The DON stated that the LPN #60 failed to write a progress note revealing the decision-making process the facility utilized to determine that facility was unable to meet Resident #174's medical needs and that required a higher level of care such as 1:1 observation of the resident 24 hours per day. The DON stated the facility's hospital liaison should not have accepted the resident originally because the resident's continuous 1:1 observation was not being met by facility. On 10/09/2025 at the time of the exit conference the facility did not provide the surveyor with any further documentation such as a progress note related to Resident #174's transfer to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect a resident's status. This was evident for 1 (Resident #5) out of 5 residents investigated for falls during the annual survey.The findings include: The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A comprehensive MDS assessment is completed at admission, annually, quarterly, and with significant change. On 10/2/2025 at 12:05PM, during a review of Resident #5's electronic medical record, the Surveyor discovered that the resident was hospitalized on [DATE] after sustaining a fall with a right femur fracture. The resident received surgical repair and returned to the facility on 8/28/2025. Further review revealed a quarterly MDS assessment completed 9/21/2025. Under Section J-Health Conditions, the facility failed to accurately answer J2100 to indicate yes, the resident had a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF (Skilled Nursing Facility) stay. Subsequently, the facility failed to accurately check off J2510, repair fractures of the pelvis, hip, leg, knee, or ankle. During an interview with MDS Coordinators #25 and #26 on 10/2/2025 at 1:02PM, the Surveyor expressed the concern that Resident #5's quarterly MDS assessment date 9/21/2025, Section J2100 and J2510 did not accurately reflect the resident's status after having a major surgical procedure to repair a femur fracture. MDS Coordinator #25 informed the Surveyor that section J2100 should have been answered yes, and subsequently J2510 should have been checked off to accurately reflect Resident #5's status during the quarterly MDS assessment completed on 9/21/2025. On 10/2/2025 at 2:22PM, MDS Coordinator #26 provided the Surveyor with a modified quarterly assessment which updated J2100's response to yes and checked off J2510.

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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 review and interview with staff, it was determined that the facility failed to develop a resident centered activity care plan that addressed the resident's physical, mental, and psychosocial needs with personalized goals with measurable objectives and interventions. This was evident for 1 (Resident #9) out of 4 residents reviewed for activities during the annual survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments. It outlines what needs to be done to plan, assess, and manage care needs. This helps to evaluate the effectiveness of the resident's care. Care plans must be person-centered and includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. On 10/07/2025 at 8:07AM, a review of Resident #9's electronic medical record revealed that the resident had a diagnosis of, but not limited to tracheostomy, anoxic brain damage, persistent vegetative state, and contractures. The resident had communication problems due to their condition. Further review of Resident #9's electronic medical record revealed an activity focused care plan stating that the resident requires 1:1 activities due to being unable to participate in other activities, created on 11/04/2022 with revision on 10/02/2025. A goal which stated the resident would be satisfied with their 1:1 activities provided thru the review period created on 11/04/2022, revised on 10/2/2025 with a target date of 12/24/2025. Interventions included provide 1:1 activities in the room or location that is the residents preference as needed created on 11/04/2022, revisions on 10/02/2025, with a target date of 12/24/2025. The care plan failed to identify resident specific activities, measurable objectives, and interventions implemented by staff that would assist in the resident reaching their goals. On 10/7/2025 at 11:00AM, during an interview with Activity Director (AD) #10, the Surveyor expressed the concern that Resident #9 did not have a resident centered care plan for activities that addressed the resident's physical, mental, and psychosocial needs and included personalized goals with measurable objectives and interventions. AD #10 stated he would look into Resident #9's activity care plan and revised it to reflect the resident's current activity status.

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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 observations, record reviews and interviews, it was determined that the facility failed to ensure residents right to participate in the development, review and revision of his/her care plan. This was evident for 2 (58 & 14) residents out of 2 residents investigated for care planning. The findings include: On 09/29/2025 at 12:35 PM during observation and interview with Resident #58, resident stated I only have care plan meetings at the bedside with the Social Worker, the most recent was 09/25/25, I receive a copy of my latest care plan and a grievance form and that is it Resident further stated, the Social Worker is unable to answer any of my questions about my medical care and business concerns, I am always told just to fill out a grievance form. The resident shared with Surveyor the copies of the Care Plan related documents they have received from the Social Worker, the items consisted of the Care Plan meeting invitation for 9/25/25-the resident documented on the letter it was received 9/23/25 at 2:56 PM; a Care Plan Report with admission Date: 6/4/25 and Revision Date: 9/15/25; and a blank Grievance form.On 09/29/2025 at 1:04 PM during observation and interview with Resident #14, resident stated, care plan meetings occur frequently, but are only attended by social worker (Staff #36) and stated the meeting is not very helpful, unable to discuss concerns regarding depression, and they do not feel supported.On 10/03/2025 at 12:45 PM during an interview with the Director of Social Services, Staff #36, surveyor shared resident expressed concerns of bedside care plan meetings with only Social Services in attendance and no support from an Interdisciplinary Team (IDT). Staff #36 confirmed Care Plan meetings are often at the residents' bedside and attended by Social Services alone. Surveyor asked what the Care Plan meeting process is, the expectation based on facility Policies & Procedures, and what is provided to the resident. Staff #36 stated I invite the IDT team who is required to attend, and the meetings are posted for participation, but IDT does not usually attend at the bedside with Social Services and the resident. I meet with the resident at the bedside and give them a copy of their care plan and medication list. Surveyor asked, of the recent meetings for Residents #58 and #14, if the IDT team participated at the bedside Care Plan meetings; staff #36 stated No.On 10/07/2025 at 8:53 AM during record review of Resident #58, it revealed 2 identical Discharge Planning notes, dated 9/1/25 and 9/8/25 both indicating Resident was alert and easily agitated. [They] has frustration and anger about [their] stay at this facility. Surveyor also reviewed the Care Plan Report Sign-In sheet, which revealed a facility signature, the Social Services Assistant, Staff #66, dated 9/25/25 at 1:10 PM and Resident #58 signature only.On 10/08/2025 at 2:17 PM a record review of Resident #14 revealed sign-in sheets for the last 4 Care Plan meetings were held 8/7/25, 6/26/25, 5/29/25, and 4/11/25 and attended only by the resident and the Social Services Assistant, Staff #66, except for the addition of the Director of Recreational Therapy, staff #10 on 8/7/25 and Physical Therapy Director, staff #30 on 5/29/25.On 10/09/2025 at 9:19 AM during follow-up interview with Director of Social Services, staff #36, regarding record review for both residents. Staff #36 stated no further documentation existed to support full Care Plan meeting interventions. Staff #36 informed this surveyor that Resident #14 is likely mad, because they had to take away the resident's weed per the DON, staff #2 request. Surveyor requested documentation and timeframe regarding this interaction and stated confiscation; staff #36, states no, there was no documentation.