STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215273	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldorf Center	4140 Old Washington Highway Waldorf, MD 20602

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and interview it was determined the facility failed to ensure privacy and confidentiality of medical records. This was evident during 1 out of 1 dual surveyor observation of the facility's warehouse building which was conducted during the facility's recertification survey and during the review of Complaint #2714840. The findings include: During review of complaint #2714840 the surveyor requested and conducted a dual surveyor observation of the facility's warehouse building on 1/20/26 at 11:09AM with the facility's Director of Maintenance #14 and Assistant Director of Maintenance #24 who unlocked the facility's warehouse for the observation at which time surveyors observed several open boxes of medical records with freely visible protected health information in different areas of the warehouse which included names and medical record assessments, and another area of the warehouse with approximately 11 closed boxes of medical records with papers affixed to the exterior of the boxes with freely visible names and medical record numbers written on them and medical record files sitting on top with freely visible names and other information written on the outside of the files. At this time surveyors conducted an interview of the Director of Maintenance who reported to the surveyors that the warehouse was used for everybody to put stuff in and that the warehouse was additional storage. When surveyors inquired as to who had access to the warehouse at any given time, they stated: the central supply lady, housekeeping, and dietary. At this time surveyors shared their concerns. On 1/23/26 at 11:23AM the surveyor conducted an interview and shared concerns with the facility's Director Of Nursing (DON) who confirmed during the interview that maintenance and environmental services did not need access to medical records and protected health information. When the surveyor inquired as to what staff had keys/access to the warehouse where the medical information was observed, the DON reported: The Maintenance Director, Environmental Services Director, the Medical Records/Supply person, and the Maintenance Assistant. During the interview the DON confirmed with the survey team that after surveyor intervention, action was taken by the facility and all medical records were taken out of the warehouse the very same day and a shred company came the next day to destroy the older medical records.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation and interview it was determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment. This was evident for 6 (Rooms #102, #103, #107, #118, #119, and #124) out of 17 Resident rooms and one hallway on the A Wing Unit during the facility's recertification survey. The findings include: 1.) On 1/15/2026 during a tour of A Wing Unit conducted between 8:33AM and 10:30AM, the Surveyor observed the following environmental concerns: 1a.) In room [ROOM NUMBER], there was one window covered with cream colored roller blinds, pulled down at the time, which contained a large area with specks of black discoloration embedded in the roller blind material, 1b.) In room [ROOM NUMBER], there were two windows. The window between A bed and B bed was covered with a cream-colored roller blind, pulled down at the time, with dried, food-like particles of dark brown, tan, and orange stains scattered throughout the blind material. At the top of the roller blind, there was a large area with specks of black discoloration embedded in the roller blind material. The second window, on the side of B bed, had large areas with specks of black discoloration embedded in the roller blind material. 1c.) In room [ROOM NUMBER], the sliding closet door was completely off the hinges and leaned against the top shelf in the closet. The headboard/footboard to the resident's bed was on the floor in the closet and leaned against the closet wall. A clear plastic bag containing resident personal items, a Christmas stocking, a blanket, trash, and other resident personal items were scattered on top of one another on the floor of the closet. A dirty, blue, twin sized bed mattress with white and brown stains leaned against the wall between the closet and bathroom. On 1/16/2026 at 8:10AM, the Surveyor observed room [ROOM NUMBER]. The closet door had been removed from the room. There was nothing in place to allow for privacy of the resident's belongings in the closet. The headboard/footboard had been replaced onto the resident's bed. The dirty blue twin sized bed mattress with white and brown stains still leaned against the wall between the closet and bathroom. On 1/20/2026 at 8:41AM, Resident #66 was observed in room [ROOM NUMBER], sleeping in bed. The blue twin sized mattress was still dirty with white and browns stains and was uncovered on the floor next to the resident's bed. There was nothing in place to allow for privacy of the resident's belongings in the closet. On 1/21/2026 at 11:12AM, an interview with Unit Manager (UM) #7 revealed that on 1/15/2026 after the surveyor's observation, the maintenance department was made aware of the closet door off the hinges and the broken headboard/footboard in room [ROOM NUMBER]. The closet door was removed from the room, the headboard/footboard was repaired, and the closet floor was cleaned. The maintenance department was to acquire the appropriate hardware to repair and replace the closet door in room [ROOM NUMBER] as soon as possible. The surveyor expressed the concern there was a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dirty, blue, twin sized bed mattress with white and brown stains that was observed on numerous occasions leaning against the wall between the closet and bathroom and observed on 1/20/2026 at 8:41AM placed next to the resident's bed while the resident was in bed sleeping. The mattress was uncovered. The surveyor recalled a physician's order which stated, Extra mattress next to bed for fall precaution while in bed, ensure the mattress is cleaned and made every day. UM #7 informed the surveyor that the extra mattress was used as an extension of the resident's bed and should be cleaned daily and made while in use. UM #7 stated they would follow up with the surveyor's concern. On 1/22/2026 at 1:40PM, during a tour conducted on A Wing Unit, the Director of Maintenance (DOM) #14 and Assistant Director of Maintenance #24 confirmed the surveyor's findings; in room [ROOM NUMBER], there was one window covered with cream colored roller blinds which contained a large area with specks of black discoloration embedded in the roller blind material, and in room [ROOM NUMBER], the window between A bed and B bed was covered with a cream-colored roller blind with dried food-like particles of dark brown, tan, and orange stains scattered throughout the blind material and a large area with specks of black discoloration embedded in the roller blind material at the top and the second window, on the side of B bed, was covered with a cream colored roller blind which contained a large area with specks of black discoloration embedded in the roller blind material. DOM #14 stated that the maintenance department would address the Surveyors concerns. The Surveyor also expressed the concern that room [ROOM NUMBER] had failed to have an enclosed closet space protected from casual access from others by having a closet door. DOM #14 stated that the maintenance department was working on repairing the closet door and will look into other options to allow for privacy of the resident's belongings in the closet. 2.) During an initial tour of the facility conducted on 1/15/26 at approximately 9:10AM an observation was made of resident rooms on Unit A Wing. An observation was made of room [ROOM NUMBER] and the following concerns were identified: Inside of the bathroom there was a large, spackled area above the baseboards and upwards approximately two thirds of the wall on the left, right and front wall opposite the sink and toilet. The large, spackled areas needed paint. The Maintenance Director walked through the facility with the surveyor on 1/21/26 and confirmed the findings. He stated that all necessary repairs would be completed. All concerns were discussed with the Administration team at the exit conference on 1/23/26. 3a.) On 1/15/2026 at 8:28 AM, during the initial observation of the facility, it was noted that one of the hallway lights was out by room [ROOM NUMBER]. The surveyor observed that there were areas on the walls where the wallpaper was noticeably peeling off and areas where the wall was cut out, with a pipe sticking out of the wall. The carpeted areas of the hallway floors appeared to have several stained areas throughout the facility. 