STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215297	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South River Rehabilitation and Wellness Center	144 Washington Road Edgewater, MD 21037

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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 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. Based on observations and facility staff interviews it was determined that the facility failed to maintain a safe clean comfortable homelike environment for Residents. This finding was found to be evident in review of Resident rooms on station 2 nursing unit of the facility during the annual recertification survey.The findings include:On 3/9/2026 at 8:30 AM during the initial tour of station 2 nursing unit several Resident rooms were observed with walls, doors, door frames, and sink counters in disrepair and in need of maintenance and repair. Observations included the following rooms: 211 - door/ doorframe marred, 212 - door/doorframe marred, 213 - wall/door marred, 214 - door marred, 215 - tile loose from wall around sink, 216 - door marred, sink counter warped, 217 - doors marred, 218 - tile missing around sink, marred door, no remote for television, 220 - door marred, 221 - wall marred, door marred with chipped wood, 222 - doorframe/ door marred, 225 - doors marred, 226 - doors marred, 227 - doors/walls marred, bedside dresser 2nd drawer not aligned on track, 228 - bathroom wall and door marred, and 230 - bathroom door marred with 2 holes in the wood, and peeling paint on the bathroom wall adjacent to the sink. The surveyor interviewed the Maintenance Director at 3:15 PM on 3/11/2026. The surveyor conveyed that several Resident rooms on station 2 nursing unit had doors and walls that were marred and chipped, sink counters that were warped and with loose tiles, and doors with chipped wood and holes in the wood. The Maintenance Director stated that he had a plan to repair the marred doors with some type of panel/plate guard on the lower half of the doors, but it takes money to repair the doors and there was a budget. The Maintenance Director accompanied the surveyor to station 2 nursing unit and observed several of the Resident rooms that were in disrepair and in need of repair and maintenance.On 3/13/2026 at 7:35 AM the Licensed Nursing Home Administrator was notified of the physical environment concerns (marred/wood chipped doors) that were observed on station 2 nursing unit.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to perform accurate Minimum Data Set (MDS) assessments. This was found to be evident for 3 (#3, #45, and #107) of 18 residents observed for coding accuracy of MDS assessments.The findings include:The MDS, is a federally mandated assessment tool, that helps nursing home staff members gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. Accurate MDS assessments ensure each resident receives necessary care. 1) On 3/9/2026 at 11:30 AM the surveyor observed Resident #45 who was sitting in wheelchair in Resident room with left arm in a sling. Resident #45 stated that he/she was going to physical therapy here at the facility because he/she fell at home and broke shoulder. The surveyor conducted a record review of Resident #45's medical record on 3/10/2026 at 2:20 PM. Review of the medical record revealed that Resident #45 fell in the walk-in closet at home and sustained a closed left scapular fracture. Further review of the medical record revealed that the 2/13/2026 Admission/Medicare – 5 Day Minimum Data Set (MDS) assessment Section J1800/1900 was coded that Resident #45 had falls since admission and that one fall was coded as no injury and that another fall was coded as major injury. Continued review of the medical record revealed that Resident #45 did not have any falls in the facility. In an interview with the Director of Nursing (DON) at 2:35 PM on 3/10/2026 the surveyor asked if Resident #45 had fallen in the facility and the DON stated that the Resident did not have any falls in the facility since admission. Resident #45 was admitted to facility from the