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on interview and record review it was determined the facility failed to ensure consultations were timely scheduled and wound care was consistently performed. This was evident for 1 (Resident #3) out of 1 resident reviewed for foot care during the facility's recertification survey.The findings include:On 10/1/25 at 9:05AM during an interview with Resident #3 they expressed that dressing changes were not occurring at the frequency they were supposed to occur due to there not being enough nursing staff available to perform the dressing changes and additionally, that their specialist appointments for the care of their foot had not yet been set up by facility staff although staff were expressing to them that they were taking care of the scheduling of the appointments. On 10/3/25 at 9:06AM the surveyor reviewed the medical record of Resident #3 and observed six medical wound care orders having been in place for the care of the resident's foot wounds during September 2025. The surveyor observed the September 2025 Treatment Administration Record which revealed that on the following dates there was no nursing sign off of the ordered wound care treatments as having been performed: one dayshift treatment on 9/6/25, two dayshift treatments on 9/13/25, and two dayshift treatments on 9/28/25. Review of the active medical orders revealed the following information: Infectious disease consultation ASAP Rt foot, dated as ordered by the provider on 9/25/25, and Vascular consultation r/t RLE stenosis dated as ordered by the provider on 7/28/25. On 10/3/25 at 12:00PM the surveyor conducted an interview with the ADON who reported to the surveyor that documentation of dressing changes occurs on the medication/treatment administration record. At this time, the surveyor shared their concern with the ADON who stated that nurses and unit managers should be taking out orders once they are completed and also that they would check on the status of the appointments and documentation of dressing changes. On 10/3/25 at 2:13PM the ADON informed the surveyor that they had checked with the unit clerk regarding the resident's infectious disease and vascular appointment status and they had nothing scheduled. The ADON stated to the surveyor: The unit clerk keeps a log and we review the orders each morning, and it should be caught, obviously it was missed, we didn't schedule it. On 10/6/25 at 3:18PM the surveyor shared concerns with and conducted an interview of the facility's Director of Nursing (DON) who reported to the surveyor that it was their expectation for unit managers to review the missed treatment report which showed any treatment that wasn't signed off on. The DON reviewed the resident's wound care documentation and stated: looks like there is holes in the documentation.On 10/9/25 at 2:52PM the DON informed the surveyor that regarding the unsigned wound care documentation, they could not say the treatments were done because they weren't documented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews and resident medical record review it was determined the facility failed to provide a resident incontinent care and services. This was evident for 1 (Resident #16) out of 11 residents reviewed and observed during the survey. The findings include the following: During observation rounds on 09/28/2025 at 8:55 AM Resident #16 was found sitting in his/her wheelchair near room window wearing a brief that was saturated with urine and stool. Resident #16 bed mattress was observed with no fitted sheet, over 75% of the mattress was saturated with a wet yellow and brown in color substance that had strong odor of urine and stool, was worn and faded, discolored, had lumps, and in poor condition. The flooring around Resident #16's bed and throughout room, was noted to have a thick layer of sticky dark in color spots of dirt accumulation. During an interview on 9/28/2025 at 8:56 AM Resident #16 stated, they came in here and took the sheets off the bed but did not clean the bed. During observation rounds on 09/28/2025 at approximately 10:45 AM Resident #16's mattress and room floor was found in the same condition as observed at 8:55 AM. During an interview on 09/28/2025 at 11:00 AM the Director of Nursing staff #2 was made aware of the observations made of Resident #16, mattress and floors. Staff #2 agreed to observations of mattress and stated, I will get the resident a new mattress. Review of Resident #16's medical record on 10/01/2025 at 7:50 AM revealed a MDS (Minimum Data Set) dated 08/14/2025 stating that Resident #16 was incontinent of bladder code 2 - frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding), was incontinent of bowel code 2 - frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement).

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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 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 observations, record reviews and interviews, it was determined that the facility failed to ensure a resident received necessary respiratory care and services that were in accordance with professional standards of practice, the resident's care plan, physician's orders, and the resident's choice. This was evident for 1 (#77) resident out of 9 residents investigated during the facility's survey.The findings include: On 09/28/2025 at 9:22 AM during initial observation, Resident #77 was observed on oxygen(O2) via Nasal Cannula intact with an O2 setting at 1.5L. Per Surveyor interview with LPN Station 2 staff #37 to confirm resident O2 needs, surveyor observe staff #37 review medical orders and stated O2 orders were for 3L.On 09/30/2025 at 9:54 AM during observation and interview, Resident #77 was in bed, restless, O2 tubing laying on the floor, and O2 Concentrator set at 1.5L. This Surveyor notified LPN Station 2 staff #24 of tubing on the floor and Oxygen concentrator set at 1.5L; promptly staff #24 went to Resident #77 bedside, discarded the tubing on the floor and replaced the O2 tubing and placed new nasal cannula on the resident.On 10/06/2025 at 7:46 AM during record review of Resident #77 revealed the following diagnosis chronic obstructive pulmonary disease(COPD). The physician orders for oxygen and monitoring were as follows: Oxygen AT 3L NC to keep SPO2 at or above 92% every shift for monitoring; SPO2 q shift monitoring: every shift for monitoring, Active 7/26/2023 (qShift). The Care Plan Report noted: Respiratory: The resident is at risk for respiratory complications secondary to COPD, seasonal allergies Created on: 11/21/2022 Revision on: 07/09/2024. The resident will be free from