3b.) The closet door in room [ROOM NUMBER] was missing, and the light at the head of the bed was missing a bulb and cover. The bathroom floor had not been cleaned after repair work had been completed on the sink. 3c.) There was a large hole in a closet door in room [ROOM NUMBER], and the pole was missing to hang clothes on. On 1/21/2026 at 2:55 PM, the surveyor interviewed with Maintenance Director #22. Maintenance (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director #22 reported that he was new and had only started a week ago, but would do his best to answer all questions. Maintenance Director #22 was asked if he was aware of the environmental issues in the facility. He replied that he has been working with his staff to address the issues as soon as possible. Maintenance Director #22 was asked to take a walk with the surveyor to see the issues that were seen. Maintenance Director #22 agreed. Walking down A wing, the Maintenance Director #22 was shown room [ROOM NUMBER], where the closet door was missing, and there had been some issues with the toilet flushing. Maintenance Director #22 stated that the toilet had been repaired earlier that day and that he was not aware of the missing closet door. While in room [ROOM NUMBER], the Resident told Maintenance Director #22 about the light at the head of the bed missing a light bulb and a cover for it. Maintenance Director #22 stated that he would get someone to get to them as soon as possible. They continued down the hallway to where the missing handrails had been, but were now replaced and secured to the wall. Maintenance Director #22 was made aware of several areas in the hallway where the wallpaper was coming off the wall, and also areas where the pipes were sitting out from the wall and not covered. In room [ROOM NUMBER], the Maintenance Director #22 was shown the closet door that had a hole in it, and the closet was missing a pole to hang clothes on. Again, the Maintenance Director #22 assured the surveyor that they would be working hard to get these repairs completed. On 1/22/2026 at 4:00 PM, the surveyor interviewed the ADON #3, who was asked how often the carpets are cleaned. She stated that she was not sure, but that they had had it done recently.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to ensure sanitary practices were followed and maintained and ensure food was stored in accordance with professional standards for food service safety. This was evident during the surveyor's review of the kitchen during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility's kitchen on 1/15/26 beginning at 8:36AM the surveyor observed a handwashing sink located within the kitchen next to the entrance to the kitchen. The handwashing sink was observed to be unclean in appearance with a visible layer of debris present on the sink surfaces with signage posted which had areas of brown discoloration and debris present. [NAME] debris was observed on the wall below the hand soap dispenser. The walls behind and adjacent to the handwashing sink were observed with an open uncovered area of disrepair with approximately 8 wall tiles and cove molding missing with broken areas of exposed dry wall and wall material with white and brown dust and debris present. No measures were observed to be in place for control or prevention of dust and particles within the kitchen. On 1/15/26 at 8:37AM the surveyor shared the concerns with Dietary [NAME] #10 who observed and acknowledged the surveyor's concerns. On 1/15/26 at 8:39AM the surveyor observed the ice machine storage bin lid with an unclean appearance with food type particles and drips present on it. On 1/15/26 at 8:39AM the surveyor observed a clear scooper present laying out on top of the ice machine with no container. On 1/15/26 at 8:40AM the surveyor conducted an interview of Dietary Aide #11 and inquired as to if the clear scoop was used for ice. During the interview Dietary Aide #11 confirmed with the surveyor that the clear scoop resting on top of the ice machine was used for scooping ice and reported that it was used by nursing staff but not by kitchen staff. On 1/15/26 at 8:42AM the surveyor observed three areas of ice accumulation in the facility's walk-in freezer, with one area in which an icicle was observed extending from the bottom of the food holding rack to the floor's surface. On 1/15/26 at 8:42AM the surveyor observed a package of turkey breast meat within the walk-in freezer labeled turkey breast, date 11/17/25, use by 12/17/25, shelf life 1 month with a manager signature present on it. On 1/15/26 at 8:43AM the surveyor observed a package of pork meat within the walk-in freezer labeled: pork, date 11/20/25, use by 12/20/25. On 1/15/26 at 8:43AM the surveyor observed a box of classic chicken breast with rib meat within the walk-in freezer with no date labeling, and upon further observation of the contents of the box, a bag of chicken breasts which had been previously opened was observed with no date or labeling present. On 1/15/26 at 8:47AM the surveyor observed a package of yellow sliced cheese sitting in a metal pan within the walk-in refrigerator in which the saran wrap did not cover areas of the cheese left open to air. On 1/15/26 at 8:48AM the surveyor observed the reach in refrigerator which was observed to contain 2 condiment containers of chopped onions with no labeling or date present. When the surveyor inquired to the facility kitchen staff as to when the contents of the containers would expire, Dietary Aide # 12 reported: I don't know. When the surveyor inquired to other kitchen staff, no staff expressed knowing when the food was made or when it was to expire. Eleven pitchers of red liquid and 4 pitchers of brown liquid were observed within the reach in refrigerator with no labeling present. Twenty containers of peach cobbler were observed within the reach in refrigerator with no label or date present. On 1/15/26 at 8:54AM the surveyor observed an area of brown liquid present on the lower tier of the table which was holding a food processor. On 1/15/26 at 8:55AM the surveyor observed six containers of spices in which the lids were left open to air. On 1/15/26 at 8:56AM the surveyor observed a container of custard cup type dishes in which food particles were observed to be present on the surfaces. On 1/15/26 at 8:56AM the surveyor shared and dually observed the kitchen concerns with the facility's Infection Preventionist #4 who acknowledged the surveyor's concerns. On 1/15/26 at 8:59AM the surveyor observed a pumpkin pie with the following label present within the walk-in refrigerator: pumpkin pie, date 1/4/26, use by 1/11/26, shelf life 7 days. On 1/15/26 at 9:00AM the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor observed an unlabeled bag of potato wedges with no labeling or date present with a nickel sized hole in the bag which was open to air. On 1/15/26 at 9:04AM the surveyor conducted an interview with Kitchen Manager (KM) #13 who observed concerns and reported in response to the unlabeled chicken rib patties: I usually put a label on when I get my new product in. At this time, KM #13 acknowledged the surveyor's concerns. On 1/15/26 at 9:05AM after surveyor intervention, KM #13 was observed removing the uncovered ice scoop from the ice machine's surface and stated to the surveyor that it was because they shouldn't be using it. On 1/15/26 at 9:06AM the surveyor conducted a dual observation with KM #13 of areas with holes and rust discoloration present on the lower tier of the food preparation table. Upon closer dual observation by the surveyor with KM #13, sharp and lifted edges were observed to be present and the metal type covering was found to be movable and covering further extensive rust discoloration with white discolored areas present underneath. On 1/15/26 at 9:08AM the surveyor observed areas of brown discoloration and splattering present on the kitchen ceiling and walls. On 1/15/26 at 9:09AM the surveyor observed a peeling area of paint on the kitchen ceiling next to a vent located adjacent to the food serving line and above the microwave and toaster area. On 1/15/26 at 9:10AM the surveyor observed KM #13 remove two personal beverages from a food prep area. On 1/15/26 at 9:11AM the surveyor observed food debris present on the surface of the kitchen door. On 1/15/26 at 9:11AM the surveyor observed a metal type covering over a wall surface which was separated from the wall in areas which were adjacent to the food serving line which was taped to the wall with clear packing tape. On 1/21/26 at 11:45AM the surveyor observed a kidney shaped personal care basin filled with ice with a container of applesauce resting in it alongside other resident food and supplements within the A wing nutrition refrigerator located at the nurse's station. On 1/21/26 at 11:47AM the surveyor shared the concern and conducted a dual observation of the concern with Licensed Practical Nurse (LPN) #15 who responded to the surveyor: Okay, thank you. After surveyor intervention, LPN #15 was observed removing the basin, ice, and applesauce from the refrigerator. On 1/21/26 at 11:50AM the surveyor observed a white ring of film present on