hospital on 2/9/2026 with a fractured scapula. The DON was notified that Resident #45's Admission/Medicare – 5 Day MDS assessment was inaccurately coded for falls. The surveyor conducted an interview with the Lead Registered Nurse MDS Coordinator at 2:45 PM on 3/10/2026. The surveyor conveyed to the MDS Coordinator that Resident #45 did not fall in the facility since admission on [DATE] and that Resident was admitted with a fractured shoulder due to a fall at home. The surveyor reviewed Resident #45's 2/13/2026 Admission/Medicare – 5 Day MDS assessment with the MDS Coordinator and stated that the MDS assessment was coded that the Resident had 2 falls in the facility since admission, one fall with no injury and one fall with major injury. The MDS Coordinator acknowledged the surveyor and stated that the 2/13/2026 Admission/Medicare – 5 Day MDS was coded inaccurately for falls as Resident #45 did have any falls in the facility and further stated that she would complete a correction to the admission MDS as that was the facility's policy for inaccurate coding of MDS assessments. In a follow-up review of Resident #45's medical record on 3/10/2026 at 3:20 PM it revealed that there was a 2/13/2026 Modification of Admission/Medicare – 5 Day MDS assessment completed on 3/10/2026 at 2:52 PM Section J1800/1900 which was coded that Resident had no falls since admission. On 3/12/2026 at 7:52 AM the surveyor conducted a record review of Resident #107's closed medical record. Review of the medical record revealed that Resident #107 had 2 falls in the facility, one on 2/11/2026 with no injury and one on 2/16/2026 with injury (except major). Further review of the medical record revealed that there were the following MDS assessments completed: 2/1/2026 Admission/Medicare – 5 Day, 2/20/2026 End of PPS Part A Stay, 2/25/2026 Quarterly – (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	None PPS, and 2/28/2026 Discharge Return Anticipated. The 2/20/2026 End of PPS Part A Stay MDS Section J1800/1900 was coded that Resident #107 had a fall with no injury and had a fall with injury (except major) which would include the 2 falls on 2/11/2026 and 2/16/2026. However, further review of the MDS assessments revealed that the 2/28/2026 Discharge MDS was coded that Resident #107 had one fall with no injury and one fall with injury (except major). There was no documentation that Resident #107 had any additional falls in the facility. In an interview with the Director of Nursing (DON) at 11:30 AM on 3/12/2026 the surveyor reviewed Resident #107's falls. The DON confirmed that Resident #107 had only 2 falls, one on 2/11/2026 with no injury and one on 2/16/2026 with injury (except major). Additionally, the surveyor conveyed that the 2/28/2026 Discharge MDS was coded that Resident had 2 falls, however, these falls were already coded on the 2/20/2026 End of PPS Part A Stay MDS assessment. In a follow-up review of Resident #107's medical record on 3/12/2026 at 1:50 PM it revealed that there was a 2/28/2026 Modification of Discharge Return Anticipated MDS assessment completed on 3/12/2026 at 12:02 PM Section J1800/1900 which was coded that Resident had no falls since prior MDS assessment. At 3:10 PM on 3/12/2026 the surveyor reviewed with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA) and the Regional Director of Clinical Services the concern with Resident #107's falls and inaccurate coding on the 2/28/2026 Discharge Return Anticipated MDS assessment. 2) On 03/11/2026 at 9:11 AM, the surveyor reviewed Resident #3's Quarterly MDS assessment dated [DATE]. The assessment read: Section N - N0350 Insulin, A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. The number was 7. The electronic medical record did not contain any orders for insulin. The surveyor interviewed the MDS Coordinator on 03/11/2026 at 9:37 AM. When the surveyor questioned the coding, the Coordinator stated, I coded Ozempic as an insulin, but that is an error. I will prepare a modification now. On 03/11/2026 at 9:42 AM, the Administrator acknowledged the incorrect coding and stated it would be corrected.

