STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215307	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Egle Nursing Home	57 Jackson Street Lonaconing, MD 21539

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews and interviews, it was determined that the facility failed to provide residents or resident representatives with written notice of transfer. This was evident for 1 (Resident #66) of 2 residents reviewed for hospital transfers.The findings include:On 10/06/25 at 4:10 PM, the Surveyor conducted a closed record review for Resident #66 related to a hospital transfer. A progress note dated 9/24/25 documented that staff heard a loud thump and found the resident (#66) on the bathroom floor. It was determined that the resident had fallen and was transferred to the hospital following an assessment. There was no documentation indicating that a written transfer notice or summary had been provided to the resident or the resident's representative.On 10/07/25 at 8:39 AM, the Surveyor conducted a second review of the resident's medical record and was unable to locate any evidence that transfer information had been provided to the resident or resident representative.During an interview on 10/07/25 at 8:59 AM, the Surveyor asked the Director of Nursing (DON) whether written notice of transfer was provided to residents or their representatives. The DON stated that she was unsure if written notices were provided but would investigate it and follow up with the Surveyor.On 10/07/25 at 9:38 AM, the DON returned to the Surveyor and stated that the facility's current process is not to provide transfer notices in writing. The DON then asked the Surveyor what the process should be. The Surveyor informed the DON that while the facility may develop its own internal process, the regulation requires that residents or their representatives receive written notice of transfer. The DON confirmed that there was no record to support that Resident #66 or her representatives were notified in writing of the hospital transfer. On 10/08/25 at 10:25 AM, the Surveyor spoke with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to address the concern that written transfer notifications were not being provided to residents or their representatives. The NHA stated that they had begun to correct the process since the Surveyor had brought the concern to the DON's attention.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, record reviews, and interviews, it was determined that the facility failed to identify Lap Buddy as a physical restraint, assess the resident for its use, and provide ongoing monitoring and evaluation for its continued use. This was evident for 1 (Resident #26) or 1 resident reviewed for physical restraints. The findings include:A lap buddy is a cushion placed in a resident's wheelchair between the armrest and in front of the resident. A lap buddy is considered a physical restraint when it is attached to a wheelchair, preventing a resident from moving freely in the chair or getting up, and it cannot be easily removed. An observation on 10/1/2025 at 11:13 AM, noted Resident #26 sitting in a wheelchair by his/her bedside, with a lap buddy in front of him/her. The resident was attempting to remove it but was unable to do so. Another observation of Resident #26 later that day showed that s/he remained in the same position, sitting in the wheelchair with the lap buddy in front of him/her. The observation failed to show opportunities for repositioning or release of the lap buddy for mobility. The resident was observed pulling at the lap buddy and trying to remove it.A subsequent observation of Resident #26 on 10/8/2025 at 8:23 AM showed that s/he was sitting in his/her wheelchair, and a lap buddy was in place in front of him/her. On 10/8/2025 at 10:34 AM, Resident #26 was observed in his/her room with staff #17, a Geriatric nurse aid present. The resident was sitting in a wheelchair with a lap buddy in front of him/her. Staff #17 reported that the lap buddy was there to remind Resident #26 not to stand up. Staff #17 also added that most of the time, Resident #26 attempted to take the lap buddy off but was only successful in removing the Velcro around the cushion, leaving the device in place. Resident #26 was asked to remove the cushion at the time and could not. The resident said to staff #17, You didn't have me trained on that. A review of Resident #26's record indicated that s/he was alert but had severe cognitive impairment due to the diagnosis of Dementia.A subsequent review on 10/8/2025 at 8:23 AM included a Post Fall Assessment completed on 9/20/2024 for Resident #26. The assessment indicated that the resident had a fall on 9/13/24. A recommendation for a lap buddy on [W/C-wheel chair] when up and [out of bed] for safety due to repeated attempts to stand from w/c unassisted was given. A review of the facility's restraint policy contained a notation that Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints.Further review of Resident #26's attending provider's orders included an