respiratory complications thru the review period Created on: 11/21/2022 Revision on: 06/30/2025 Target Date: 09/23/2025. Oxygen AT 3L NC to keep SPO2 at or above 93% Created on: 01/05/2024. Administer medications as ordered Created on: 11/21/2022. Administer oxygen as ordered Created on: 11/21/2022. Head of bed elevated to prevent Shortness of breath as tolerated Created on: 11/21/2022. Observe for signs and symptoms of respiratory complications thru review period Created on: 11/21/2022. Vitals as needed Created on: 11/21/2022. On 10/06/2025 at 11:04 AM during a follow-up (3rd) observation, Resident #77 was observed in Dining Room in wheelchair seated at table, Nasal Cannula intact to humidified O2, however Oxygen concentrator set at 1.5L. This Surveyor interviewed Resident #77 and asked did they know their O2 settings; Resident #77 appeared to be winded and stated, I should be on 3L, but I often feel winded when speaking. Of note, there were no staff in the Dining Room at this time. Surveyor went to Station 2 front desk, alerted LPN staff #37 of the situation who then returned to Dining Room with Surveyor to observe Resident #77. LPN staff #37 confirmed the Oxygen concentrator read 1.5L and attempted to adjust Oxygen concentrator dial to ordered level, then stated the concentrator is broken and will not go to 3L. The Quality Improvement/Infection Prevention Nurse staff #22 and RN Nurse Manager staff #23 then entered the Dining Room as well, came to Resident #77 and both attempted to adjust the Oxygen concentrator and confirmed it was broken. The RN Nurse Manager staff #23 left and returned with a portable O2 tank and placed resident on the prescribed 3L; after a few minutes the residents' O2 Sat was then measured and reflected 96% SpO2, now on the 3L. LPN staff #37 left and returned with a new Oxygen concentrator and proceeded to set up the new device.On 10/08/2025 at 12:45 PM, during a 4th observation of Resident #77, the resident was observed lying in bed with the nasal cannula intact but mildly winded when attempting to speak. This Surveyor noted the Oxygen concentrator now set at 1LNC and the humidified bottle was not flowing; Surveyor immediately left room and notified LPN Station 2 staff #37 and LPN Station 2 staff #74 who were in the hall. Both came to the bedside of Resident #77, confirmed Oxygen concentrator was on 1L, O2 Sat was obtained and read 88%. Surveyor observed Staff attempt to adjust dial on concentrator and no change (increase/decrease) of amount, staff #37 then stated, it's not working again. Staff #37 then stated, it's working now, I turned it off and on and it's working now; we will request a new concentrator.On 10/08/2025 at 3:01 PM during interview with Director of Nursing staff #2, this Surveyor shared concerns of 4 observations of Resident #77 noted to be on wrong O2 settings and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 complaints of feeling winded at times while speaking. Staff #2 stated I will look into this immediately.On 10/09/2025 at 8:01 AM during 5th observation, Resident #77 in bed, nasal cannula intact, 3L humidified O2 in progress via Oxygen concentrator, resident looked well rested in bed, no shortness of breath noted or anxiousness. Resident #77 then stated, I slept so well last night, the best sleep ever. Final observation shared with DON staff #2 during exit conference.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This was evident for 3 (#58, #117, and #65) residents out of 9 residents investigated for medically related Social Services. The findings include: 1. On 07/10/2025 Complaint #319266 received to State Agency (OHCQ) regarding multiple concerns related misappropriation of property via misuse of resident personal funds by facility; quality care/treatment and nursing service issues. On 09/29/2025 at 12:35 PM during observation and interview, Resident #58 shared several concerns and stated: my care plan meetings are at bedside, attended only by the social worker, and I receive a care plan report and grievance form; there are no other staff members to discuss my care or multiple concerns. There is no support for discharge or transfer to return to my home state where I feel I can get access to more community resources. I have missed appointments for over a year due to my lost wheelchair which could fit into the cab, the current replacement wheelchair is larger and unable to fit in with the only cab service that is offered by the facility; I was fitted for a power wheelchair and told I was approved but never received it. The Social Worker is not helpful, I have asked about my money no longer going into my personal account since about April of this year (2025) and being told by Social Security that a facility doctor signed a statement that I cannot handle my finances anymore, no one will give me information. I had no money to obtain my lost documents (birth certificate and social security card) and to get a lawyer. When I asked for help from the Social Worker, they just give me a grievance form, but nothing is ever done; I feel like the only way out for me is if I die. Resident further stated, I still have not received statements or funds since this change and have requested money from the facility.On 10/07/2025 at 9:49 AM during record reviews and interviews regarding Resident #58's concerns of missed appointments related to transportation, revealed in the Front Desk Appointment log, Resident #58 missed the following appointments on 7/19/24, 1/23/25 and 8/21/25 due to rescheduled W/C wouldn't fit in taxi'. During interview with Unit Clerk staff #76, this Surveyor asked about missed appointments due to transportation or alternate forms of transportation; staff #76 states we only are allowed to schedule with Friendly Taxi service and that company cannot fit the resident's large wheelchair and the physician offices that are scheduled cannot accommodate alternate stretcher transport, so I just reschedule the appointments.On 10/07/2025 at 9:59 AM during an interview with Director of Rehab Services staff #30 regarding resident #58 wheelchair, this Surveyor was told I did dispense resident #58 a larger wheelchair (28in.) when their personal wheelchair was lost, and then registered and obtained approval for the power wheelchair, however, once the facility was billed for the wheelchair, I no longer have control when the bill will be paid for the resident to receive the wheelchair. Staff #30 provided an Email communication dated 7/10/2025 to9/29/2025. This communication indicated that Resident #58 was recommended for the Freedom Mobility Power Wheelchair program, met the requirements, was cleared through the loaner screening process to be able to properly handle the power wheelchair, and the final bill received at the facility, but remains unpaid at the time of the annual survey.On 10/07/2025 at 10:19 AM during record reviews and interviews regarding concerns for incompetence and resident funds, it revealed the following: Resident #58 was admitted to facility 5/18/2022 via active Medicare A, transitioned on 8/26/2022 to Medicaid-MD Active, completed a 5-month Hospice period during 2/21/2023 to 7/1/2023, and returned to Medicaid-MD Active billing on 7/18/2023. The record reveals a BIMS Interview and Staff Assessment, dated 09/19/2024, with a Score of 15, indicating the resident was cognitively intact. The record revealed three Physician Certification Related to Medical Condition, Decision Making, and Treatment Limitations forms, dated 05/19/2022, 10/15/2023, and 6/5/2025; all indicating the Certification Regarding Decision Making Capacity, that Resident #58 has adequate decision making capacity (including decisions about (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	life-sustaining treatments). Of note, the last certification was completed by Resident #58 current physician (Physician #30). However, the facility filed a SSA-787 form Medical Source Opinion of Patient's Capability to Manage Benefits, the process used to make the facility Representative Payee, completed by Physician #30, citing Resident not capable of handling funds due to their medical condition." dated 3/17/25. The facility received a decision letter dated May 7, 2025 assigning the facility as Representative Payee and that effective on or about April 30, 2025, Resident #58 direct deposit information was changed. Of note, there were no progress notes about the change of decision-making ability regarding Resident #58 around the time of the filing of the changes to Social Security. During an interview with Business Office Manager staff #51, this Surveyor asked why resident was not informed of the Resident Payee request and no statements or funds received until Surveyor intervention; staff #51 stated I am new, but the resident had an outstanding unpaid bill of over $40,000 and that was why the Resident Payee process was started, and because resident had a SSA-787 and deemed unable to handle their own finances, I don't give them statements. But we did give the resident their allowance amount just last week after I was informed, I sent the receptionist to this resident to give them money, that is our process.On 10/07/2025 at 12:06 PM during record reviews regarding concerns for discharge planning to return to their home state for Long Term Care and Social Worker supports, it revealed resident #58 demonstrated frustrations and no documents related to actual attempts to assist with discharge. Discharge Planning Notes, dates 09/01/2025 and 09/08/2025, stated resident has frustration and anger about (their) stay at this facility and attempts have been made for transfer but have been unsuccessful. Resident #58 Care Plan Report, Created on 06/06/2025, notes ?the resident is expected to remain in the facility long term and has no plans to discharge at this time. Goal: the resident/resident representative will have their needs met thru the review period. Interventions: assess for the resident's preference to return to community and refer if needed; and review and update discharge plans with the resident when needed.'On 10/09/2025 at 9:19 AM during interview with Director of Social Services staff #36, this Surveyor asked about Resident #58's various concerns. Staff #36 recalled an attempt to help the resident to recover their lost documents, (Birth Certificate, Social Security Card) online, and stated resident was unwilling to proceed because of the money and always says (they) don't have money because facility is taking (my) money. Staff #36 further stated they spoke with the Business Office Manager regarding Resident #58 funds and was told funds are now going to the resident's care and attempted to explain this to the resident. This Surveyor asked if there was any documentation related to this follow-up provided to the resident; staff #36 stated No.2. On 09/30/2025 at 10:17 AM during follow-up observation and interviews, Resident #117 shared with Surveyor that they were unable to return to family, but would like to go to the community, however, they did not have access to their funds to be able to apply to any programs. This Surveyor asked Resident #117 were they aware of the Waiver Program and was this discussed with them; Resident #117 stated No, I have low vision issues, but I was never told I am unable to live alone.On 10/09/2025 at 9:55 AM during interview with Director of Social Services staff #36, this Surveyor shared Resident #117's concerns of lack of discharge support and why their survivor's benefits and personal money disappeared and being told family handles everything despite their desire to return to community and no longer having access to personal funds. Staff #36 stated that resident #117 has requested to go home/community, but Social Services is being told (by Business Office) resident has no funds, the family is getting survivor's benefit and paying privately. Per staff #36 no further assistance or documentation was offered for Resident #117.On 10/09/2025 at 10:16 AM during record review of Resident #117 revealed a Discharge Planning Note, dated 03/03/2025 08:38, which noted that resident's family is unable to care for resident anymore and daughter is interested in LTC and that resident agreeable. Additionally, on 03/03/2025, Physician Certification Related to Medical Condition, Decision Making, and Treatment Limitations, states resident has adequate decision making capacity (including decisions about life-sustaining treatments). Per the Care Plan Report, created on 06/20/2025, it indicates to assess for the (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's preference to return to the community and refer if needed and review and update discharge plans with the resident when needed. Of note, this Surveyor was unable to locate any follow-up regarding Resident #117's current interest in returning to the community and no further documentation provided to survey team.3. On 09/30/2025 at 10:35 AM during observation and interviews, Resident #65 shared with this Surveyor, that I have a court appointed Guardian but they are not helpful with anything, I want my granddaughter to be my POA/Guardian, but when I requested this to the Social Worker during Care Plan meetings or to the Guardian, I'm often told too much paperwork.On 10/08/2025 at 10:27 AM during record review it revealed Resident #65's court appointed Guardian dated 6/9/25; a BIMS Score of 15 dated 11/21/24; and the Physician Certification Related to Medical Condition, Decision Making, and Treatment Limitations, states resident has adequate decision making capacity (including decisions about life-sustaining treatments), dated 1/17/22. These findings and Resident #65's concerns were shared with the Director of Social Services staff #36.On 10/09/2025 at 4:36 PM during interview with Director of Social Services staff #36, stated I met with [resident #65] regarding Guardian stating too much paperwork and confirmed that resident does want granddaughter to be POA. Staff #36 stated I will assist resident #65 to get POA with the granddaughter.

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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 observation, record review, and interview with a resident and staff, it was determined that the facility failed to: 1.) establish a system of records of receipt of controlled drugs 2.) to ensure accurate reconciliation of a controlled medication, 3.) immediately document medication administration of a controlled drug in the accountability record and Medication Administration Record (MAR), and 4.) submit timely requests for a residents controlled drug before it runs out. This was evident for 1 (Resident #39) out of 12 residents review for medications. The findings include:Controlled Drugs (narcotics) are substances that have an accepted medical use, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. 