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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 observations, staff interviews and surveyor record review it was determined that the facility failed to maintain sanitation practices in the kitchen and in the nursing unit nourishment refrigerator. This finding was found to be evident in review of the kitchen, service area and the nourishment refrigerator on the nursing unit. The findings include: On the initial tour of the kitchen and service area at 7:45 AM on 3/9/2026 with the Food Services Director (FSD) and District Manager the following were observed: in the dry storage room was a pair of shoes in a plastic recycle bag and 4 boxes of disposable gloves in a cardboard box under the storage rack in the corner on the floor in the walk-in freezer was a personal bag of lunch including a frozen entrée in the corner on the top shelf items on both sides of the service hall outside the kitchen – wheelchair, metal cart, maintenance cart and 3 cardboard boxes with bottles of chemicals directly on the floor The FSD on 3/9/2026 during this initial tour removed the shoes, boxes of gloves and personal bag of lunch from the kitchen walk-in freezer and the dry storage room. At 8:10 AM on 3/10/2026 with the Director of Nursing (DON) in attendance the nourishment refrigerator and freezer were observed on station 2 nursing unit. The following items were stored in the nourishment refrigerator not dated: take-out pizza box, plastic container of fruit, paper bag with food items inside, and disposable paper bowl with vegetables. The following items were stored in the nourishment freezer not labeled with name and date: a large chick filet milkshake cup with lid full of frozen substance, and a large McDonald's plastic cup with straw and lid 1/4 full of frozen substance. In an interview on 3/10/2026 with the DON during this observation, the surveyor asked what the expectation was for food items in the nourishment refrigerator and freezer. DON stated that the food items should be labeled with Resident name and dated. Additionally, the DON confirmed with the surveyor that only Resident food items were to be stored in the nourishment refrigerator and freezer. The surveyor reviewed the facility's Storage of Resident Food policies and standard procedures on 3/10/2026 at 9:25 AM. The policy indicated that refrigerators / freezers for storage of foods brought in by visitors will be properly maintained, daily monitoring for refrigerated storage duration and discard of any food items that have been stored for equal to or > than 7 days, and food not for immediate consumption will be properly contained and labeled for storage to be consumed at a later time. Additionally, the dietary staff will monitor refrigerator contents for food safety and reserve the right to dispose of outdated, expired, unsafe foods or otherwise foods unfit for consumption. No additional information was provided by the facility at the time of the survey exit.

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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 and interviews, it was determined that the staff failed to perform consistent hand hygiene in between resident interactions. This was evident for 2 (Staff #19 and #20) out of 2 staff observed during the medication administration task. The findings include: On 03/11/2026 at 7:25 AM, the surveyor observed LPN #19 administering medications to Rooms 121, 122 and 129. The surveyor noted that Staff #19 only performed hand hygiene after leaving room [ROOM NUMBER]. On 03/11/26 at 7:36 AM, the surveyor observed LPN #20 administering medications to rooms [ROOM NUMBERS]. The surveyor noted that Staff #20 only performed hand hygiene after leaving rooms [ROOM NUMBERS]. On 03/13/26 at 9:55 AM, [NAME] President of Infection Preventionist acknowledged the concerns.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews and surveyor record review it was determined that the facility failed to provide notification of room change when a Resident was transferred to another room in the facility. This finding was found to be evident in 1 (Resident #107) out of 10 Residents reviewed for notification of room change.The findings include:The surveyor conducted a record review of the closed medical record for Resident #107 on 3/13/2026 at 6:50 AM related to a complaint that was submitted online to the Office of Healthcare Quality (OHCQ). Review of the medical record revealed that Resident #107 was transferred from room [ROOM NUMBER]-A on station 2 nursing unit to room [ROOM NUMBER]-B on station 1 nursing unit on 2/4/2026. Further review of the medical record revealed that there was no documentation that indicated that Resident #107 and/or Responsible Party were notified of the room change.In an interview with the Director of Nursing (DON) at 8:38 AM on 3/13/2026 the surveyor conveyed that Resident #107 was transferred from room [ROOM NUMBER]-A to room [ROOM NUMBER]-B on 2/4/2026, and that there was no documentation in the medical record that Resident #107 and/or Responsible party were notified of the room change. The DON stated that she would look for the room change notification for Resident #107.In a follow-up interview with the DON at 9:20 AM on 3/13/2026 the DON stated that she was unable to locate documentation of notification of room change for Resident #107, but she was still looking for it. The surveyor asked what the expectation was for the facility to document notification of a room change to the Resident and/or Responsible Party. The DON stated that it was the expectation of the facility to notify the Resident and/or Responsible party of the room change and to document in the medical record the notification of room changes.At the time of survey exit no information was provided by the facility for notification of room change for Resident #107.