order for a lap buddy for safe positioning and stability while seated. However, the review failed to identify Lap Buddy as a restraint. It did not include a pre-restraining assessment of Resident #26 regarding its use.Continued review of the facility's policy on restraint stated that Restrained residents must be repositioned at least every two (2) hours on all shifts. However, earlier review of Resident #26's record lacked documentation for ongoing monitoring, including repositioning at least every two hours.In an interview on 10/8/2025 at 11:46 AM, Staff #18, an occupational therapy assistant, stated that a recommendation was made for the use of a Lap Buddy for Resident #26 after his/her fall on 9/13/24. Staff added that no specific assessment was completed for its use as a restraint, as s/he was not on the case load for therapy.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and staff interviews, it was determined that the facility failed to ensure a resident's medication regimen was free from unnecessary psychotropic medication use by failing to adequately monitor a resident for behaviors, side effects, or adverse consequences related to antianxiety medication use. This was evident for 1 (Resident #8) of 5 residents reviewed for unnecessary medications.The findings include:A review on 10/3/2025 at 11:46 AM of Resident #8's Medication administration record (MAR) and Treatment administration record (TAR) from August to October 7, 2025, showed that Resident #8 had received antianxiety medication daily for anxiety.Continued review of Resident #8's plan of care included interventions for psychotropic drug use that stated, Monitor and record drug use effectiveness, side effects, and adverse consequences and Monitor for behaviors per protocol. Quantitatively and objectively document behaviors.However, the review lacked evidence that the facility staff monitored Resident #8 for changes in behaviors that necessitated the use of the antianxiety medications or for side effects related to the use of the medicines.In an interview on 10/7/2025 at 4:01 PM, staff #20, a registered nurse, reported that staff documented behaviors and side effects related to psychotropic medication use in the MAR or Treatment Administration Record (TAR) for all residents. However, earlier record review for Resident #8 lacked documentation for monitoring adverse effects and behaviors for the use of antianxiety medications.In an interview on 10/7/2025 at 4:20 PM, the Director of Nursing (DON) stated that she expected her staff to monitor every resident on psychotropic medications for side effects and behaviors every shift. The DON checked Resident #8's MAR and TAR at that time. She confirmed that the record lacked documentation for monitoring Resident #8's behaviors and side effects for the use of the antianxiety medications.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate an injury of unknown origin. This was evident for 1 (Resident #69) out of 1 facility-reported event (#361395) reviewed for abuse.The findings include:Resident #69 has Alzheimer's disease, dementia, and muscle wasting and weakness.On 10/02/25 at 1:43 PM, the Surveyor reviewed the facility-reported investigation (FRI #361395) which revealed that on 8/31/24 the resident was discovered sitting in their wheelchair with their right leg in an unnatural position. The resident was examined, and a fracture was suspected. Due to the resident's inability to vocalize what had occurred, this was deemed an injury of unknown origin. The resident was transferred to the hospital, and later that night the hospital confirmed a right hip fracture requiring surgical intervention.Further review of the facility's documentation revealed that the facility interviewed all staff members involved in the resident's care. Staff reported that the resident had remained in their room all day due to the roommate's COVID-19 diagnosis. Security footage confirmed that the resident remained in their room throughout the day on 8/30/24. However, there was no evidence that any facility residents had been interviewed as part of the investigation.On 10/06/25 at 3:01 PM, the Surveyor interviewed the Director of Nursing (DON) and asked about the process for investigating injuries of unknown origin. The DON stated she reviews the staff schedule for the previous 24 to 48 hours to determine which staff to interview and then asks if they had any knowledge of the incident or observed any changes in the resident, such as grimacing.When asked what she considered a thorough investigation, the DON stated it would involve talking with all staff to try to determine what happened. The Surveyor asked if residents were ever interviewed, and the DON stated she might interview cognitively intact residents who were in the same social circle as the resident in question.The Surveyor then asked the DON to review the investigation file for Resident #69 and identify whether any residents had been interviewed. The DON stated that the roommate could not be interviewed due to medical conditions affecting cognition