STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215313	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Glade Valley	56 West Frederick Street Walkersville, MD 21793

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and review of pertinent documentation it was determined that the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to affect all residents. The findings include: 1)The initial tour of the kitchen began on 5/26/26 at 8:15 AM. During this tour of the kitchen surveyor observed, with the Food Service Director (FSD) #6, in the walk-in refrigerator a metal container with meat in it with plastic wrap covering the container. Written in marker on the plastic wrap was an expiration date of 4/25. FSD #6 reported this was a pork loin they had just recently cooked and then would cut off pieces to make pork chops. She indicated the date was in error since they had just recently cooked the pork loin. FSD #6 removed the item from the refrigerator and indicated she was going to throw it out. On 5/27/26 at 2:00 PM during a follow-up tour of the kitchen, FSD #6 confirmed that they do have a cooling log that is used when they prepare items in advance that need to be cooled. Review of this form revealed the following information: All cooked foods not prepared for immediate service must be cooled from 135* F to 70* F within two hours of preparation and from 70*F to 41* or colder within an additional four-hour period. No documentation was found on the cooling log provided about a pork loin. FSD #6 confirmed that there was no cool down log documented for the pork loin that was cooked on Saturday. The District Manager #7 then reported that they had a fill in cook on Saturday.2) On 5/27/26 review of the Record of Food Temperature policy, with a reviewed date of 10/27/25, revealed: When holding hot foods for service, food temperature should be measured when placing it on the steam table line.On 5/27/26 surveyor requested the tray line temperature logs for May 2026 from the FSD. On 6/1/26 copies of the temperature logs for the rest of May were obtained from District Manager #7.Review of these logs failed to reveal temperatures for the pureed or mechanical soft versions of entrees for multiple meals, including but not limited to:May 6 dinner entree; May 10 dinner entree; May 11 lunch entree; May 13 dinner entreeMay 15 lunch entree; May 16 dinner entreeMay 21 lunch entreeReview of the temperature logs for Saturday May 23 and Saturday May 30 failed to reveal documentation of items served for breakfast or lunch on those dates and therefore no documentation of the temperatures of any items served for those meals.Review of the temperature log for the 5/29/26 dinner meal revealed that hotdogs, hamburgers and baked beans were served but no documentation of temperatures of any of these items.On 6/1/26 at 9:40 AM surveyor reviewed the concern with the District Manager #7 regarding the missing temperatures for pureed items for several meals in May.3)On 5/27/2026 at 12:47 PM during observation of lunch service in the main dining room revealed the food was served restaurant style from a tray line in the dining room. In this tray line area was a refrigerator that when opened revealed a cardboard box that was wet on the bottom, sitting on top of a dirty washcloth. This box contained several individual cream cheese packets. District Manager #7 was present during this observation and indicated she would throw out the box of cream cheese. District Manager #7 went on to report they use the fridge in the adjacent kitchen area, however when surveyor opened the other door of the of the refrigerator in the tray line area surveyor observed that there were several cups of pudding with a label indicating they were from the day of the observation.There was a thermometer in the refrigerator at the time of (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the observation, and the current temperature was within acceptable range, however no documentation was found to indicate staff were regularly monitoring the temperature of this refrigerator. There was a book on the counter that was titled Main Dining Room Temps which revealed a refrigerator temperature log for January 2026, but no documentation was found for February, March, April or May 2026.On 5/27/26 at 5:18 PM surveyor observed the puddings in the Main Dining Room tray line refrigerator with the Director of Nursing (DON) who indicated they were used for the medication pass. Surveyor informed the DON of the concern regarding the failure to monitor the temperature of this refrigerator.4)On 5/26/26 at 9:13 AM Resident #2 reported that the cups always have stains on them.On 5/27/26 at 1:36 PM while walking down the hallway with the Nursing Home Administrator, surveyor observed clean coffee cups sitting open end down on a tray on top of a food delivery cart. A random check of the inside of the cups revealed two out of the three observed with significant stains. The NHA confirmed the observation and reported if they can't be cleaned they should be thrown out.5)On 5/26/26 at 8:21 AM FSD #6 reported the dishwashing machine provided heat sanitation. Observation of the machine revealed a temperature gauge that indicated the minimum temperature for the rinse cycle should be 180 degrees. FSD #6 then ran the dishwasher three times, the maximum temperature for the rinse cycle was 178 degrees. FSD #6 reported the service company was there on Friday (May 22) and indicated she would contact them about this issue.On 5/27/26 at 1:48 PM observation of the dishwasher temperature gauge during the rinse cycle revealed a maximum temperature of 178 degrees; this observation was confirmed by Dietary Worker #8. At 1:53 PM surveyor observed the dishwasher again, this time with