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, it was determined that the facility failed to ensure that physicians and Responsible Party (RP)'s were notified of changes in a resident's condition. This was evident for 1 (Resident #6) of 1 resident reviewed for nutrition. The findings include: Center for Medicare and Medicaid (CMS) defines a significant unintentional weight loss as a loss of 5% of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days On 3/9/26 at 8:21 AM, the surveyor interviewed Resident #6. During the interview Resident #6 stated that he/she was not interested in his/her breakfast and only consumed the drinks. On 3/10/26 at 12:45 PM, the surveyor observed that Resident #6 did not eat his/her lunch but only drank the two juices. On interview Resident #6 stated that he/she did not like what was served for lunch. On 3/11/26 at 11:01 AM, the surveyor reviewed Resident #6's medical record. The review revealed that Resident #6 had been admitted to the facility in May of 2025 and on 6/2/25 Resident #6' attending physician assessed that Resident #6 lacked adequate decision making capacity. On further review it was noted that Resident #6 weighed 173 pounds (lbs) on 1/5/26 and weighed 155 lbs on 3/2/26. This was an 18 pound loss in less than three months, a 10.4 % weight loss. Next the surveyor reviewed a progress note written by a Dietitian that noted the weight loss and increased Resident #6's med pass (fortified nutritional shakes that provide supplemental calories and protein) from twice a day to three times per day along with increasing weights from monthly to weekly. The note stated that the interdisciplinary team was aware and that laboratory orders were done per providers. The surveyor reviewed the last provider note written on 2/20/26. There was no mention of monitoring weight loss, only a comment of, eating well, and a noted weight of 168 lbs dated 2/6/26. On 3/11/26 at 10:34 AM, the surveyor conducted an interview with Dietitian #15. During the interview the surveyor asked how providers are notified when a Resident has significant weight loss. Staff #15 stated that she discussed weight loss at the weekly risk meeting and that nurses and the medical director are made aware at that time. On 3/11/26 at 2 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked the DON what the process was for notifying the provider or RP when there is a significant weight loss. The DON stated that a change of condition note should be completed that documents the provider and RP were notified and the actions taken. The surveyor reviewed the concern that there was no documentation in Resident #6's medical record that indicated that the provider or the RP were notified that Resident #6 had a significant weight loss.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, it was determined that the facility failed to provide treatment and services to maintain hearing abilities. This was evident in 1 (Resident #81) out of 8 residents reviewed for vision and hearing during the recertification survey. The findings include:On 03/09/26 at 9:26 AM, the surveyor interviewed Resident #81 during the initial observation. The resident tapped their right ear and mouthed bed bath The resident had a journal on their bedside table and confirmed that they use it to communicate with staff. Resident #81 stated they have never worn hearing aids. Shortly after the interview, the resident's roommate reported that staff typically speak loudly when communicating with Resident #81. On 03/13/26 at 7:45 AM, the surveyor conducted another interview with Resident #81. During this interview, the surveyor typed questions for the resident to answer. The resident stated that the facility assessed their hearing well over a month ago and had not followed up. On 03/13/26 at 8:00AM, the surveyor performed a record review and discovered that the facility was aware of the resident's hearing loss. This was confirmed through various documentation found in the resident's Electronic Health Record (EHR). The onset date for unspecified hearing loss, unspecified ear was noted on 04/01/2025.The Treatment Administration Record (TAR) included a start date of 02/15/2024 for as needed consults with Audiology, Dental, Optometry, Ophthalmology and/or Podiatry. The resident's care plan was initiated on 02/16/2024 and revised on 10/21/2024, indicated that the resident was at risk for a communication problems and had poor hearing in the right ear.The quarterly Minimum Data Set (MDS) dated [DATE] noted that the resident's ability to hear was moderate difficulty. Resident #81 was referred on 01/05/26 by doctor due to a complaint of newly decreased hearing. On 01/08/26, the resident was evaluated by Audiologist. The clinical findings determined that both ears were non-occluded and that there was moderately severe to profound sensorineural hearing loss in both ears. The audiologist recommended hearing aids for both ears, and impressions were taken. A signed and dated note from the audiologist on 01/08/26 stated: Patient is eager for amplification to improve hearing in all situations. Improved hearing will allow patient to enjoy attending activities more frequently. Improved hearing will help the patient to hear and understand nursing staff or interactions. Improved hearing will help the patient become as independent as possible through improved understanding and safety.The audiologist's note included that the resident would need a medical consult to obtain medical clearance for the hearing aids. On 03/13/26 at 9:00 AM, the Unit Manager began addressing the concern.