1. On 10/7/2025 at 3:00PM, during a review of the Controlled Substances log book for controlled drugs administered to Resident #39, the Surveyor discovered a controlled medication logs for Diazepam on page 100, 146, and 190; Dilaudid on page 121, 137, 157, 173, and 189; and, Methadone on page 122, 138, 159, and 182; in which when new inventory was received and the facility failed to initiate a new page. During an interview with the Director of Nursing (DON) on 10/7/2025 at 3:35PM, the Surveyor was informed that the expected practice is to start a new page for each new controlled drug medication supply from the pharmacy. Controlled substance logs must account for every medication and dose from receipt to administration, and resident records must be accurate and complete.2a. During a review of Resident #39's controlled medications in the Controlled Substances log book on 10/7/2025 at 2:30PM, on page 138, the Surveyor discovered a last record of Methadone was 7/26/2025 at 6:00AM and the amount on hand was 46 tablets, the amount used was -4 tablets, and the amount left was 42 tablets. The medication was transferred to page 159. The initial record of Methadone on page 159 was on 7/26/2025, a transfer of +38 tablets. The facility failed to ensure their record keeping system was accurate.Controlled drugs, due to its potential for abuse and addiction, is required to be thoroughly tracked and accounted for by the facility. This includes but is not limited to an accounting of all narcotics in storage whenever a change of shift among nursing staff occurs. This medication count must be performed by two nursing staff at the same time to verify the counts being conducted. Any discrepancy in the count from what is expected to be found must be addressed immediately.2b. On 10/7/2025 at 3:00PM, during a review of Resident #39's controlled medications in the Controlled Substance log book, the Surveyor reviewed the book's shift counts for 8/11/2025 through 10/7/2025. During the review, it was noted that two signatures were not present for the following changes of shift:8/12/2025, 3pm-11m shift: only one signature8/12/2025, 11pm-7am shift: only one signature8/13/2025, 3pm-11pm shift: only one signature8/15/2025, 7am-3pm shift: only one signature8/21/2025, 3pm-11pm shift: only one signature8/21/2025, 9pm: no signatures8/25/2025, 7am-3pm shift: only one signature8/25/2025, 3pm-11pm shift: only one signature8/25/2025, 11pm-7am shift: only one signature8/27/2025, 3pm-11pm shift: only one signature8/29/2025, 11pm-7am shift: only one signature8/30/2025, 3pm-11pm shift: only one signature8/30/2025, 11pm-7am shift: no signatures8/31/2025, 3pm-11pm shift: no signatures8/31/2025, 11pm-7am shift: no signatures9/6/2025, 7am-3pm shift: only one signature9/7/2025, 7am-3pm shift: only one signature9/12/2025, 3pm-11pm shift: only one signature9/13/2025, 7am-3pm shift: only one signature9/15/2025, 11pm-7am shift: only one signature9/17/2025, 3pm-11pm shift: only one signature9/20/2025, 3pm-11pm shift: no signatures9/22/2025, 3pm-11pm shift: only one signature9/22/2025, 11pm-7am shift: only one signature9/24/2025, 7am-3pm shift: only one signature9/24/2025, 11pm-7am shift: only one signature9/29/2025, 3pm-11pm shift: no signatures9/29/2025, 11pm-7am shift: only one signature9/30/2025, 7am-3pm shift: only one signature10/1/2025, 3pm-11pm shift: only one signature10/1/2025, 11pm-7am shift: only one signature10/2/2025, 7am-3pm shift: only one signature10/2/2025, 3pm-11pm shift: only one signature10/7/2025, 7am-3pm shift: no signatureDuring an interview with the DON on 10/7/2025 at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:35PM, the Surveyor confirmed the findings. The DON informed the Surveyor that two nurses are to complete a controlled drug count at every 8-hour shift change, even if they are working a double shift.2c. On 10/9/2025 at 5:00PM, during a review of Resident #39's controlled substance sheets #159 and #165 for Methadone, the Surveyor discovered that both sheets contained signed accountability records for dates 8/1/2025 through 8/9/2025. Additionally, both sheets contained documentation that a dose of the medication was administered to the resident on 8/8/2025 at 2:00PM. On page #159, it was recorded that there were 16 tablets on hand, -4 tablets used, and 12 tablets left. On page 165, it was recorded that there were 303 tablets on hand, -4 tablets used, and 299 tablets remaining.3a. On 10/7/2025 at 2:06PM, the Surveyor observed Licensed Practical Nurse (LPN) #21 documenting the medication administration of Methadone, a controlled drug, which was given to Resident #39 earlier that day. LPN #21 confirmed that the medication was given to the resident at about 1:30PM and that the LPN should have documented in the Controlled Substance log book at the time of administration.During an interview with the DON, the Surveyor expressed the concern that LPN #21 failed to document the administration of a controlled drug to Resident #39 in the Controlled Substance log book at the time of administration. The DON stated that the expectation is for the nursing staff to check the orders for the medication to be given, check the medication administration record (MAR), compare the MAR and the controlled drug sheet in the Controlled Substance log book, once the medication is administered, immediately sign the medication off in the MAR and the log book at the same. The DON informed the Surveyor that the nursing staff will be educated on administration and documentation of all medications.3b. On 10/9/2025 at 4:30PM, a review of controlled substance sheet #189 for Hydromorphone HCL revealed that Resident #39 received a dose on 9/16/2025 at about 1:16PM, 9/16/2025 at 10:10PM, 9/18/2025 during the day, and 9/18/2025 at 9:36PM. A review of the controlled substance sheet #212 revealed the resident received a dose on 9/26/2025 during the day, 9/26/2025 at 9:30PM, 9/29/2025 at 2:00PM, 9/29/2025 at 10:00PM, 9/30/2025 at 2:00PM, and 9/30/2025 at 10:00PM. A review of the resident's MAR for September 2025 failed to have documentation of Hydromorphone HCL medication administration on 9/16/2025, 9/18/2025, 9/26/2025, 9/29/2025, and 9/30/2025.4. On 10/2/2025 at 2:31PM, Resident #39 was observed yelling and complaining to the DON that the facility was constantly running out of their Methadone.During an interview conducted with Resident #39 on 10/7/2025 at 12:00PM, the Surveyor was informed that the facility was always running out of their controlled drugs, Methadone HCL and Hydromorphone HCL. The resident stated that the nursing staff recognizes when a residents medication gets down to the last few doses, a new supply needs to be ordered from the pharmacy to have the medication on hand when it's due or when the resident requests.On 10/7/2025 at 3:15PM, a review of Resident #39's electronic medical record revealed a physician order for Diazepam 2mg tablet, 1 tablet by mouth at bedtime, Hydromorphone HCL 4 mg, 1 tablet by mouth every 4 hours as needed, and Methadone HCL 10mg, 4 tablets by mouth 3 times a day at 6:00AM, 2:00PM, and 10:00PM.A review of the Controlled Substance log book revealed that on 6/10/2025 at 2:00PM there were 3 tablets of Methadone HCL left, 3 tablets used, and 0 tablets remaining, even though the order was for 4 tablets. A new supply was received on 6/20/2025 at 6:00PM. On 6/30/2025 at 8:00PM, the last 4 tablets of Methadone HCL were administered. A new supply was received on 7/1/2025 at 2:40PM. On 10/2/2025 at 6:00AM there were 3 tablets of Methadone HCL left, 3 tablets used, and 0 tablets remaining, even though the order was for 4 tablets. A new supply was received on 10/2/2025 at 6:00PM. On 10/1/2025 at 10:00PM, the last tablet of Diazepam was administered. A new supply of Diazepam was received on 10/4/2025 at 10:15PM. An additional review revealed that the last Hydromorphone HCL tablet was given on 9/25/2025 at 9:15PM. A new supply of Hydromorphone HCL was received on 9/26/2025 at 8:00AM. The facility failed to ensure Resident #39 had a sufficient supply of prescribed controlled medications on hand to meet his/her needs.