the District Manager #7, who confirmed the rinse temperature did not reach 180 degrees. At approximately 2:30 PM District Manager #7 reported they have contacted the service company again and will be re-washing the dishes.On 6/1/26 at 9:16 AM surveyor observed the mechanical dishwasher was running and the wash temperature maxed at 145 degrees. District Manager #7 confirmed the wash temperature should be at least 150 degrees. At 9:49 AM staff indicated the temperature was now up and surveyor did observe that the wash temperature was now 180 degrees. Surveyor reviewed the concern with District Manager #10 that this was the surveyors third observation in the kitchen and there was an issue with the temperature of the dishwasher on each observation. Surveyor also observed that the area of the dishwasher directly above where the dishes leave the washer was not sealed. District Manager #10 was unable to clarify if this was tape or what the problem was with the unsealed area. At approximately 10:16 AM District Manager #10 reported they had contacted the service company regarding the area of the dishwasher above where the dishes exit the washer that was not sealed. Further observations on 6/1/26 at 10:16 AM revealed : where the exhaust vent for the dishwasher met the ceiling was not flush with the ceiling. 6) Further observations of the kitchen on 6/1/26 at 10:16 AM revealed: There was an area of the wall next to the three compartment sink that had two holes in the wall, one was approximately 1.5 x 0.5 inches and the other was approximately 1.0 inch by 0.5 inches. Additional damage to the drywall was also noted under the three compartment sink. There was also damage to the ceiling near the handwashing station of approximately two feet of paint splitting.On 6/01/26 at 11:00 AM surveyor reviewed with the Nursing Home Administrator (NHA) the concerns in the kitchen regarding the physical environment. NHA acknowledged the concerns and indicated that walls should be intact.7) During the initial tour of the kitchen on 5/26/26 the surveyor observed an area in the ice machine bin that was discolored. When asked about the cleaning schedule of the ice machine, FSD #6 indicated the maintenance department handles that. Surveyor requested documentation of the cleaning of the ice machine. On 5/27/2026 at approximately 12:50 PM surveyor observed an ice machine located in the kitchen area next to the main dining room. No documentation was found on or near this ice machine to indicate when, or if, the machine was being cleaned on a regular basis. On 6/1/26 at 9:24 AM when surveyor again asked about the cleaning schedule for the ice machine, the FSD #6 reported the maintenance department has the cleaning schedule for the ice machine and that she had asked them about it when surveyor first asked (last week) then forgot all about it.On 6/01/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 9:30 AM surveyor observed the discoloration in the ice machine bin with District Manager #7 and District Manager #10. Surveyor informed them due to this unusual observation surveyor had requested the cleaning schedule last week and none was received so far. Surveyor re-requested this documentation.On 6/01/26 at 11:00 AM surveyor informed the NHA that the dietary staff reported the ice machine cleaning schedule is handled by the maintenance department. The NHA reported the maintenance department does the quarterly check but the monthly cleaning is under the kitchen. Surveyor informed the NHA that FSD #6 had indicated this was completed by maintenance.On 6/01/26 at 11:18 AM Maintenance Director provided documentation to indicate they complete quarterly maintenance on the ice machine on 3/31/26. And reported it was his understanding that it is the dietary department that is cleaning the machines weekly. He went on to report that this cleaning would require food safe chemicals.Review of the facility's policy regarding Ice revealed under Procedures: 2. The Dining Services Director will coordinate with the Maintenance Director to ensure that the ice machine will be disconnected, cleaned and sanitized quarterly and as needed, or according to manufacturer guidelines; 3. The exterior of the machine will be cleaned weekly; 4. Ice bins will be cleaned monthly and as needed. On 6/1/26 at 11:55 AM District Manager #10 reported that it was his understanding in this facility maintenance is responsible for cleaning the ice machine. Surveyor reviewed the concern that the maintenance department is only cleaning the machine monthly. As of time of survey exit on 6/1/26 at 5:00 PM no documentation was provide to indicate either of the facility's two ice machines was cleaned in April or May of 2026.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to ensure linens were processed in a manner that prevents cross contamination. This deficient practice had the potential to affect all residents of the facility. The findings include:On 5/28/26 at 12:20 PM, Laundry aide (Staff #27) explained her process as she demonstrated processing soiled linens. Staff #27 donned appropriate PPE while sorting and loading the washer with soiled linens. However, after doffing the washable gown and hanging it on the hook beside the sink, she proceeded to the clean side of the laundry room and started to fold clean linens.On 5/28/26 at 12:40 PM, Staff #27 was invited back to the soiled area of the laundry room. The account manager (Staff #28) followed into the soiled area of the laundry room. The observation of Staff #27 not performing hand hygiene before going into and folding clean linens was discussed with both staff. Staff #27 acknowledged and washed her hands. Staff #28 indicated that she would re-educate Staff #27 as it was part of her initial training.