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, medical record review and interviews, it was determined the facility staff failed to clarify and document appropriate care measures to prevent complications from a hand contracture. This was evident for 1 (resident #10) of 1 resident reviewed for mobility. The findings include: A contracture is an abnormal shortening of muscle, tendons, skin, or tissues, causing the resistance to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. On 3/13/26 at 7:36 AM, the surveyor observed Resident #10 resting in bed. His/her left hand was noted to be contracted, and no splint was applied or visible in the room. Next the surveyor reviewed Resident #10's orders. The review revealed two orders for a left hand splint. The first order was written on 5/29/26 that stated, nursing to don (apply) left hand splint following morning Activities of Daily Living (ADLs). The patient should be able to remove following about 4 hours and to monitor skin integrity. The next order was written on 9/18/25 and stated, nursing to apply left hand orthotic following ADLs and again to monitor skin integrity. The surveyor reviewed Resident #10's Treatment Administration Record (TAR). The review revealed neither order was placed on the treatment record and no documentation of application and removal was present. On 3/13/26 at 8:30 AM, the surveyor conducted an interview with Unit Manager #14. During the interview the surveyor asked if Resident #10 had a splint. UM #14 stated that he/she did and it was applied for 4 hours a day. The surveyor asked if the application was documented in the medical records. UM stated it was documented in the TAR and would provide a copy. Next the surveyor reviewed the Occupational Therapy (OT) discharge summary note dated 9/19/25. The summary reported the patient's response and stated, Resident #10 reported decreased pain in the left hand/wrist during movement. It continued and stated that the patient demonstrated increased tolerance for left hand orthotic for more than 4 hours with no signs of redness or irritation. On this same day the newest order for the hand splint was ordered without the 4 hour limit. On 3/13/26 at 9:22 AM, the surveyor conducted a follow-up interview with UM #14. During the interview UM#14 stated that the order for the splint never appeared on the TAR and that there was no documentation to demonstrate the splint's application for Resident #10. The surveyor also reviewed the concern that there were two orders written and that there was no clarification as to what order should be followed. UM #14 stated she would clarify the order with therapy and that therapy usually communicates these changes with the Unit Manager at the time of the change.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interviews with staff, it was determined that the primary medical provider failed to review the total program of care for 1 (Resident #11) out of 43 residents reviewed during the survey. The findings include: On 3/9/26 at 8:38 AM, the surveyor interviewed Resident #11. During the interview Resident #11 stated that he/she had recently been admitted to the facility after a hospital stay and alleged that the facility was not following his/her transplant drug regimen correctly. On 3/10/26 at 8:01 AM, the surveyor reviewed Resident #11's medical record. Review of Resident #11's discharge paperwork revealed Resident #11 was discharged to the facility on 2/19/26. The medications were ordered as recommended, however, in the course of stay from the hospital report it was noted that Resident #11's renal function was improving and stable but recommended that Resident #11 needed to have repeat labs such as a Basic Metabolic Panel (BMP) in 1 week. The discharge instructions stated, Labs Needed at Rehab: followed by, please check hematocrit and BMP weekly on Mondays while at rehab. Next the surveyor reviewed the new patient note written by the provider on 2/20/25. The note acknowledged Resident #11's transplant and medications, however, no laboratory monitoring was mentioned or ordered. On 3/11/26 at 9:37 AM, the surveyor requested all laboratory orders for Resident #11 from the Director of Nursing (DON). On 3/11/26 at 2 PM, the surveyor conducted an interview with the DON. During the interview the DON confirmed that the only laboratory order written was for the lab that was to be drawn on 3/10/26. The surveyor reviewed the concern that Resident #11 had been admitted for over two weeks and never had the weekly labs that were recommended to be drawn while in rehab.