and acknowledged that it did not occur to her to interview other residents. The Surveyor expressed concern that without interviewing other residents, the facility could not rule out possible abuse or determine whether staff handling may have contributed to the injury. The DON acknowledged that interviewing other residents would have been an important step in ensuring that abuse was not a factor and could have helped determine what had occurred.On 10/08/25 at 10:25 AM, the Surveyor interviewed the Nursing Home Administrator (NHA) and DON to discuss concerns identified during the survey process. The NHA stated that the DON had informed him of the findings after the Surveyor raised the concern, and that they were working on improving the investigation process.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments for residents within the regulatory time frames to facilitate appropriate care planning and maintain current and accurate assessment records. This was evident for 2 (#8, #61) of 34 residents reviewed during the recertification survey.The findings include:The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. The admission MDS assessment is a comprehensive assessment for new residents and, under some circumstances, returning residents. It must be completed by the end of day 14, considering the date of admission to the facility as day 1.1) A review on 10/2/2025 at 10:05 AM of Resident #8's admission MDS assessment with ARD 3/18/2025 revealed that Resident #8 was admitted to the facility on [DATE]. A continued review of the MDS assessment showed that it was to be completed on 3/24/2025. However, it was completed and signed in sections V0200B2 and Z0500B on 4/4/2025, day 25, after Resident #8's admission to the facility, and it was eleven days late. 2) A review on 10/2/2025 at 10:15 AM of Resident #61's admission MDS assessment with ARD 6/20/2025 contained an admission date of 6/16/2025. Further review of Resident #61's MDS assessment found that it had to be completed on 6/29/2025. However, it was completed and signed in section V0200B2 on 7/1/2025, which was day 16 after Resident #61's admission to the facility and two days late.In an interview on 10/9/2025 at 10:06 AM, staff #7, an MDS nurse, confirmed that the admission MDSs for both Residents #8 and #61 were completed late.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment for a resident within the regulatory time frames to facilitate appropriate care planning and maintain the current assessment record. This was evident for one (Resident #61) reviewed during the recertification survey.The findings include:The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. The Quarterly assessment must be completed within 92 days of the MDS Completion Date of the last OBRA assessment. It must also be completed no later than 14 days after the ARD, which is the date of the ARD plus 14 days. The last day of the observation period is the Assessment Reference Date (ARD). This date provides a common reference point for all team members participating in the assessment. A review of Resident #61's record showed that s/he had been residing in the facility since June 2025. The resident's admission MDS dated [DATE] was completed on 7/1/2025. The resident's following MDS assessment was to be completed by 9/20/25. However, the review failed to show that the facility staff had completed and submitted a quarterly MDS for Resident #61 as of this review on 10/7/2025, making it 109 days since the last OBRA MDS assessment was completed. During an interview on 10/9/2025 at 8:28 AM, staff #6, an MDS nurse, said that she missed completing Resident #61's quarterly MDS assessment, which was scheduled for 9/23/2025.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were accurately recorded. This was evident for one (Resident #2), who was reviewed for Resident Assessments during the survey.The findings include:The MDS (Minimum Data Set) is a complete assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need.A review of Resident #2's medical record included an MDS assessment dated [DATE]. The MDS assessment had recorded anticoagulant drug use during the MDS observation period for Resident #2.Continued review of Resident #2's medication administration record (MAR) for August 2025 showed documentation of antiplatelet use during the observation period of Resident #2's MDS assessment dated [DATE]. However, the MAR had no documentation on anticoagulant use. This means that Resident #2's MDS assessment dated [DATE] failed to document the use of antiplatelet medication during the look-back period. Instead, it recorded anticoagulant drug use, even though Resident #2 did not receive anticoagulation during the observation period. In an interview on 10/3/2025 at 9:38 AM, staff #6, an MDS nurse, said that anticoagulant use was recorded in error on Resident #2's MDS dated [DATE]. Staff #6 also stated that antiplatelet use should have been documented on the MDS as the Resident received aspirin during the observation period of the MDS assessment. Staff added that she would correct the MDS assessment for Resident #2.