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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 interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately documented. This was evident for 3 (Residents #106, #5, #54) out of 6 Residents reviewed for Resident assessment. The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility with the necessary information to develop a care plan, deliver appropriate care and services to the Resident, and modify the care plan based on the Resident's status. 1) A review of Resident #106's medical record on 5/27/26 at 1:57 PM included an occupational therapy (OT) evaluation and plan of treatment dated 2/24/26, noting that the Resident had a limited range of motion (ROM) in all extremities. However, further review of Resident #106's MDS assessment dated [DATE] showed one-sided impairment in the resident's upper- and lower-extremity ROM. During an interview with staff #30, the regional therapy director, on 5/27/26 at 12:36 PM, she was asked whether Resident #106 had any impairment in his/her range of motion and responded that, per the OT evaluation, Resident #106 had an impairment affecting both sides of his/her upper and lower extremities. In a subsequent interview on 6/1/26 at 11:47 AM, staff #31, an MDS nurse, reported that her process for assessing a resident's limited ROM involved observing and reviewing physical and occupational therapy documentation. Staff #31 reviewed Resident #106's OT evaluation dated 2/24/26 and confirmed that Resident #106's MDS dated [DATE] should have been recorded with an impairment in range of motion across all extremities. 2) A record review on 5/29/26 at 2:48 PM for Resident #5 contained an MDS assessment dated [DATE], which recorded that the Resident had an indwelling Foley catheter and received an insulin injection during the assessment observation period. A continued review of Resident #5's medication administration and treatment record for April 2026 found no evidence of insulin use or of an indwelling Foley catheter during the observation period for the 4/23/26 MDS assessment. The review also found no attending provider's order for insulin or for an indwelling Foley catheter during the observation period. During a follow-up interview on 6/1/26 at 11:12 AM, staff #31 and #32, both MDS nurses, confirmed that insulin and indwelling Foley catheter use were recorded in error on Resident #5's MDS dated [DATE]. 3) A review of Resident #54's MDS assessment dated [DATE] showed that it documented a YES for anticoagulant use during the assessment observation period. Further review of Resident #54's March 2026 medication administration record showed no documentation of anticoagulant use during the assessment observation period. Continued review of Resident #54's order summary as of 3/31/26 failed to identify an attending provider's order for anticoagulant use during the 3/24/36 assessment observation period. During an interview with staff #31 and #32 on 6/1/26 at 11:28 AM, they confirmed that anticoagulant use was incorrectly documented on Resident #54's MDS dated [DATE].