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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 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, interview, and record review, it was determined that the pharmacy failed to deliver the correct medication dosages to the facility. This was evident in 1 (Resident #95) out of 6 residents evaluated for accurate dispensing during the medication administration task. Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II—V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The findings include: On 03/11/26 at 8:00 AM, the surveyor observed a discrepancy between Resident #95's Diazepam order and the pharmacy script. The resident's active order stated: Diazepam 2mg tablet. Give 1.5 tablets by mouth in the morning for anxiety. Please hold for sedation, while the script stated: Diazepam 2 mg tablet. Give 1 tablet by mouth in the morning for anxiety. The tablets in the bubble packet were only available in one strength and form, consisting of whole 2 mg tablets. On 03/11/26 at 8:03 AM, the surveyor interviewed Staff #19. Staff #19 stated that they administered 1.5 tablets by splitting the available 2mg Diazepam tablets. On 03/11/26 at 12:20 PM, the surveyor interviewed a senior pharmacy technician at Pharmscript. The senior pharmacy technician confirmed that an active script was sent out and received on 03/03/26. Pharmscript reported that they are responsible for providing both partial and whole tablets for specific dosages, such as Resident 95's active order of Diazepam. The technician also reported that the former order was not picked up by the pharmacy and the new Diazepam was not delivered to the facility. The technician added that the delivery was anticipated later in the afternoon or evening. On 03/11/26 at 12:30 PM, the surveyor reviewed the facility's medication administration policy and controlled substances policy. The medication administration policy stated Do not split or alter tablets and Contact pharmacy for correct dosage. The controlled substance policy stated When the prescribed drug is discontinued, or the resident is discharged , the container and control sheet must be removed for drug destruction. Resident #95's 2 mg Diazepam bubble packet containing whole tablets and the corresponding control sheets were still present during medication administration on 03/11/26. On 03/11/26 at 12:45PM, the Unit Manager acknowledged the concerns.