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Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure a medication error rate of less than 5 percent for 4 (#27, #52, #170, and #104) residents out of 5 residents observed during 33 medication administration opportunities which resulted in an error rate of 12.12% by 2 of 2 certified medicine LPNs observed during the survey.The findings include: 1. On 10/02/2025 at 8:02 AM during medication administration for resident #27, this Surveyor observed LPN staff #21 dispensed insulin to resident #27 from an unlabeled Insulin Aspart Injection FlexPen, Exp 2027-10-31, Lot RZFSM68. This Surveyor asked about the non-labeled medication; LPN staff #21 replied, ?the label fell off, but this is the only resident on this FlexPen medication'. Surveyor then asked what the facility expectation with this non-labeled medication is; LPN staff #21 replied ?we should have requested another labeled FlexPen from pharmacy for the resident.'2. On 10/02/2025 at 8:27 AM during medication administration for resident #52, this Surveyor observed LPN staff #21 at the bedside to obtain a fingerstick prior to administering resident #52 pre-meal insulin. Resident had a half-eaten Breakfast tray and commented to staff #21 I already ate my breakfast. Staff #21 proceeded with the point of care testing to obtain and then record resident #52 Fingerstick as 140. Staff #21 then prepared and administered the medication ?3 ML insulin lispro 100 UNT/ML Pen Injector 'Inject 8 units Subcutaneously before meals'; despite resident #52 meal had already been eaten.3. On 10/02/2025 at 9:18 AM during medication administration for resident #170, this Surveyor observe LPN staff #21 reviewed 12 medications to be given: 1. cyclobenzaprine hydrochloride 5 MG Oral Tablet; 2. 12 HR bupropion hydrochloride 150 MG Extended Release Oral Tablet; 3. prednisone 10 MG Oral Tablet; 4. calcium carbonate 1000 MG Chewable Tablet [Tums]; 5. ferrous fumarate 325 MG Oral Tablet; 6. furosemide 20 MG Oral Tablet; 7. magnesium oxide 400 MG Oral Tablet; 8. meloxicam 7.5 MG Oral Tablet; 9. polyethylene glycol 3350 17000 MG Powder for Oral Solution; 10. sennosides, USP 8.6 MG Oral Tablet; 11. hydroxychloroquine sulfate 200 MG Oral Tablet; and 12. Bacillus coagulans 1000000000 UNT / inulin 250 MG Oral Capsule. This Surveyor observed LPN staff #21 pull all 12 medications from the cart, however failed to include the calcium carbonate 1000 MG Chewable Tablet [Tums], proceeded to resident #170 bedside, administered 11 of the 12 medications. LPN staff #21 then returned to the medication cart and charted on all 12 medications. This Surveyor interviewed staff #21 and discussed the observation of the medication bottle being returned to the cart without adding the medication to the medication cup. After Surveyor intervention, staff #21 then retrieved and administered the medication (calcium carbonate 1000 MG Chewable Tablet [Tums]) to the resident as prescribed and originally charted.4. On 10/02/2025 at 10:01 AM during medication administration for Resident #104, Surveyor observed LPN staff #24 prepare polyethylene glycol 3350 17000 MG Powder for Oral Solution incorrectly. This Surveyor observed LPN staff #24 access Google on their cell phone and began to search measurements. This Surveyor asked LPN staff #24 what was occurring and was the use of Google allowed at facility for medication administration; LPN staff #24 replied, I never given before, the med stated it was equal to 10ml. Per physician orders the resident was prescribed the following: polyethylene glycol 3350 17000 MG Powder for Oral Solution Give 17 gram by mouth two times a day. The medication bottle clearly states: 17 g (cap filled to line), indicating the provided cap on the bottle was the recommendation for proper measurement to prepare to the prescribed dose. Surveyor then observed LPN staff #24 measure out 10ml of the powdered medication into a medicine cup, poured the powder into an approximate 8oz drinking cup, fill the cup about 1/2 way with approximately 4oz of water, mixed the solution, and then administered to Resident #104. Of note, Resident #104 refused this medication during the administration. During an interview with staff #24, this Surveyor pointed out the dose reconstitution directions on the label of the medication; the LPN staff #24 simply shrugged their shoulders and offered no explanation. On 10/02/2025 at 10:35 AM during interview with Director of Nursing staff #2 and Clinical Regional Nurse staff #43, this surveyor discussed concerns of the errors observed with LPN staff #21 and #24 during (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication administration facility task. This Surveyor asked was the use of Google the facility's expectation to assist with reconstitution of medications; DON staff #2 stated ?No'.

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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 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. Based on observations, record reviews and interviews, it was determined that the facility failed to assist a resident in making transportation arrangements to and from the source of service, when the resident needs assistance. This was evident for 1 (#58) resident out of 1 residents investigated for missed appointments due to transportation services during the facility's survey.The findings include:On 09/29/2025 at 12:35 PM during observation and interview, resident #58 shared I have missed appointments for over a year due to my lost wheelchair which could fit in the cab for transport, but the current replacement wheelchair is larger and unable to fit in with the only cab service that is offered by the facility. I was fitted for a power wheelchair and told I was approved but never received it. When I asked for help from the Social Worker, they just give me a grievance form, but nothing is ever done.On 09/30/2025 at 8:39 AM during interview with Director of Nursing (DON) staff #2, Nursing Home Administrator (NHA) staff #1, and Administrator in Training (AIT) staff #3, this Surveyor shared Resident #58's concerns regarding missed appointments due to transportation and a power wheelchair approval.On 10/07/2025 at 9:49 AM during record reviews and interviews regarding Resident #58's concerns of missed appointments related to transportation, it revealed in the Front Desk Appointment log, resident #58 missed the following appointments on 7/19/24, 1/23/25 and 8/21/25 due to rescheduled W/C wouldn't fit in taxi'.During interview with Unit Clerk staff 76, this Surveyor asked about missed appointments due to transportation or alternate forms of transportation; staff #76 states we only are allowed to schedule with Friendly Taxi service and that company cannot fit the resident's large wheelchair and the physician offices that are scheduled cannot accommodate alternate stretcher transport, so I just reschedule the appointments.On 10/07/2025 at 9:59 AM during an interview with Director of Rehab Services staff #30 regarding resident #58 wheelchair, this Surveyor was told I did dispense Resident #58 a larger wheelchair (28in.) when their personal wheelchair was lost, and then registered and obtained approval for the power wheelchair, however, once the facility was billed for the wheelchair, I no longer have control when the bill will be paid for the resident to receive the wheelchair. Staff #30 provided an Email communication dated 7/10/2025 to 9/29/2025. This communication indicated that Resident #58 was recommended for the Freedom Mobility Power Wheelchair program, met the requirements, was cleared through the loaner screening process to be able to properly handle the power wheelchair, and the final bill received at the facility via email dated 9/17/25, but remains unpaid at the time of the annual survey.On 10/08/2025 at 2:39 PM during interview NHA staff #1, Regional VP of Operations staff #61, Regional Director of Operations staff #62, this Surveyor discussed Resident #58's wheelchair issues and missed appointments for over a year due to current transport unable to accommodate wheelchair, the resident being approved by Freedom Mobility for a Power Wheelchair, and invoice sent to facility dated 9/17/25. This Surveyor asked what the billing process was and why the delays in obtaining the power wheelchair for the resident that could assist with transportation to keep the medical appointments; staff #62 stated the facility could pay the invoice upfront and submit for