the C wing nutrition room sink. On 1/21/26 at 11:51AM the surveyor observed a movable floor tile and a missing floor tile located in front of the C wing nutrition room ice storage bin. Areas of visible soiling was observed to be present on the nutrition room flooring and on cove molding below the cabinetry. Cove molding was observed to be separated from the wall in the C wing nutrition room revealing an exposed area of wall damage with debris present. The hand-washing sink was observed to have an unclean appearance with areas of film present. A two-quart opened container of milk was observed unattended on the nutrition room counter and was felt to be warm to the touch. On 1/21/26 at 11:56AM the surveyor conducted a dual observation and shared concerns with LPN #16 who observed and acknowledged the concerns and informed Housekeeper #17 of the concerns. On 1/21/26 at 11:58AM the surveyor shared concerns with Housekeeper #17 who observed and acknowledged the concerns and informed the surveyor that they would be performing cleaning of the area. On 1/21/26 at 2:22PM the surveyor shared concerns with the facility's Director of Nursing who thanked this surveyor for sharing the concerns and reported they would go remove the milk carton. On 1/21/26 at 12:40PM the surveyor conducted an observation of the tray line and observed Dietary Aide #18 actively plating resident food with no hair net on to cover their hair. At this time, the surveyor shared the concern with Dietary Aide #18 and KM #13 who observed the concern, and after surveyor intervention, KM #13 paused the food line and Dietary Aide #18 was observed obtaining a hair net and putting it on at 12:43PM prior to resuming the food service tray line. On 1/21/26 at 12:48PM the surveyor observed one kitchen window freely open to outside air with a bent and broken screen present adjacent to the compartment sink and food prep table in which bread slices were observed prepped on trays.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews with staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices. This was evident for 7 (Resident #2, #1, #66, #65, #5, #3, and #43) out of 45 residents reviewed during the annual survey.The findings include: 1. On 1/16/2026 at 12:40 PM, during a review of Resident #2's Fall Risk Evaluation completed on 1/11/2026, the Surveyor discovered that the assessment was incomplete and the facility failed to accurately assess the resident's gait/balance and medications to determine if the resident was a high risk for falls.On 1/16/2026 at 1:10PM, during a review of Resident #1's Fall Risk Evaluation completed on 12/24/2025, the Surveyor discovered that the assessment was incomplete and the facility failed to accurately assess the resident's history, current status, predisposing conditions, and medications to determine if the resident was a high risk for falls.On 1/20/2026 at 9:00AM, during a review of Resident #66's Fall Risk Evaluation completed on 1/15/2026, the Surveyor discovered that the assessment was incomplete and the facility failed to assess the resident's gait/balance and medications to determine if the resident was a high risk for falls.On 1/21/2026 at 11:12AM, during an interview conducted with Unit Manager (UM) #7, the Surveyor expressed the concern that Resident #2's, Resident #1's, and Resident #66's most recent Fall Risk Assessment was incomplete and failed to accurately assess the resident's current condition in relation to the fall assessment to determine if the resident was a high risk for falls. UM #7 informed the Surveyor that they would review the Fall Risk Evaluations for those residents and make the necessary corrections.On 1/21/2026 at 2:20PM, UM #7 provided the Surveyor with copies of Resident #2's, Resident #1's, and Resident #66's updated Fall Risk Assessment completed on 1/21/2026. 2. On 1/16/2026 at 12:49PM an observation of Resident #65 revealed the resident was on a trach collar setting of 80%, 2.5 liters, and the concentrator at 20 PSI (pounds per square inch). Resident was awake and resting comfortably.On 1/20/2026 at 8:48AM an observation of Resident #65 revealed the resident was on a trach collar setting of 80% FIO2, 2.5 liters, and the concentrator at 20 PSI (pounds per square inch). Resident was sleeping comfortably.On 1/21/2026 at 10:15AM during a review of Resident #65's electronic medical record, the Surveyor reviewed a physician's order for a trach collar setting of 80% FIO2 and 3 Liters, concentrator at 20 PSI, monitor oxygen saturation every shift. Resident oxygen saturation readings from 1/16/2026 have ranged from 97% to 100%.During an interview conducted with Licensed Practical Nurse #15 on 1/21/2026 at 11:48AM in Resident #65's room, LPN #15 and the Surveyor confirmed the resident settings of trach collar at 80%, 2.5 liters oxygen, and 20 PSI. The Surveyor expressed the concern that the resident's order was for 3 liters oxygen and not 2.5 liters oxygen, as it was set and observed at on multiple occasions. LPN #15 recalled an order for 2.5 liters and the resident had been on 2.5 liters with stable oxygen saturations. LPN #15 would confirm the desired setting with the Respiratory Therapist and the Nurse Practitioner.During an interview conducted with Respiratory Therapist (RT) #20 on 1/21/2026 at 1:40PM, the Surveyor was informed that Resident #65 should be on 2.5 liters oxygen setting. The resident's oxygen saturation has been stable and the resident looked great during their assessments. The Surveyor expressed the concern that the resident's current oxygen setting at 2.5 liters did not match the order for 3 liters in the medical record. The Surveyor and RT #20 observed the resident's setting and RT #20 stated that the resident should be set at 2.5 liters oxygen and will have Unit Manager #7 update the order in the resident's medical record.3. On 1/15/2026 at 12:27PM, during an interview with Resident #3, the Surveyor was informed that the resident was a smoker.On 1/15/2026 at 1:00PM, during an interview with Resident #5, the Surveyor was informed that the resident was a smoker.On 1/16/2026 at 8:20AM, a review of the facility's smoking list revealed that Resident #3 and Resident #5 were independent smokers.On 1/20/2026 at 9:15AM, the Surveyor reviewed Smoking Evaluation assessments for Resident #3 which included an assessment completed on 6/2/2025 with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a smoking decision that independent smoking is allowed; however, additional comments state supervise with smoking: follows policy and procedure for smoking and another assessment completed on 12/3/2025 with a smoking decision that independent smoking is allowed.In addition, during a review of Resident #3's care plans, the Surveyor discovered 2 current care plans for smoking. One care plan was initiated and created on 10/25/2022 and revised 12/3/2025 with a focus which states, Patient may smoke independently per smoking assessment and a goal which states, Patient will smoke safely by next review. The care plan did not include interventions. The other care plan was initiated and created on 10/16/2024 with a focus which states, Patient may smoke with supervision per smoking evaluation, a goal with a target date of 3/23/2026 which stated, Patient will smoke safely x 90 days per smoking assessment and listed appropriate interventions.On 1/20/2026 at 9:30AM, the Surveyor reviewed Smoking Evaluation assessments Resident #5 which included an assessment completed on 6/2/2025 with a smoking decision that independent smoking is allowed; however, additional comments state supervised smoking required: follows policy and procedure for smoking and another assessment completed on 12/3/2025 with a smoking decision that independent smoking is allowed.In addition, during a review of Resident #5's care plans, the Surveyor discovered 2 current care plans for smoking. One care plan was initiated and created on 12/2/2019 and revised 12/3/2025 with a focus which stated, Patient may smoke independently per smoking assessment and a goal which stated, Patient will smoke safely x90 days. The care plan did not include interventions. The other care plan was initiated and created on 10/16/2024 with a focus which stated, Patient may smoke with supervision per smoking evaluation, a goal with revisions on 1/20/2025 and a target date of 12/22/2025 which stated, Patient will smoke safely x 90 days per smoking assessment and listed appropriate interventions.During an interview with Unit Manager (UM) #7 on 1/21/2026 at 11:20AM, the Surveyor expressed the concern that according to the Director of Nursing (DON) and the smoker's list provided, Resident #3 and Resident #5 were independent smokers. However, the documentation within Resident #3's Smoking Evaluation assessments on 6/2/2025 and 12/3/2025 and Resident #5's Smoking Evaluation assessments on 6/2/2025 and 12/3/2025 evaluated the residents as independent smokers and supervised smoking required without an explanation in the assessment. The Surveyor also expressed the concern that