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to provide activity programs to meet residents' needs and preferences. This was evident for 1 (#8) of 2 residents reviewed for Activities.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure each resident receives the necessary care.Observation on 10/1/2025 at 2:54 PM showed Resident #8 lying in bed and not involved in any activity.A subsequent observation on 10/2/2025 at 9:55 AM showed Resident #8 lying in bed, not involved in any activity, and calling out, Help me, help me.A record review for Resident #8 on 10/3/2025 at 2:03 PM showed that his/her diagnoses included Dementia and had severe impaired cognitive status.Further review included an MDS assessment dated [DATE] for Resident #8, which had recorded his/her Activity Preferences. The review showed that it was very important to Resident #8 to listen to music s/he likes and to go outside for fresh air when the weather is good.A review of activity logs for Resident #8 for August 1 - September 30, 2025, was completed. The review showed that the activities provided to the resident included 1:1 visits, family visits, and music.The review failed to show that Resident #8 was involved in activities, such as going outside to get fresh air when the weather was good, which were previously documented as his/her activity preferences on his/her MDS assessment. In an interview on 10/7/2025 at 11:03 AM, staff #21, the Activity Director, expressed understanding of the concern and stated she would add more outdoor activities when the weather was good.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record reviews, observations, and interviews, it was determined that the facility failed to ensure residents with pressure injuries receive appropriate services for treatment and prevention. This was evident for 1 (Resident #43) of 2 residents reviewed for pressure injuries.The findings include:Resident #43 had been a resident of the facility since 2023 with diagnoses that include dementia, muscle wasting, and adult failure to thrive.A review of the facility matrix document provided by the Director of Nursing (DON) was conducted on 10/1/25 at 3:41 PM. The document indicated that Resident #43 had a pressure injury/ulcer.Resident #43 was observed on 10/6/25 at 10:11 AM. During the observation, the resident was sleeping in bed equipped with an air mattress. The control for the air mattress was located at the foot of the bed and was observed to be set on the max weight setting of 450 lbs.A review of Resident #43's medical record was conducted on 10/6/25 at 10:43 AM. The review revealed no documentation to indicate that the resident's weight had been taken for 2025. The resident's medical orders or care plan also did not indicate what the air mattress weight setting should be on.The charge nurse for the 2nd floor unit, a Licensed Practical Nurse (LPN #1) was interviewed on 10/6/25 at 11:06 AM. During the interview, LPN #1 confirmed that Resident #43 had a pressure ulcer and was using an air mattress as a pressure reducing device, as one of the interventions to treat and prevent pressure ulcers. LPN #1 was asked how the facility ensures that air mattresses are appropriate and functioning properly. She reported that the nursing staff checks at least every shift that the bed is functioning and that it was not deflated. She further explained that whenever an air mattress is ordered for a resident, a maintenance staff member is the one responsible for setting the bed up for the resident. She was also asked, who gives the maintenance staff instructions on how to setup the air mattress, and she stated, I don't know.On 10/6/25 at 11:23 AM, an observation of Resident #43 was conducted with LPN #1. During the observation, she reviewed the controls of the air mattress and stated, S/he is definitely not 450 lbs. We definitely have to fix that.On 10/6/25 at 12:01 PM, the maintenance lead (Staff #3) was interviewed about the use of air mattresses. He reported that he brings the air mattresses up to the resident's bed and ensures that it is functioning properly with no leaks. He further explained his process, noting that all air mattresses are inflated to max firm setting to ensure that they fully inflate with no leaks. Then he informs the nurses on the floor that the mattress is ready and can be adjusted to the resident's individual needs. Staff #3 stated, I don't know every resident medical condition so I don't know if they need it at full or what setting it should be (referring to the weight setting of the air mattress).On 10/8/25 at 10:02 AM, Resident #43 was again observed sleeping in bed and the air mattress was set at 130 lbs.The nurse assigned to the 2nd floor unit (LPN #15) was interviewed on 10/8/25 at 10:06 AM. She indicated that she had been working for the facility for almost 9 years. LPN #15 was asked about her process when a resident gets an order for air mattress. She stated, since I've been here, I have not done anything for settings with the air