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	215297	A. Building B. Wing	03/13/2026

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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 observation, record review and interview, it was determined that the facility failed to ensure that a controlled medication was labeled and stored properly. This was evident for 1 (Resident #95) out of 6 residents observed during the medication administration task. Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II—V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The findings include: On 03/11/26 at 8:00 AM, the surveyor observed a discrepancy in Resident #95's medication order. Staff #19 retrieved a bubble packet for Resident #95 labeled, Diazepam 2 mg tab. Give 1 tablet by mouth in the morning for anxiety. When the surveyor checked the order in the Medication Administration Record (MAR), the script on the medication bubble packet did not match the active order. The order on the bubble packet had been discontinued on 03/03/26, and the new order was initiated on 03/04/26. The active order was Diazepam 2mg. Give 1.5 tablets by mouth in the morning for anxiety. Please hold for sedation. The surveyor interviewed Staff #19 to verify the resident's order. Staff #19 confirmed that the order was to give 1.5 tablets of Diazepam and stated they had already administered the dose to Resident #95. On 03/11/26 at 8:03 AM, the surveyor observed half a tablet that had been placed back into Resident #95's previously punctured bubble. Staff #19 confirmed that they returned half a tablet (1mg) of Diazepam to the punctured bubble. Staff #19 stated that Resident #95 did not have an updated order of Diazepam available. On 03/11/26 at 9:30AM, Staff #19 informed the surveyor that they wasted half a tablet of Diazepam that they initially returned to Resident #95's bubble packet. On 03/11/26 at 12:07 PM, the Unit Manager acknowledged the concerns.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #9) of 1 resident reviewed for dental services during the survey. The findings include: On 3/9/26 at 8:10 AM, the surveyor interviewed Resident #9. During the interview Resident #9 stated that he/she was still waiting for the facility to follow up on making an appointment for his/her bottom teeth. On 3/11/26 at 7:30 AM, the surveyor reviewed Resident #9's medical record. The review revealed that a dental consult note written on 9/11/25 stated that Resident #9 was seen for a tooth extraction. The note stated that the resident was not able to tolerate the procedure and stated the safest course would be extractions under General anesthesia in the hospital setting. The recommendations were to refer Resident # 9 to Oral and Maxillofacial Surgery OMFS at a local hospital. On further review a dental note was written by a dental provider that sees residents in the facility and was dated 11/3/25. The reason for the visit was the initial exam. The note recommended cleaning every 6 months and stated partial dentures reported missing at the hospital and would recommend Full Mouth Xray (FMX) to further evaluate teeth for extractions and dentures. Resident #9 was seen again on 1/2/26 by the inhouse dental provider for step 1 for dentures. The recommendations were for extractions of retained roots for 9 teeth and again for Full Mouth Xray (FMX) to evaluate teeth further. Resident #9 was seen again on 2/17/26 by the inhouse dental provider due to a request to be seen by the facility for extraction. The note stated that x-rays were not taken and that a successful extraction could not be guaranteed. The note stated the extraction attempts were not successful and after the procedure Resident #9 informed the provider he/she was referred to the hospital for extraction but there had been no follow-up. This provider also documented a referral for an oral surgeon. On 3/11/26 at 8:04 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor relayed the concern that the original recommendation for Resident #9 to be seen in a hospital setting for oral surgery care was not acted upon and after several visits by the in-house dental provider the same recommendation was made 6 months later. The DON stated she would look into the issue. On 3/11/26 at 9:35 AM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated that after the most recent visit the facility had been pursuing the oral surgery consultation for Resident #9 but agreed that they only started the process after the visit on 2/17/26 and not on the September recommendation which was 6 months prior. Additionally, no documentation was provided to demonstrate the requested x-rays had been completed even with several requests