Resident #3 and Resident #5 have 2 current smoking care plans, one which stated, Patient may smoke independently per smoking assessment and the other which stated, Patient may smoke with supervision per smoking evaluation. The documentation does not clarify if the residents are independent smokers or require supervision in order to smoke. UM #7 stated the facility prefers to have a designee supervising the designated smoking area during the smoking sessions even though the current residents who smoke are assessed as independent smokers, including Resident #3 and Resident #5. The facility prefers to monitor the area to ensure the safety of the residents, not because they are unsafe smokers. UM #7 acknowledged that the Smoking Evaluation assessments and care plan for Resident #3 and Resident #5 need to be revised to reflect the residents' actual smoking status and the facility would provide education to staff to ensure the Smoking Evaluation assessments and smoking care plans are completed the same by all staff.4. On 1/20/2026 at 1:25PM, the Surveyor reviewed Resident #43's Social Service Assessment and Documentation dated 12/30/2025 which stated Information [advanced care planning] provided to the resident and family however, due to continued cognitive decline, resident is unable to complete this at this time; [Social Worker] to follow up with the resident and family at next review. Further review revealed another Social Service Assessment and Documentation date 4/1/2025 which stated Information [advanced care planning] provided to the resident and family however, due to continued cognitive decline, resident is unable to complete this at this time; [Social Worker] to follow up with the resident and family at next review.On 1/21/2026 at 8:40AM, during a review of Resident #43's paper chart, the Surveyor discovered 2 voided Physician Certifications Related to Medical Condition, Decision Making, and Treatment Limitations from 1/21/2024 which stated the resident lacked decision making capacity and a current Physician Certifications Related to Medical Condition, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Decision Making, and Treatment Limitations from 12/13/2024 which stated the resident had adequate decision making capacity. A review of the resident's current quarterly MDS (Minimum Data Set) completed on 1/5/2026 revealed Resident #43's BIMS (Brief Interview for Mental Status) was 15/15, indicating the resident was cognitively intact.During an interview with Social Service Assistant (SSA) #27 on 1/21/2026 at 1:30PM, the Surveyor expressed the concern that in the Social Services Assessment and Documentation completed on 4/1/2025 and 12/30/2025, the same documentation was present; Information [advanced care planning] provided to the resident and family however, due to continued cognitive decline, resident is unable to complete this at this time; [Social Worker] to follow up with the resident and family at next review, and expressed a concern that the facility failed to accurately document the resident's current cognitive status, with a BIMS of 15 and adequate decision making capacity per the physician. SSA #27 stated that some documentation in the assessments may be copied and pasted to the next assessment if there has been no change in the resident's condition. SSA #27 acknowledged that the resident was cognitively intact and the need to accurately assess the resident's cognitive status when completing the Social Service Assessment and Documentation.

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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 observation, interview, and record review it was determined the facility failed to ensure staff performance of basic infection control measures, follow appropriate infection control management of biohazard waste and storage of clean supplies and handling linens in a safe and sanitary manner. This was evident for 1 out of 1 dual surveyor observation of the facility's warehouse storage, and during an observation of the clean and soiled laundry processing rooms. The findings include: 1.) On [DATE] at 10:22 AM the surveyor observed Activities Assistant (AA) #22 throw their personal cell phone onto Resident #18's bed and proceed to unlock the resident's furniture with a key. At this time, the surveyor conducted an interview of AA #22 who confirmed that the cell phone placed on Resident #18's bed was their personal cell phone. At this time, the surveyor shared the concern with AA #22. On [DATE] at 9:01 AM the surveyor conducted an interview with the facility's Director of Nursing who acknowledged and confirmed understanding of the surveyor's concern and reported to the surveyor that they had provided training to AA #22 and that AA #22 was rushed, moving fast with what they needed to do and didn't think about it when they put their phone on the resident bed. 2.) During review of complaint #2714840 the surveyor requested and conducted a dual surveyor observation of the facility's warehouse storage building on [DATE] at 11:09AM with the facility's Director of Maintenance #14 and Assistant Director of Maintenance #24 who unlocked the facility's warehouse for observation. The surveyors observed the following in addition to other concern(s): a.) Biohazard waste managed in an area with additional biohazard bags present and open boxes of medical gloves, with the boxed bio hazard waste stacked against and with boxes of clean medical supplies, b.) An opened box of drinking cups and an opened box of cup lids stored on the floor near to a plastic container of used belongings which included a wheelchair arm rest which was worn and cracked, c.) Lancets, medical tape and various expired syringes present in the warehouse environment with various boxes stacked around with no separation of clean vs dirty supplies/stored items, and d.) Boxed medical supplies to include gloves, packages of incontinence briefs, and wound cleanser and dressing supplies were stored directly on the floor. At this time, surveyors conducted an interview of the Director of Maintenance who reported to the surveyors that the warehouse was used for everybody to put stuff in and that the warehouse was additional storage. When surveyors inquired as to who had access to the warehouse at any given time, they stated: the central supply lady, housekeeping, and dietary. At this time surveyors shared their concerns. On [DATE] at 1:30 PM the surveyor conducted an interview of Infection Preventionist (IP) #4 who confirmed with the survey team that the conditions identified by surveyors regarding the storage of supplies and the management of biohazard waste was not acceptable and stated: Biohazard waste should never be where there are clean gloves and clean items. IP #4 confirmed with the surveyor that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after surveyor intervention, they went out to the warehouse with Director of Maintenance #14 and Assistant Director of Maintenance #24 to ensure the conditions were taken care of, and reported that things were separated, a call was made to the bio hazard company to have the boxed waste removed, and staff had come in early to address the warehouse environment. 3.) On [DATE] at 1:25PM, an observation of the clean laundry processing area, in the presence of Environmental Services Manager (EVS) #23 and the District EVS Manager, revealed an uncovered metal linen cart which contained facility white blankets on the top, first shelf piled high and leaning on the wall, white towels and white washcloths on the second shelf, a small pile of white fitted sheets on the third shelf, and piles of white and cream colored thicker blankets on the bottom shelf, close to the floor. There was an uncovered white laundry basket with a pile of clean Resident laundry, which was unfolded, overflowing, and leaning against the wall. The surveyor inquired about the pile of Resident laundry and EVS #23 informed the surveyor that that pile was unidentified Resident laundry. The surveyor and EVS #23 identified 3 additional uncovered, unfolded, containers of unidentified resident laundry which were located under the folding tables. One container was overflowing and laundry items were touching the floor. EVS #23 and the District Manager of EVS acknowledged the overwhelming amount of unidentified Resident laundry. The surveyor expressed the concern that the Residents' personal garments and linens and the facility linens were not maintained in a safe and sanitary manner. The surveyor was informed that all clean linen should be covered, kept off the wall and floor, and stored in a manner to prevent contamination. On [DATE] at 1:35PM, an observation of the soiled laundry processing area, in the presence of EVS #23 and District EVS Manager revealed: a.) Five, unlined, 32 gallon (approximate) trash bins lined up along the wall. Three were overflowing with unbagged resident laundry items and facility linens piled high and touching the wall. One was filled with bagged resident laundry and facility linens. b.) One