mattress. As far as I know, maintenance staff is the one who sets it up and brings it up here. LPN #15 was asked about Resident #43 and she indicated that due to the resident's condition, they have not taken the resident's weight. LPN #15 was asked, how do you know that Resident #43's air mattress setting is appropriate for his/her weight, and she stated, To be honest, I don't know.On 10/8/25 at 10:45 AM, the DON was interviewed in the presence of the Nursing Home Administrator. The finding was discussed with both staff that a resident using an air mattress was not assessed and monitored to ensure appropriate settings like weight setting, was instituted to treat and prevent pressure injuries/ulcers. The DON indicated that the facility would be doing an audit to ensure resident weights match the mattress setting. Both staff verbalized understanding that overinflated beds put residents at risk for pressure injuries and/or falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure urine collection bags were secured and off the floor. This was evident for 1 (Resident #4) of 1 resident reviewed for urinary catheter.The Findings include:Resident #4 was admitted into the facility in mid-2025 with diagnosis that includes urinary retention.Urinary retention refers to the inability to completely empty the bladder, resulting in the accumulation of urine in the body. Treatment includes but is not limited to Catheterization.An intermittent (straight) catheter is inserted through the urethra into the bladder to empty it, then removed.An indwelling urinary catheter is inserted in the same way as an intermittent catheter, but the catheter is left in place. The catheter is held in the bladder by a water-filled balloon, which prevents it from falling out. These types of catheters are often referred to as Foley catheters.A Foley catheter is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons. Another name for a Foley catheter is an indwelling urinary catheter.Securing a urine collection bag is crucial to prevent leaks, reduce the risk of infection, and ensure proper catheter function, as well as prevent damage to the bladder neck or urethra.On 10/1/25 at 10:47 AM, Resident #4 was observed in bed with his/her urine collection bag laying directly on the floor.The finding was discussed with the Licensed Practical Nurse (LPN #19) who was assigned to care for Resident #4 on 10/1/25 at 11:07 AM. LPN #19 checked on the resident and stated, Oh you're right, its laying on the floor (referring to the urine collection bag). Staff then walked into the resident's room and secured the bag on the resident's bed frame.On 10/9/25 at 9:26 AM, a review of Resident #4's care plan for the use of an indwelling catheter had interventions that includes, do not allow tubing or any part of the drainage system to touch the floor.In an interview with the Director of Nursing (DON) on 10/9/25 at 11:40 AM, the concern was discussed that facility staff had failed to secure a resident's urine collection bag off the floor. The DON verbalized understanding and acknowledged the concern.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record reviews and interviews, it was determined that the facility failed to complete the residents' Matrix accurately. This was evident during the recertification survey. The findings include:The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents. The facility completes the resident name, resident room number, and corresponding care categories. All information entered on the form should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of the survey.After the initial entry to the facility for this survey on 10/1/25, the director of nursing (DON) presented a complete matrix for all the residents to the survey team.A review of the Matrix showed that there was no resident receiving end-of-life care/Comfort Care, /Palliative Care. However, a review of Resident #4's medical record included an attending provider's note dated 9/30/25, stating that Pt [patient] seen. Pt is found to be in terminal condition.Further review included a care plan focus for Resident #4 titled Terminal/End stage condition created on 9/30/25.In an interview on 10/2/2025 at 1:30 PM, the DON mentioned she was unsure why the information about Resident #4's end-of-life care did not transfer from the electronic health record to the Matrix. The DON confirmed that Resident #4 was receiving end-of-life care and should have been reflected in the residents' Matrix.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to ensure that resident records were accurate. This was evident for 1 resident (Resident #12) who had duplicate and contradictory active Medical Orders for Life-Sustaining Treatment forms of 2 residents reviewed for advance directives.The findings include:A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient.The Maryland MOLST form includes a third page with instructions and states, in part, the MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form. Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.On [DATE] at 9:30 AM a review of Resident #12's electronic record revealed that there were three separate active MOLST forms in the scanned records portion of the resident's electronic chart. Two of the MOLST forms were identical but the third MOLST form was different. The MOLST form dated [DATE] was completed to indicate that the resident should have CPR, and the 2nd and 3rd MOLST forms - duplicates which were dated [DATE] - were completed to indicate that the resident should not have CPR.On [DATE] at 9:45 AM a review of Resident #12's paper chart revealed paper copies of the same three MOLST forms found in the electronic record. In an interview with unit nurse (Staff #15), she confirmed the presence of duplicate and contradictory active MOLST forms in the resident's record. When asked how she would know whether the resident should have CPR or not, she said that if there was a discrepancy between two MOLST forms, she would honor the most current form. On [DATE] at 10:33 AM the Director of Nursing (DON) was interviewed to review the facility's process for MOLST form documentation, and she said that the Assistant Director of Nursing (ADON) was responsible for MOLST forms. The DON explained her understanding of the process of MOLST forms and indicated a line should be drawn through an inactive form but she did not state that the word void should be written on it, or that is should include a signature or date.On [DATE] at 11:10 AM an interview was conducted with the ADON (Staff #9) and she reviewed the facility's process for managing MOLST documents. When she was asked what to do when a resident's MOLST was updated, she said there should be a line drawn through the old document and it should be scanned into the electronic record. When asked if there were any other requirements, she said she was not sure. When asked if the facility had a policy for MOLST documents she said no. She confirmed that the facility did not have a specific process for voiding inactive MOLST documents.The surveyor showed Staff #9 the third page of a blank MOLST form found on the internet, which gave the directions for voiding inactive MOLST forms. Staff #9 said she said she thought she had seen this information before but it was not the current practice at the facility. She said she would follow up on it. On [DATE] at 11:47 AM the DON was interviewed, and she confirmed that the facility did not follow the proper process for inactive MOLST documents.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, it was determined that the facility failed to ensure that the required attendees participated in the facility's Quality Assessment and Assurance (QAA) committee meetings at least quarterly. This was evident in 8 out of 12 sign-in sheets reviewed during the survey.The findings include:A review of the sign-in sheets for the facility's Quality Assurance (QAA) Committee meetings from August 2024 to August 2025 was completed. The review revealed that meetings were held monthly. However, the review failed to show that the Nursing Home Administrator attended the meetings in November 2024, January 2025, April 2025, May 2025, and September 2025. The review also failed to show that the Director of Nursing attended the meetings in March 2025 and April 2025. An interview on 10/9/2025, at 10:51 AM, with staff #20, the current QA Nurse, and staff #6, the former QA nurse, failed to provide documentation confirming that all attendees were present in all meetings. By the time the survey ended, no additional evidence was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined that the facility failed to properly store clean linens. This was evident for 2 of 2 soiled laundry areas observed during the recertification survey.The findings include:On 10/02/25 at 9:44 AM an observation of the facility's laundry facilities was conducted with the Director of Housekeeping (Staff #7) and the laundry aide (Staff #8). The first area observed was the laundry room which on one side contained two washing machines (dirty area), and on the other side contained two dryers (clean area). There was no separation between the clean and dirty sides of the room. On the dirty side of the room, directly across from the washing machines was a cart with a pile of folded bed pads. When asked, Staff #7 said that they were clean and were ready to be taken to the nursing units for resident use. Staff #7 confirmed that the washing machine area was the dirty linen area in the room. Staff #8 confirmed that clean linens should not have been stored in the dirty linen area.Staff #7 and Staff #8 then showed the surveyor to separate dirty linen room across the hall and explained that the facility used a laundry service to wash the facility's sheets and towels. The dirty linen room was large and contained a large bin full of blue plastic bags which Staff #7 said contained dirty linens that were ready for pickup by the laundry service. There were also multiple smaller dirty linen bins in the room which Staff #7 said were used to pick up and transport dirty linens from the nursing units to