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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 Resident and staff interviews, observations and surveyor record review it was determined that the facility failed to ensure that a Resident's food preferences, food intolerances and food allergies were followed. This finding was found to be evident in 1 (Resident #41) out of 8 Residents reviewed for food and nutrition services.The findings include:On 3/9/2026 at 11:15 AM Resident #41 stated to the surveyor that he/she had a food intolerance to dairy products, but he/she continues to receive dairy products on the meal trays.The surveyor conducted a record review of Resident #41's medical record on 3/11/2026 at 10:45 AM. Review of the medical record revealed that Resident #41 had an allergy to dairy products as indicated on the physician orders/order summary report. Further review of the Diet History/Food Preferences assessment completed by the Food Services Director (FSD) on 2/11/2026 revealed that Resident #41 had a food allergy/intolerance to dairy products.In an interview with the FSD at 12:15 PM on 3/11/2026 he stated that Resident #41 had a food preference not to receive dairy products and that this was indicated on the Resident's meal tray tickets.At 7:40 AM on 3/13/2026 the surveyor observed Resident #41 in bed eating his/her breakfast tray. Resident #41 had an 8 oz carton of whole milk on the breakfast tray. Resident stated that there was not supposed to be milk on the meal tray and that it was wasteful to have milk on the meal tray because he/she has a dairy intolerance and cannot drink the milk.The surveyor reviewed the meal tray ticket that was on Resident #41's breakfast tray and Milk - 8 oz was indicated on meal tray ticket. Additionally, the meal tray ticket indicated Resident #41's name, breakfast, and date of 3/13/2026.In a follow-up interview with the FSD at 7:45 AM on 3/13/2026 the surveyor conveyed that Resident #41 had a carton of milk on his/her breakfast tray and that the meal ticket on the breakfast tray had Milk - 8 oz indicated on it. The FSD reviewed the breakfast meal ticket and stated that it was incorrect, and that Resident #41 was not supposed to have milk on the meal ticket or on the meal tray.At 9:04 AM on 3/13/2026 the FSD provided the surveyor with a corrected copy of the breakfast meal ticket which did not have milk indicated on the meal ticket.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and facility staff interviews it was determined that the facility failed to ensure that garbage and refuse was maintained in a proper manner. This finding was found to be evident during the review of the outside dumpster area adjacent to the service hall during the annual recertification survey. The findings include: During the initial tour of the kitchen and the outside dumpster area of the facility on 3/9/2026 at 7:45 AM the surveyor with the Food Services Director (FSD) and District Manager in attendance observed the outside dumpster area. There were 2 trash dumpsters outside. One of the trash dumpsters did not have the attached lid closed on the dumpster. In an interview with the FSD on 3/9/2026 the surveyor asked what the expectation was for the lid being closed on the trash dumpster. The FSD stated that the dumpster should have the lid closed. The FSD closed the lid to the trash dumpster. At 2:10 PM on 3/11/2026 the surveyor observed that the door to one of the trash dumpsters outside the facility was opened. There were no staff in attendance at the outside dumpster area. On 3/11/2026 at 3:10 PM the surveyor observed with the Maintenance Director the door opened to one of the outside trash dumpsters. The Maintenance Director called out to the FSD who was outside to close the trash dumpster door. The Maintenance Director stated that the staff recently took trash out to the dumpster and did not close the trash dumpster door.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and facility staff interviews it was determined that the facility failed to have call lights accessible for Residents. This finding was found to be evident in 2 (Resident #18 and Resident #75) out of 28 Residents reviewed for accessibility of Resident Call System.The findings include:Resident Call System (or nurse call systems) are essential safety communication tools in nursing homes, enabling Residents and families to alert staff via push-button stations or pull cords. The call station is fixed units in rooms, bathrooms or common areasDuring tour of station 2 nursing unit on 3/9/2026 at 10:15 AM the surveyor observed the attached pull cord/string to the call light device panel next to the toilet in Resident #18's shared bathroom that was short in length. The call light device was not accessible to Resident #18 if he/she was on the floor. Resident #18 was not in his/her room or the bathroom.Additionally, on 3/9/2026 at 12:30 PM the surveyor observed that there was no pull cord/string attached to the call light device panel next to the toilet in Resident #75's shared bathroom. Resident #75 was asleep in bed. In an interview with the Maintenance Director on 3/11/2026 at 3:15 PM the surveyor toured station 2 nursing unit with the Maintenance Director. The surveyor asked what the expectation was for call lights in the Resident bathroom and he stated that the Resident bathrooms should have a call light accessible for the Residents. The Maintenance Director observed the short cord for the call light device in Resident #18's shared bathroom, and no cord for the call light device in Resident #75's shared bathroom. The Maintenance Director stated that he would replace the short cord on the call light device in Resident #18's bathroom, and that he would attach a cord to the call light device in Resident #75's bathroom.On 3/13/2026 at 8:15 AM the surveyor toured station 2 nursing unit and observed that Resident #18 and Resident #75 had accessible pull cords to the call light device panels in each of their bathrooms.