white 13 gallon (approximate) laundry bin lined up along the wall overflowing with unbagged resident laundry items and facility linens, piled high and touching the wall. c.) One 55 gallon (approximate) yellow trash bin full of unbagged white facility linen. d.) One black utility tilt truck half full of bagged resident laundry and facility linen. e.) An odorous soiled utility room. EVS #23 and District EVS Manager confirmed the surveyor's findings and concerns for infection control. The surveyor was informed that the laundry facility was currently operating with 1 out of 2 washing machines, which has increased the amount of soiled laundry sitting in the soiled laundry processing area. The facility is currently in the process of getting the inoperable washing machine repaired in order to manage the high volume of soiled laundry. The District EVS Manager informed the surveyor that they are working on implementing new systemic approach to managing laundry services within the facility to ensure infection control practices are followed, resident garments and linens are collected and labeled accurately to decrease the unidentified resident laundry, and ensure clean and soiled laundry is stored, handled, and maintained in a safe and sanitary manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview it was determined the facility failed to maintain dignity for a Resident, evident for 1 (Resident #98) out of 2 Residents reviewed for bowel and bladder; and failed to ensure residents were treated with dignity and respect, evident for 1 (Resident #4) out of 43 residents reviewed during the facility's recertification survey. The findings include: 1.) During the surveyor's initial tour of the facility on 1/15/26 at 10:29AM the surveyor observed Resident #98 to be laying in a copious amount of feces and yellow and brown colored soiling with areas that appeared both dry and moist on their incontinence brief and extending onto their bed pad with feces visibly present laying on the bed pad next to their right hip that was no longer able to be contained by the incontinence brief. On 1/15/26 at 10:30AM the surveyor conducted an interview with Resident #98 who expressed to the surveyor that they felt uncomfortable regarding their hygiene and had been left in their bowel movement for a few hours. Resident #98 expressed that they had informed nursing staff of the need to be assisted into a clean gown and cleaned up, however, staff had not come back to provide the needed assistance with care. On 1/15/26 at 10:33AM the surveyor requested and conducted a dual surveyor observation and shared and observed the concern with the facility's Administrator who after surveyor intervention, at 10:36AM directed facility nursing staff to attend to Resident #98's need for incontinence care and personal hygiene. On 1/15/26 at approximately 10:43AM surveyors observed Resident #98 express to Unit Manager, Licensed Practical Nurse (UM, LPN) #8 that they had asked for help, to which UM, LPN #8 responded: This is the first time I've been in here. On 1/16/26 at 9:36AM the surveyor conducted an interview with Resident #98 who reported they had told a Geriatric Nursing Assistant (GNA) that they needed assistance and did not receive the assistance. Resident #98 confirmed with the surveyor that after surveyor intervention, staff had provided hygiene and incontinence care assistance. On 1/21/26 at 12:02PM the surveyor conducted an interview with UM, LPN #8 who was assigned to care of Resident #98 on 1/15/26. During the interview, UM, LPN #8 confirmed they were the Unit Manager that day and additionally reported the following information: I was the nurse on the floor that day, the nurse had called out last minute, so I took that assignment, it would've been the nurse that called out's assignment, I had done my rounds when I came in the morning I came in at 8am. UM, LPN #8 confirmed the rounds occurred at 8am on 1/15/26. UM, LPN #8 reported to surveyors that Resident #98 had reported the following information to them regarding the soiling event: I had told you all. When the surveyor inquired as to if soiling was present during their 8am rounds on 1/15/26 with Resident #98, UM, LPN #8 reported: I would've smelled something, but when I rounded s/he had the blanket on, I did not see. UM, LPN #8 further reported to surveyors that the assigned GNA had not provided incontinence care to Resident #98 and that GNA was provided with education about rounding and making sure patients are dry before breakfast. During the interview UM, LPN #8 confirmed that the facility attempted to provide staff replacement for call offs but did not end up getting the staff for the shift, and on the morning of the Resident's concern there was one Nurse call out and one GNA call out. UM, LPN #8 reported that usually the nursing wing where Resident #98 is located is staffed with 4 GNA's. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 1/15/2026 at 10:59 AM, Resident #4 was lying in bed resting comfortably. Noted that the resident's pants were extremely too big and the belt was tied in a knot in front of the pants. On 1/20/2026 at 11:08 AM, Resident #4 was lying across the bed horizontally. It was noted again that the resident had jeans on that were too big with some type of knot wrapped around the buckle part of the pants. The surveyor checked in the resident's closet to find that all of his jeans and pants were a size 44 and that they all had some type of knot in the front of the pants. There are some sweatpants noted in the closet as well. On 1/21/2026 at 2:19 PM, the DON #2 was interviewed and asked how long Resident #4's pants have been too big. The DON #2 replied that she did not know and referred the surveyor to the unit manager for A wing. On 1/21/2026 at 2:30 PM, Unit Manager #7 was interviewed and asked how long the resident's pants had been too big for them, and who was responsible for getting him clothes that fit. The Unit Manager #7 responded that Resident #4 has a responsible party (RP) who was responsible for getting him clothes that fit, and they were notified on 1/16/2026 by the nurse that the resident needed new pants and a belt that fit. The unit manager #7 was asked again how long the resident's pants had been too big. The Unit Manager responded that the last time the RP brought clothes in was back in September 2025. On 1/21/2026 at 3:00 PM, the Unit Manager #7 brought the inventory of personal effects that the RP had brought clothes for the resident back in September 2025. However, the inventory form did not say what size clothes had been received.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews with residents and staff members, it was determined that the facility failed to ensure that each resident had the opportunity to exercise his or her autonomy regarding those things that are important in their life. This was evident for 1 (Resident # 11) out of 43 residents reviewed during the survey.The findings include: On 1/16/2026 at 11:15 AM, the surveyor interviewed Resident #11 about his/her stay at the facility. Resident #11 was non-verbal and used a paper typewriter to type words to communicate with the staff members. During the interview with Resident #11, they expressed to the surveyor that the staff takes away their wheelchair at night and did not allow them to call their spouse. On 1/22/2026 at 3:45 PM, Resident #11 expressed that they would like to keep their wheelchair at the bedside. The resident stated that all of the staff members remove his/her wheelchair at night as a punishment, so that they are unable to go to the bathroom. The ADON #3 and the surveyor went to speak with Resident #11 in their room. The GNA who took care of Resident #11 was coming out of Resident #11's room when the surveyor stopped her to interview her. The GNA was asked how the resident speaks with their spouse. The GNA did not know. The unit manager #8 was also asked. She stated that they (facility staff) will call the resident's spouse on the phone for Resident #11, but most of the time, he/she does not answer. If the spouse answers, the call is placed on speaker, and the resident would type the words to say. Both the GNA and the unit manager #8 were asked why the wheelchair was taken away from the resident at night. The GNA responded that she does not take the wheelchair away from them; most of the time, Resident #11 wants to stay in their wheelchair at the end of her shift. She continued to say that they were taking the wheelchair away before the new year started, until there was an incident where Resident #11 was found crawling on the floor to go to the bathroom. The unit manager #8 states that staff were moving the wheelchair at night to prevent Resident #11 from trying to get up by themselves as the resident was at risk for falls and will not call for assistance. The unit manager #8 denied ever telling staff to take away his/her wheelchair. She stated that now that she is aware, she will make sure all staff are also aware not to remove the wheelchair from the room.