the laundry area. On the back wall was an uncovered linen cart that had what appeared to be clean folded personal bedding linens on top. When asked, Staff #7 said that the linens stored uncovered on top of the cart were the clean personal linens of a resident who had passed away, and their linens would be donated, so they were stored there temporarily. When asked if the clean linens should be stored in the dirty linen room, she said no. Staff #8 also confirmed that the clean linens should not have been stored in the dirty linen room.On 10/06/2025 at 10:44 AM an interview was conducted with the facility's infection preventionist nurse (Staff #5) to review the finding that clean linens were stored in the dirty linen areas of the facility. She confirmed the finding and said she would be conducting training with the laundry staff.On 10/09/25 at 9:51 AM in an interview with the Director of Nursing to review the deficiency, she explained that there would be improvements made to the laundry area and the storage of linens.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview it was determined that the facility failed to maintain documentation of screening, education, offering, and current COVID-19 vaccination status. This was evident for 1 (Staff #16) of 2 staff reviewed for COVID-19 immunizations during the infection control task portion of the recertification survey.The findings include: On 10/02/25 during the entrance conference, a list of all employees was requested. Four staff were randomly selected from this list for health record review. Of the selected staff, two (Staff #10 and Staff #16) would have been eligible for the 2024-2025 version of the COVID-19 vaccine. On 10/06/25 at 2:29 PM ,a review of the health records provided by the facility for Registered Nurse (Staff #16) failed to reveal any evidence that she was screened, educated, or offered the 2024-2025 COVID-19 vaccine. On 10/07/25 at 10:38 AM, an interview with the infection preventionist nurse (Staff #5) was conducted. She stated that it was her understanding that the facility did not offer COVID vaccines to employees due to insurance reimbursement. She also stated that it was not the facility's practice to track employee's COVID-19 vaccine status, nor did the facility offer education on the COVID-19 vaccine. On 10/09/25 at 9:32 AM, Staff #5 provided a copy of the facility's COVID-19 immunization policy and procedure document, which was titled Policy on Resident and Staff COVID-19 Immunizations, Education, and Reporting. A review of the policy was conducted with Staff #5, and revealed two statements listed under the heading Procedures that read: 1) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;, and 2) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine. Staff #5 confirmed that the facility did not follow the regulation or their own policy regarding COVID-19 vaccines. On 10/09/25 an interview with the Director of Nursing was conducted to review the survey findings and she acknowledged the deficiency. No further evidence was provided by the end of the survey.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observations and interviews, it was determined that the facility failed to provide full visual privacy to a resident residing in a non-private room. This was evident for 1 (Resident #4) of 1 resident reviewed for privacy.The findings include:During the initial pool process on 10/1/25 at 10:56 AM, Resident #4's room was inspected. It was observed during the inspection that the room had two occupied beds, and both were equipped with a railing system for overhead privacy curtains. However, the curtain that was used for Resident #4's bed (window side of the room), when fully extended, only covered one side and left the foot side of the bed completely open.On 10/6/25 at 10:16 AM the charge nurse for the unit where Resident #4 resided, a Licensed Practical Nurse (LPN #1) was interviewed outside the resident's room. LPN #1 was asked how staff maintain privacy when incontinence care is provided to Resident #4. She indicated that she would use the overhead privacy curtain. LPN #1 was asked to demonstrate use of the privacy curtain in Resident #4's room. As LPN #1 pulled the curtain on the window side bed, she confirmed that it was not long enough to cover all sides of the bed. On 10/6/25 at 1:15 PM, the finding was discussed with the Director of Nursing (DON) and an inspection of Resident #4's curtain was conducted. The DON confirmed the finding and stated, it looks like we have enough railing and hooks, but the curtain needs to be longer.In a subsequent interview with the DON on 10/9/25 at 11:39 AM, she reported that the facility had ordered curtains that were 4 feet longer to provide full visual privacy.