reimbursement, there should be no delays to resident.On 10/09/2025 at 10:30 AM during interview with Business Office Manager (BOM) staff #51, regarding power wheelchair for resident #58, stated invoices received in September, are billed in October. The facility never pays upfront, always send to Medicaid via this next month process and BOM does not pay vendors directly, they bill Medicaid. The bill was sent to Regional Business Office for payment as they handle billing; local BOM does not handle billing per staff #51. Staff #51 shared the 2nd invoice payment request, email documentation chain and invoice sent to Regional Business office on 9/17/25 with no payment status provided.On 10/09/2025 at 11:38 AM during follow-up conversation with Regional Director of Operations staff #62 regarding the invoice for the power wheelchair, clarified previous statements about facility upfront payment and stated, the facility could not pay the invoice upfront, it is submitted to Regional Business Office for Medicaid billing monthly; however, I do not have that payment status.On 10/09/2025 at 2:05 PM after Surveyor (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention, record review revealed a new transport company was selected and transport set up resident #58 next appointment schedule for 10-23-25.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review, observation, and interview it was determined the facility failed to ensure staff assigned the supervisory responsibilities for the facility's food and nutrition services was a qualified dietetic service supervisor. This was evident during the surveyor's review of the kitchen during the facility's recertification survey. The findings include:Upon surveyor's initial tour of the facility's kitchen on 9/28/25 at 7:43AM the surveyor conducted an interview with [NAME] #69 who confirmed with the surveyor that Dietary Manager (DM) #54 was the full time supervisor in charge of the kitchen's operations. On 9/30/25 at 2:01 PM the surveyor conducted an interview with Regional Registered Dietitian #12 who stated to the surveyor that they did not provide oversight to the types of diets within the facility and did not provide oversight of the facility's kitchen.On 9/30/25 at 2:12 PM the surveyor conducted an interview of DM #54 who reported that for ten years they have supervised and run the facility's kitchen. During the interview, DM #54 confirmed with the surveyor that they were not a certified dietary manager and were currently in the training for it.On 10/1/25 at 12:58PM the facility's Administrator provided a copy of a dietary manager continuing education course registration form dated 7/8/25 with DM #54's information listed on it. During an interview conducted by the surveyor on 10/2/25 at 9:51AM the facility Administrator confirmed that DM #54 has not completed the educational training s/he is still in the course. Regional Dietary Manager #55 confirmed with the surveyor during an interview on 10/9/25 at 11:49AM that they were a regional supervisor and visited the facility approximately two times per week.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure each resident received and the facility provides food that accommodates resident allergies, intolerances, and preferences. This was evident for 3 (Resident #58, #117 and #14) residents out of 9 residents reviewed during the survey.The findings include: 1. On 09/28/2025 at 12:39 PM during initial observation and interview, resident #58 was observed in bed with their lunch tray on their lap. Resident #58 stated ?no variety, limited vegetables, too many carbs, and wrong timing'. Surveyor observed the meal ticket; it revealed on the top portion: Regular - Heart Healthy; Thin Liquids. On the mid-portion of the ticket, it revealed: 4oz Baked Pork Chop, 4oz Italian Blend Vegetables, 1@ Dinner Roll, 4oz Diet Ice Cream; Tray Notes:, Instructions and Dislikes: Tomato Products, Tomatoes, Gravy. Surveyor observed the actual tray contents, resident was served the following: approximate 4 inch white meat-like substance, small bowl of green bean-like vegetable, a scoop of mashed potatoes-like substance with a generous amount of brown gravy-like substance, and a 4oz cup of 100% Apple Juice. Per the meal ticket, there was no roll or Ice Cream, and no indication that substitutions were made. Additionally, there was a generous amount of ?brown gravy'-like substance over the mashed potatoes-like substance despite Resident #58's preferences listing ?gravy' as a dislike.2. During multiple observations, record reviews, and interviews, Resident #117 expressed concern regarding the facility food. On 09/30/2025 at 10:20 AM resident #117 stated the food is always cold, tasteless, and not enough, I request an extra portion but never receive it. Resident #117 further stated, I requested an evening snack, but was told no. During record review of resident #117 Dietary Orders revealed: Heart Healthy Diabetic diet, Regular texture, Thin Liquids consistency; DM Heart Healthy Allergies: Shellfish, Fish. On 10/08/2025 at 12:52 PM during a follow-up observation and interview, resident #117 was observed up in chair eating lunch at bedside table. Surveyor observed the meal ticket, it revealed on the top portion: Regular - Diabetic Heart Healthy; Thin Liquids; Allergies: Shellfish, Fish. On the mid-portion of the ticket, it revealed: 4oz Baked Fish, 4oz French Fries, 4oz Coleslaw, 1/2-2x2 Cake w/Icing. Surveyor observed the actual tray contents, resident was served the following: approximate half of about a 4in brown meat-like substance with brown gravy-like substance, small empty bowl of green bean-like vegetable pieces, a scoop of mashed potatoes-like substance with brown gravy-like substance, 4oz container of 100% Apple Juice, 1 cup of brown coffee-like liquid, small bowl of coleslaw-like substance, and an approximate 2 inch square of cake-like substance with brown icing-like substance on top. Per the meal ticket, Resident #117, did not receive the contents indicated on the meal ticket, no substitutions were indicated. Additionally, despite Resident #117 listed allergies, the meal ticket indicated they were to receive the fish entree.3. During multiple observations, record reviews, and interviews, Resident #14 expressed concerns regarding the facility food. On 09/29/2025 at 1:06 PM surveyor met with resident #14 at bedside, the resident stated I require double portions due to my dialysis, but I never receive it. The record review revealed the following Dietary Orders: Renal Diabetic diet, Regular texture, Thin Liquids consistency. Reg - DM Renal, Thin Liquids, Double Portion, Allergies: Shellfish, Fish. On 10/08/2025 at 12:54 PM Surveyor observed Resident #14 during lunch at bedside, the meal ticket revealed on the top portion: Regular - Diabetic Renal, Thin Liquids, Double Portion, and Allergies: Shellfish, Fish. On the mid-portion of the ticket, it revealed: 4oz Baked Fish, 4oz [NAME] Rice, 4oz Coleslaw, and 1/2-2x2 Cake w/Icing. The Surveyor observed the actual tray contents, the resident was served the following: a fish patty-like substance, coleslaw-like substance, a cup of brown coffee-like substance, 4oz 100% Apple Juice container and an approximate 2 inch square of cake-like substance with brown icing-like substance on top. Per the ticket, resident #14, did not receive double portions, the items such as the white rice, and received food marked clearly as an allergy.On 09/30/2025 at 2:01 PM during interview with Regional Registered Dietician staff #12, surveyor shared resident dietary concerns regarding double (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portions and snacks requests; RD #12, stated I don't handle that, those concerns go to the kitchen CDM (Certified Dietary Manager) or RD (Registered Dietician).On 10/08/2025 at 2:39 PM during interview with Administrator staff #1, Regional VP of Operations staff #61, and Regional Director of Operations, staff #62, Surveyor shared resident dietary concerns and meal ticket discrepancies. The surveyor team was informed that facility is aware of dietary concerns within the facility and they are currently evaluating Nutrition contracts and Dietary processes.On 10/09/2026 at 10:00 AM during interview with Director of Nursing (DON) staff #2, surveyor shared concerns regarding resident listed allergies in Dietary Orders and on Meal Tickets and residents receiving and potentially receiving those items. Staff #2 stated I spoke with Resident #14, they said they are not really allergic to fish, only shellfish and prefers to eat only fish they have caught. Surveyor was not given any more evidence of corrected meal tickets prior to the end of survey.