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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 record review and interview with staff, it was determined that the facility failed to provide the Resident and/or Resident Representative with written notification of a transfer to the hospital and written notification of the facility's bed hold policy upon transfer to the hospital with the opportunity to request to reserve the bed privately. The was evident for 2 (Resident #23 and #100) out of 3 Residents reviewed for hospitalization during the facility's recertification survey.The findings include: Resident representatives are authorized to act on behalf of the resident.Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. 1. On 1/16/2026 at 1:14PM, during a review of Resident #23's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on [DATE]. The resident was not their own resident representative.On 1/20/2026 at 2:34PM, a review of Resident #23's electronic and paper medical record failed to reveal documentation to verify the resident/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 [DATE].A review of the facility's Discharge and Transfer policy section 5.1 on 1/20/2026 at 2:40PM revealed that Prior to the transfer, the patient and the patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific form and a copy would be placed in the patient's medical record. In addition, a review of the facility's Bed Hold policy process stated, When it is known that a resident will be temporarily transferred out of the Center, staff involved with the resident's transfer out (e.g., Nursing, Admissions, Social Services, etc) will: Provide the Bed Hold Notice of Policy and Authorization form to the resident/resident representative. If the resident representative is not present to receive the written notice upon transfer, the notice will be delivered via email, fax, or hard copy by mail within 24 hours. Maintain a copy in the medical record. The resident representative will receive the Bed Hold Notice of Policy and Authorization regardless of payer source and should have an opportunity to confirm or deny the private pay bed hold within 24 hours the resident's transfer. 2. On 1/20/2026 at 2:07PM, during a review of Resident #100's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on [DATE]. The resident was not their own representative. Further review of the electronic and paper medical record failed to reveal documentation to verify the resident/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 [DATE]. On 1/21/2026 at 12:30PM, during an interview with the Director of Nursing (DON) in the presence of the Corporate Clinical Lead, the Surveyor expressed the concern that Resident #23 and Resident #100 failed to have documentation to verify their resident representatives were provided written notification of transfer to the hospital on [DATE] (Resident #23) and 12/18/2025 (Resident #100) and written notification of the facility's bed hold policy at the time of transfer. The Surveyor was informed that nursing staff and the business office are responsible for providing notification of transfers and the bed hold policy to the residents/resident representatives.On 1/21/2026, Business Office Manager (BOM) #25 provided the Surveyor with a copy the Resident #23's and Resident #100's Bed Hold Notice of Policy and Authorization. A review of the forms revealed that both forms were incomplete and did not include private pay information for bed hold. During an interview with BOM #25 at 2:19PM, the Surveyor reviewed the forms. BOM #25 was unable to confirm that the residents' representatives received a copy of the form and had the opportunity to decide to hold a private pay bed because there was no documentation to verify. In addition, the Surveyor expressed the concern that Resident #23 and #100 were not their own representatives and they both failed to have documentation in their medical record to verify their resident representatives were provided written notification of transfer to the hospital on [DATE] (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident #23) and 12/18/2025 (Resident #100) and written notification of the facility's bed hold policy at the time of transfer. BOM #25 confirmed that the facility does not send written notification of transfer or a copy of the Bed Hold Notice of Policy and Authorization to the resident representatives when a resident is transferred to the hospital.On 1/22/2026 at 12:30PM, during an interview with BOM #25, the Surveyor was informed that after a conversation with their corporate manager, the facility will ensure that residents and resident representatives are provided with written notification of transfer to the hospital and a completed written notification of the bed hold policy upon 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. 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 2 (Resident #3 and #5) out of 9 Residents reviewed for smoking during the facility's recertification 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 1/15/2026 at 12:27PM, during an interview with Resident #3, the Surveyor was informed that the resident was a smoker.On 1/15/2026 at 1:00PM, during an interview with Resident #5, the Surveyor was informed that the resident was a smoker.On 1/16/2026 at 8:20AM, a review of the facility's smoking list revealed that Resident #3 and Resident #5 were independent smokers.On 1/20/2026 at 9:15AM, the Surveyor discovered a Smoking Evaluation completed on 9/2/2025 which stated that Resident #3 was an independent smoker.On 1/20/2026 at 9:30AM, a review of Resident #5's electronic medical record revealed a Smoking Evaluation dated 12/3/2025 which revealed the resident was an independent smoker.On 1/22/2026 at 9:30AM, during a review of Resident #3's annual MDS assessment completed on 9/22/2025, section J1300 revealed No to tobacco use.During an interview with MDS Coordinator #26 on 1/22/2026 at 9:45AM, the Surveyor was informed that tobacco use should have been captured during the annual MDS assessment completed on 9/22/2025.On 1/22/2026 at 10:23AM, MDS Coordinator #26 provided the Surveyor with a copy of the modified annual MDS assessment from 9/22/2025 which reflected yes to Resident #3's current tobacco use in section J1300. On 1/22/2026 at 10:30AM during a review of Resident #5's annual MDS assessment completed on 12/06/2025, section J1300 revealed No to tobacco use.On 1/22/2026 at 10:35AM, during an interview with the Corporate Clinical Lead, the Surveyor expressed the concern that Resident #5's annual MDS assessment completed on 12/06/2025 did not reflect the resident's current tobacco use and a modification was completed on 1/22/2026 for the annual MDS assessment completed on 12/6/2025 due to Surveyor intervention with Resident #5. The Corporate Clinical Lead provided the Surveyor with a copy of the initial annual MDS assessment completed on 12/06/2025 and the modification completed on 1/22/2026.