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interviews, it was determined that the facility failed to ensure that staff were educated on abuse. This was evident for 5 (Director of Nursing [DON] and Staff #10, #11, #12, and #13) out of 5 employee training records reviewed during the Sufficient and Competent Staffing task.The findings include: On 10/02/25 at 10:58 AM, the Surveyor reviewed the facility assessment (dated January 2025), Section 3.3 Staff Training/Education, which states:Employees at our facility require various levels of education, training, and certifications to be employed. Upon hire, the following non-exhaustive protocols are followed, which in part include that staff are, at a minimum, educated on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; the procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property; and care and management of persons with dementia and resident abuse prevention. On 10/02/25 at 2:06 PM, the Surveyor interviewed the DON and requested employee training records. The Surveyor asked whether staff completed abuse training, and the DON stated that abuse training is part of the annual education program. On 10/02/25 at 2:24 PM, the Surveyor reviewed the education records for five employees (the DON, Staff #10, #11, #12, and #13) and found no evidence of abuse training during onboarding or that any had received abuse training since February 2024—approximately 20 months prior. The DON also provided a document titled Egle Monthly Education, which listed completed topics and projected education for 2025; however, abuse training was not included. On 10/02/25 at 2:44 PM, the Surveyor spoke with the DON and expressed concern that the last abuse training occurred in February 2024 and was not listed on the 2025 education calendar. The DON confirmed the Surveyor's findings and stated that the social worker typically conducts abuse training but had been out of work, and it must have been missed. She further stated that she would add abuse training to the annual calendar and she confirmed that abuse training was not a part of the onboarding education. On 10/08/25 at 10:25 AM, the Surveyor spoke with the Nursing Home Administrator (NHA) and the DON to address concerns about the lack of abuse education. The DON reiterated that the social worker usually conducts that training but had been out on FMLA. The NHA and DON agreed that they need to develop a consistent education calendar to ensure that abuse training occurs at least annually and upon hire.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to ensure that nurse aides received in-service education that included dementia management and abuse prevention. This was evident for 2 (Staff #12 and #13) out of 5 staff reviewed under the Sufficient and Competent Staffing task.The findings include:Regulatory guidelines require that nurse aides receive a minimum of 12 hours of in-service education annually. These in-services must include training in dementia management and abuse prevention.On 10/02/25 at 10:58 AM, the Surveyor reviewed the facility assessment (dated January 2025), Section 3.3 Staff Training/Education, which states: Employees at our facility require various levels of education, training, and certifications to be employed. Upon hire, the following non-exhaustive protocols are followed, which in part include: Abuse, neglect, and exploitation training that at minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. Includes procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property, and care and management for persons with dementia and resident abuse prevention. Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year, which includes dementia training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, training must also address the care of the cognitively impaired. Caring for persons with Alzheimer's or other types of dementia. Caring for residents with mental and psychosocial disorders.On 10/02/25 at 2:06 PM, the Surveyor interviewed the Director of Nursing (DON) and requested employee training records. The Surveyor asked if staff completed onboarding and annual training. The DON stated that staff receive some training upon hire and participate in monthly one-hour courses. She stated that she maintains an annual calendar that includes scheduled and completed education. The DON provided a document titled [NAME] Monthly Education, which listed all training completed since January 2020 and the projected education through the end of 2025. The surveyor was unable to find evidence that dementia management or abuse training had been included in the nursing assistant training.On 10/02/25 at 2:44 PM, the Surveyor spoke with the DON and expressed concern that there was no documented evidence of training related to dementia management or abuse prevention. The DON confirmed the Surveyor's findings and stated that she would update the onboarding and annual calendar to include any missing education.On 10/08/25 at 10:25 AM, the Surveyor spoke with the Nursing Home Administrator (NHA) and the DON to address concerns that the facility did not include abuse and dementia training in its onboarding or annual education for nurse aides. Both the NHA and DON agreed that this would be corrected and that they were in the process of revamping the education program to ensure compliance with regulatory requirements.