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review it was determined the facility failed to maintain accurate medical records for residents. This was evident for 5 of 38 residents (Resident #109, #3, #4 and #55, #105) reviewed. The findings include: 1.) On 10/3/25 at 2:03PM the surveyor reviewed the medical record of Resident #109 which revealed their care plan sign in sheet listed the resident's family member as being their poa (power of attorney), however, the care conference invitation dated 8/28/25 was observed to be addressed directly to the resident. Review of the resident's face sheet by the surveyor revealed documentation that Resident #109 had a family member listed as their power of attorney and responsible party for their care, medical, and financial decision making. Review of the resident's Maryland Orders for Life Sustaining Treatment form documented the resident had made their own decision as a basis for the orders on 6/23/25. Further review of the resident's power of attorney document by the surveyor revealed the following information regarding the family member listed and appointed within the document: This power of attorney does not authorize the agent to make health care decisions for you. Review of Resident #109's physician certification form dated 6/26/25 revealed that Physician #52 certified Resident #109 has adequate decision making capacity. On 10/9/25 at 9:52AM the surveyor conducted an interview and shared the concern with Director of Social Services (DSS) #6 who reported to the surveyor that they did not know if Resident #109 was their own responsible party and they would look into the surveyor's concern further. On 10/9/25 at 10:37AM, DSS #6 reported to the surveyor that the face sheet for Resident #109 was incorrect and that the resident is their own health care decision maker. After surveyor intervention, DSS #6 reported that they had corrected the resident's face sheet to reflect them as being their own responsible party for health care decision making. DSS #6 provided the surveyor with a copy of the corrected face sheet in which the family member was changed to be listed only as a power of attorney for financial decision making for the resident. 2.) On 10/1/25 at 9:05AM the surveyor observed Resident #3 with no date or time on their peripherally inserted central catheter dressing. On 10/1/25 at 9:33AM the surveyor shared the concern and conducted a dual observation of the concern with the facility's Assistant Director of Nursing (ADON) who observed, acknowledged, and confirmed surveyor's observation. On 10/1/25 at 9:43AM the surveyor conducted an interview with the ADON who, after surveyor intervention, reported to the surveyor that Resident #3's dressing change would be performed now. On 10/3/25 at 9:06AM the surveyor reviewed the medical record of Resident #3 and observed there was no documentation present to reflect the resident's dressing change had been performed on 10/1/25. On 10/3/25 at 12:00PM the surveyor conducted an interview with the ADON who reported to the surveyor that Resident #3's dressing had been changed immediately by the nurse on 10/1/25. The (continued on next page)

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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 - Few	ADON further reported to the surveyor that documentation of dressing changes occurs on the medication/treatment administration record. At this time, the surveyor shared their concern with the ADON. On 10/3/25 at 2:13PM the surveyor conducted an interview with the ADON and inquired to them as to if the dressing change had been documented. After surveyor intervention, the ADON reported to the surveyor that the s/he (the nurse) did not put the documentation in for the dressing change but it is there now. 3.) On 9/29/2025 at 10:30AM, during an interview with Resident #4, the resident stated that they can smoke independently in designated areas of the facility. The Surveyor observed 2 packs of cigarettes sitting on the bedside table. On 10/1/2025 at 12:50PM, the review of the facility's Smokers List revealed Resident #4 was an independent smoker. On 10/6/2025 at 9:45AM, a review of Resident #4's electronic medical record revealed a Smoking Safety Screen assessment completed on 7/14/2025 with a score of 10. Scores of 0-4 indicate the resident may smoke unsupervised and scores 5 or greater indicate the resident requires supervision with smoking. Further review revealed a care plan created on 7/14/2025 with focus the resident prefers to smoke, a goal the resident will smoke safely thru the review period, and an intervention to supervise with smoking. On 10/6/2025 at 10:15AM, the Surveyor conducted an interview with Unit Manager (UM) #67. During the interview, UM #67 informed the Surveyor that smoking assessments are completed on admission, quarterly, and as needed. Residents can progress from a supervised smoker to an independent smoker. A nurse would have to directly observe the resident during a smoking session and complete an updated smoking assessment to determine that they no longer require supervision with smoking. The care plan should then be updated to reflect the independent smoking status in the medical record. UM #67 continued to inform the Surveyor that Resident #4 is an independent smoker. The resident needed supervision when they were first admitted to the facility due to their medical condition but since then have been evaluated and can smoke independently. The Surveyor expressed the concern that the facility failed to update the resident's Smoking Safety Screen assessment and care plan to reflect the resident is an independent smoker. UM #67 stated that the resident's smoking assessment and care plan will be revised to reflect the resident's current smoking status. On 10/7/2025 at 12:56PM, the AIT provided the Surveyors with an updated smokers list as of 10/6/2025 at 5PM. According to the updated list, Resident #4 is still an independent smoker. 4.) On 10/6/2025 at 10:34AM, a review of the facility's Smokers List revealed that Resident #55 was an independent smoker. A review of the resident's electronic medical record revealed a Smoking Safety Screen assessment completed on 6/23/2025 which indicated the resident did not smoke. The Surveyor reviewed a care plan created on 6/16/2025 with a focus resident refuses nicotine patch, the resident prefers to smoke cigarettes, a goal the resident will smoke safely thru the review period, and an intervention may smoke independently. On 10/6/2025 at 1:23PM, during an interview with the DON, the Surveyor expressed the concern that Resident #55's Smoking Safety Screen assessment completed on 6/23/2025 failed to indicate that the resident was a smoker and the resident was care planned for smoking on 6/16/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215269	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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	On 10/7/2025 at 12:56PM, the AIT provided the Surveyors with an updated smokers list as of 10/6/2025 at 5PM. According to the updated list Resident #55 is still an independent smoker. 5.) Review of resident #105's medical record on 10/07/2025 at 11:00 AM revealed that resident sustained an unwitnessed fall with no injuries, on 08/20/2025 at 19:55 PM. Progress note Type: 72-hour Post Fall Documentation Effective Date: 08/21/2025 documented resident fall occurred on 08/20/2025 at 12:00 AM. Progress note Type: 72-hour Post Fall Documentation dated 08/27/2025 stated resident fall occurred on 08/20/2025 at 12:00 AM, Progress note Type: 72-hour Post Fall Documentation Effective dated 08/31/2025 stated resident fall occurred on 08/26/2025 at 12:00 AM. During interview on 10/07/2025 at 11:20 AM the Director of Nursing staff #2 was notified and shown the progress notes reflecting different time frames related to the when Resident #105 sustained a fall on 08/20/2025. Staff #2 stated Yes and agreed that the progress notes reflected different times of when the fall occurred. Staff #2 also stated Resident #105 had only 1 fall since his/her admission to the facility which was on 08/20/2025. During interview on 10/07/2025 at 11:51 AM the Director of Rehabilitation Services staff #30 stated, Resident #105 had 1 fall since his/her admission, that the department has documented on 08/20/2025.