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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 it was determined the facility failed to: 1.) ensure a care plan was comprehensive and complete, evident for 1 (Resident #57) out of 1 Resident reviewed for change in condition; and 2.) ensure comprehensive person-centered care plans were developed and implemented for residents which reflect resident's goals, measurable objectives, and interventions to meet the specific goal, evident for 2 (Resident #3 and #5) out of 7 residents reviewed for accidents during the facility's recertification survey. The findings include:A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. 1.) On 01/16/2026 at 11:47 AM the surveyor conducted a review of Resident #57's care plan and observed the following care plan focus dated 12/31/25 by Assistant Director of Nursing, Registered Nurse (ADON, RN) #3: Resident is at risk for falls: CVA, Impaired mobility. Further review of Resident #57's care plan revealed the following goal was documented as initiated and created on 12/31/25 to address the care plan focus: Resident will have no falls with injury x 90days. The following interventions on the care plan were observed by the surveyor to be incomplete: 1.) Fall mat(s) Indicate Number/side(s) dated as created on 1/8/26 and dated as initiated on 1/5/26, and When resident is in bed or bed-side chair place the following personal items within reach:_____ dated as both created and initiated on 12/31/25. On 01/23/2026 at 10:30 AM the surveyor reviewed and observed Resident #57's care plan with the facility's Director of Nursing (DON) who reported to the surveyor that the care plan could be more personalized, individualized. The DON further reported to the surveyor during the interview that their expectation was: The care plan needs to be developed based on what the Resident needs are, or be specific to the Resident, this one doesn't say what personal items need to be in reach, and the fall mat intervention says to indicate the number and sides but it's not specified. After surveyor intervention, the DON informed the surveyor that they would ensure all care plans were individualized. 2.) On 1/15/2026 at 12:27PM, during an interview with Resident #3, the surveyor was informed that the Resident was a smoker. On 1/15/2026 at 1:00PM, during an interview with Resident #5, the surveyor was informed that the Resident was a smoker. On 1/16/2026 at 8:20AM, a review of the facility's smoking list revealed that Resident #3 and Resident #5 were independent smokers. On 1/20/2026 at 9:15AM, a review of Resident #3's electronic medical record revealed a smoking evaluation dated 12/3/2025 which revealed the Resident was an independent smoker. Further review revealed a care plan initiated and created on 10/25/2022 and revised 12/3/2025 with a focus which states, Patient may smoke independently per smoking assessment and a goal which states, Patient will smoke safely by next review. The care plan did not include interventions for specific care and services that would be implemented for the Resident. On 1/20/2026 at 9:30AM, a review of Resident #5's electronic medical record revealed a smoking evaluation dated 12/3/2025 which revealed the resident was an independent smoker. Further review revealed a care plan initiated and created on 12/2/2019 and revised 12/3/2025 with a focus which (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	states, Patient may smoke independently per smoking assessment and a goal which states, Patient will smoke safely x90 days. The care plan did not include interventions for specific care and services that would be implemented for the resident. On 1/21/2026 at 11:20AM, during an interview with Unit Manager (UM) #7, the surveyor expressed the concern that the facility failed to develop a complete person-centered care plan for a resident who is evaluated as an independent smoker by identifying interventions to be implemented and to meet the Resident's objectives. UM #7 stated they would review and update Resident #3's and Resident #5's care plans as necessary. On 1/21/2026 at 11:30AM, the Director of Nursing (DON) was made aware of the surveyor concerns.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, medical record review and interviews with facility staff, it was determined the facility failed to follow professional standards of practice during medication administration observation by not signing off a medication for a resident (#40) after administration, and not administering physician ordered medications to residents (#106 and #107) at their scheduled times. This was found to be evident during medication administration observation during the survey.The Findings Include:1. During the initial screening process of residents on the A Unit Wing, a Licensed Practical Nurse (LPN) #5 was observed on 1/15/26 at approximately 9:55 AM in resident #40's room. At this time resident #40 complained of an upset stomach and headache. The surveyor accompanied the nurse to the medication cart, and she retrieved Oxycodone 5 milligrams (mg) (1) tablet labeled for resident #40 from the narcotic drawer and signed the narcotic medication book. She went to resident #40's room and administered the oxycodone 5 mg tablet to the resident.During a medical record review for resident #40 on 1/21/26 at 11:00AM, it revealed the resident had a physician order for Oxycodone HCL Oral tablet 5 mg; give 1 tablet by mouth every 4 hours as needed for pain 4-6. Further review of the medication administration record (MAR) for resident #40 revealed, Oxycodone 5 mg tablet was not signed off as administered.During an interview with the DON on 1/21/26 at 12:38PM she was made aware of the concerns that the LPN #5 did not document that she administered resident #40 oxycodone 5 mg tablet. At this time the DON reviewed the narcotic book that confirmed the oxycodone was signed out for resident #40 by LPN #5. The DON reviewed the MAR for the resident and confirmed that Oxycodone 5 mg tablet was not signed off by the nurse as administered. The DON stated that the expectation of staff is to sign both the narcotic book when the medication is removed from the narcotic drawer and to document on the MAR that the medication was in fact administered to the resident. She stated that education will be provided to staff.2. A medication administration observation was conducted on 1/15/26 at 10:30 AM for resident #106. LPN #5 reviewed the computer screen as she poured medications for the resident. The computer highlighted a pink screen displaying the resident medication information for Metformin 500 mg tablet, Eliquis 2.5 mg tablet, Aspirin 81 mg tablet, Metoprolol 25 mg tablet, Amlodipine 5 mg tablet, Cetirizine HCL 10 mg tablet, Furosemide 40 mg tablet, Omeprazole 20 mg tablet, Multivitamin 1 tablet, Fluticasone 100 microgram (mcg) /25 mcg inhalation. All the medications were displayed at a scheduled time of 9:00AM. LPN #5 administered resident #106's medications at 10:30 AM. LPN #5 explained that the computer highlights a pink screen when the medications are not signed off as given at the scheduled displayed time. LPN #5 confirmed that the medications were given outside of the scheduled ordered time. She stated that she has two hallways of residents to administer medications to.Review of the physician orders for resident #106 on 1/15/26 revealed the following:Metformin 500 mg give 1 tablet by mouth two times a day for Type 2 Diabetes. Scheduled for 9:00 AM. Metformin is an oral diabetic medication that is used to help control high blood sugar levels.Eliquis 2.5 mg give 1 tablet by mouth two times a day for blood clot prevention. Scheduled for 9:00AMAspirin 81 mg 1 tablet by mouth one time a day for Heart Health.Amlodipine 5 mg 1 tablet by mouth one time a day for Hypertension (High Blood Pressure).Cetirizine 10 mg 1 tablet by one time a day for Congestion.Furosemide 40 mg 1 tablet by one-time for Edema.Metoprolol 25 mg 1 tablet by mouth two times a day for Hypertension. Scheduled for 9:00AMMultivitamin 1 tablet by mouth one time a day for SupplementOmeprazole 20 mg 1 capsule by mouth one time a day for GERD (Reflux)3. A medication administration observation was conducted on 1/15/26 at 10:45AM for resident #107. LPN #5 reviewed the computer screen as she poured medications for the resident. The computer highlighted a pink screen displaying the resident medication information for Protein Liquid 30 milliliter (ml), Amlodipine 2.5 mg, Metoprolol 25 mg (1/2 tab), Multivitamin with Mineral, Omeprazole 20 mg, Sodium Bicarb 650 mg 2 tabs, Vitron 65/125 mg. All the medications are displayed on the highlighted pink screen at the scheduled time of 9:00AM. LPN #5 administered resident #107's medications at 10:45 AM. She confirmed that the medications were (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given outside of the scheduled ordered time. Review of the physician orders for resident #107 on 1/15/26 revealed the following:Protein Liquid 30 ml by mouth two times a day for MalnutritionAmlodipine 2.5 mg by mouth one time a day for Hypertension (High Blood Pressure)Metoprolol 25 mg (0.5/1/2 tablet) by mouth two times a day for Hypertension with parameters.Multivitamins-Minerals 1 tablet by mouth one time a day for SupplementSodium Bicarbonate 650 mg two tablets by mouth two times a day for supplementVitron-C 65/125 mg 1 tablet by mouth one time a day for Anemia (lack of healthy red blood cells or hemoglobin resulting in reduced oxygen transport to organs)Omeprazole 20 mg 1 capsule by mouth one time a day for Reflux During an interview with the DON on 1/21/26 at 12:38 PM she was made aware of concerns identified during medication administration observations and she stated that the expectation is that when a medication is highlighted on the computer screen it alerts that the medication is outside of the scheduled time and the nurse is to notify the physician. She stated that education will be provided for staff.All concerns were discussed with the Administration Team at the exit conference on 1/23/26.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interviews with staff, it was determined that the facility failed to ensure the tube feed formula container and bag of flush was labeled. This was evident for 1 (Resident #65) out of 2 Residents reviewed for tube feeding during the facility's recertification survey. The findings include:On 1/15/2026 at 9:24AM, an observation of Resident #65 revealed that he/she was in the process of receiving enteral nutrition by means of tube feeding. During further observation of the tube feeding system, the Surveyor discovered that the facility failed to label the tube feeding formula container with the attached tubing with the resident's name, formula name/type, date/time hung, and administration rate/method. The facility failed to label the clear bag of flush with the resident's name, the volume and type of flush, and the date/time hung.A review of Resident #65's electronic medical record on 1/15/2026 at 12:00PM revealed the resident had a feeding tube for nutritional support due to medical condition. There were physician orders which included NPO (nothing by mouth), Enteral feed order for Jevity 1.5 CAL, Administer continuous via Pump 50ML per hour, Downtime 12PM-6PM, and Enteral feed order four times a day Flush 225ML, every 6 hours.During an interview conducted with Licensed Practical Nurse (LPN) #15 on 1/15/2026 at 12:30PM, the Surveyor was informed that the expectation is to label resident's tube feeding formula container, which includes the tubing, with the resident's name, the date/time hung, the name and type of formula, and the administration rate/method. The flush bag, which includes the tubing, should be labeled with the resident's name, the volume and type of flush, and the date/time. During a continued interview in Resident #65's room, the Surveyor expressed the concern that Resident #65's tube feeding formula container and bag of flush failed to be labeled. LPN #15 confirmed the Surveyor's findings. LPN #15 stated that the tube feed was hung at 6PM on 1/14/2026 and LPN #15 took it down at 12PM today per the physician's order. LPN #15 stated that the tube feed formula container and the bag of flush should have been labeled when it was hung at 6PM on 1/14/2026.On 1/15/2026 at 2:00PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #65's tube feeding formula container and bag of flush had not been labeled. The DON acknowledged the tube feeding formula container and the bag of flush should have been labeled.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview it was determined that the facility failed to ensure that Residents were properly assessed for the safe use of bedrails, obtain consent from the Resident or Resident Representative prior to use of bedrails, and obtain a physician's order for the use of bedrails. This was evident for 2 (Resident #15 and # 23) out of 8 Residents reviewed for accidents during the facility's recertification survey.The findings include:Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident's Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails.On 1/15/2026 at 8:55AM, the Surveyor observed Resident #15 in bed with black quarter sized bed rails raised at the top of the bed on both sides.On 1/15/2026 at 9:00AM and 1/20/2026 at 10:20AM, the Surveyor observed Resident #23 in bed with black quarter sized bed rails raised at the top of the bed on both sides. During an interview with the resident on 1/20/2025 at 10:20AM, the Surveyor was informed that the bed rails help him/her with repositioning themselves in bed.On 1/20/2026 at 1:38PM, a review of Resident #15's electronic medical record revealed a Bed Safety Evaluation assessment dated [DATE] which stated that no side rail use was recommended and a care plan created on 12/12/2025 with a focus, Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Right sided weakness decline of function and advanced dementia Hypertension, and an intervention for Bed rail(s) used as an enabler, created on 12/15/2025. Further review failed to reveal an updated Bed Safety Evaluation assessment, consent from the resident representative, or an order from the physician for the current use of bed rails.On 1/20/2026 at 1:45PM, a review of Resident #23's electronic medical record revealed a Bed Safety Evaluation assessment dated [DATE] which stated that bed rails were not indicated. Further review failed to reveal an updated Bed Safety Evaluation assessment, consent from the resident representative, or an order from the physician for the current use of bed rails.On 1/20/2026 at 1:50PM, a review of the facility's policy for Bed Rails, section 2.3 states to Obtain informed consent from the patient or, if applicable, patient representative, prior to installation using the Consent of Use of Bed Rails form that is part of the Bed Safety Evaluation; Maintain the Consent form in the patient's medical record. Section 2.4 states to Obtain physician or advanced practice provider (APP) order for use of a bed rail. A review of Resident #23's electronic medical record failed to reveal documentation of resident or resident representative consent or physicians order for the use of bed rails.On 1/21/2026 at 8:30AM, the Surveyor reviewed the concerns regarding the use of bed rails, Bed Safety Evaluation assessments, bed rail consent from the resident representative, and a physician order for bed rails with the Director of Nursing (DON).During an interview conducted with Unit Manager (UM) #7 on 1/21/2026 at 11:12AM, the Surveyor was informed that the facility utilizes quarter sized bed rails as enablers. The nursing staff will assess the residents for the use of bed rails as enablers and complete a Bed Safety Evaluation. The nursing staff would review the risks and benefits of bed rail use with the resident and/or resident representative, consent and a physician order would then be obtained.During a follow up interview with UM #7 on 1/21/2026 at 11:30AM, the Surveyor expressed the concern that bed rails were being used for Resident #15 and Resident #23 and there was no documentation of a Bed Safety Evaluation indicating use, no consent, and no physicians order for the use of bed rails. UM #7 stated Resident #15 had been discharged but would review their medical (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record. UM #7 stated that they spoke with the resident representative and explained the risk and benefits for using bed rails as enablers and obtained consent and a physician's order for quarter bed rails.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews with facility staff it was determined the facility failed to store biologicals in accordance with guidance and ensure that medications opened and refrigerated had a date opened label on it. This was found to be evident for medications found in 1 of 2 medication rooms (B wing) observed during the facility's survey. The Findings Include: An observation was made of a B wing medication room on 1/21/26 at approximately 9:00AM with staff # 3, a Registered Nurse (RN) present. While observing the medications that were stored in the refrigerator, the following concerns were identified: 1. An opened multidose bottle of Tuberculin Purified Protein Derivative with a written date label of 1/9/25 on the bottle. 2. An opened multidose bottle of Tuberculin Purified Protein Derivative that did not have a date label on the bottle indicating when the bottle was opened.Staff # 3 stated at that time that all medications are to be labeled upon opening. She went on to say that the medications are to be discarded after 30 days. On the same date the facility provided the survey team with a copy of pharmacy documentation guidance titled, Abridged List of Medications with Shortened Expiration Dates. Upon review, it revealed the following documentation: Tuberculin Tests 30 days after opening (Refrigerated).During an interview with the DON on 1/21/26 at 9:50AM she was made aware of the identified concerns. She stated staff are to adhere to the facility's policy and guidance and that required medications are to be dated upon opening and to discard all expired medications accordingly. All concerns were discussed with the Administration team at the exit conference on 1/23/26.