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure a physician documented the resident's current health status and failed to write, sign, and date new orders during physician visits. This was evident for 1 (Resident #59) of 1 resident reviewed for transmission-based precaution and 1 (Resident #123) of 2 residents reviewed for respiratory care. The Findings include:1) Irritable Bowel Syndrome (IBS) is a common, long-term gastrointestinal disorder characterized by abdominal pain, cramping, bloating, and recurring changes in bowel habits (such as diarrhea, constipation, or both).Resident #59 was admitted into the facility in early 2026 with diagnosis that included irritable bowel syndrome (IBS). During an interview on 5/26/26 at 9:18 AM, the resident stated, I was on an antibiotic for C. diff and was put on isolation but was taken off once they (the facility) found out I was ok.C. diff (short for Clostridioides difficile) is a highly contagious bacterium that infects the colon, causing severe inflammation and watery diarrhea. It typically occurs when taking or recently finishing antibiotics, as these drugs kill beneficial gut bacteria and allow C. diff to overgrowA review of Resident #59's medical orders on 5/26/26 at 12:43 PM revealed an active order for an antibiotic (Metronidazole -often known by the brand name Flagyl) that started on 5/19/26 with an end date of 5/29/26. The instruction on the order read, give 1 tablet by mouth three times a day for C. diff colitis for 10 days. On 5/28/26 at 2:20 PM, the Infection Preventionist nurse (Nurse #23) was interviewed and was asked about Resident #59. Nurse #23 confirmed that the resident was initially positive for C. diff on 5/19/26, was transferred to a private room, was placed under contact isolation, and was started on antibiotic treatment. Then on 5/22/26, lab results revealed that the resident was colonized, indicating no active infection, returned to prior room, and taken off contact precautions.Nurse #23 was asked about Resident #59's antibiotic use and she stated, I advocated that it be stopped. I wrote that s/he was colonized on my antibiotic stewardship. And explained that the medical provider must have decided to continue the antibiotic treatment. Nurse #23 was asked to provide documentation to indicate that the medical provider was aware of the lab result and had documented their rationale for continuing the antibiotic treatment. On 5/28/26 at 2:38 PM, she reported that she would gather the documents and provide them to the surveyor.On 6/1/26 at 9:01 AM, Nurse #23 was reminded of the documents she was gathering to provide to the surveyor.On 6/1/26 at 9:18 AM, a subsequent review of Resident #59's medical record was conducted. The review revealed the order for contact precaution was discontinued on 5/22/26 by the attending physician, however there was no documentation found to indicate the rationale behind it. Further review of the progress notes revealed: a) Included in the Physician assistant's (PA #18) notes with an effective date of 5/25/26 at 12:49 PM read, C.diff positive-acute, improving. Continue Flagyl 500 mg TID x 10 days to completion. b) A medication regimen review was conducted by the pharmacist (Staff #25) that indicated an irregularity was identified with an effective date of 5/26/26 at 11:14 AM. c) Included in the Nurse practitioner's (NP #16) notes with an effective date of 5/26/26 at 12:19 PM read, S/he continues on Flagyl for C.difficile colitis. d) Included in NP #22's notes with an effective date of 5/27/26 at 12 AM read, Recently tested positive for c/diff continues on metronidazole for now. e) Included in NP #16's note with an effective date of 5/28/26 at 1:27 PM read, S/he continues on Flagyl for C.difficile colitis.On 6/1/26 at 9:36 AM, Resident #59's hard chart was reviewed and revealed the medication regimen review report by Staff #25 was regarding an unused controlled substance and had not identified any concern with the resident's antibiotic use.On 6/1/26 at 10:11 AM, Nurse #23 provided the surveyor with a handwritten form that indicated a risk meeting was conducted on 5/22/26 where the medical director was informed that Resident #59 was negative for C.diff infection and decided to discontinue the contact isolation but continue the antibiotic. Nurse #23 confirmed that there was no other documentation found to indicate that the medical director had discussed with the other medical providers the decision to continue with the prescribed antibiotic for C.diff colitis.The (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	findings were discussed with the Director of Nursing (DON) on 6/1/26 at 10:18 AM. The DON stated, I don't know why there was no note about it. (decision to continue the antibiotic treatment) and explained that after Nurse #23 had reported the concern to her, she had contacted the different medical providers to get clarification. On 6/1/26 at 10:54 AM, the licensed pharmacist (Staff #25) was interviewed about Resident #59. He reported that based on the resident's medical records, on 5/26/26, he did not find any concern with the resident's antibiotic use as it was indicated for an active C.diff infection with provider notes that indicated the resident was improving. He also reported that he did not know that the resident was removed from contact isolation.A subsequent interview with the DON was conducted on 6/1/26 at 11:49 AM. During the interview, the concern was discussed that multiple medical providers had failed to document Resident #59's current health status. The DON reported that they (all medical providers that reviewed the resident) all need to make Addendums and/or clarifying notes to reflect the resident's current health status. The resident was still having loose stools, that's why the medical director wanted the resident to remain on the antibiotic but failed to document about it. The DON verbalized understanding and acknowledged the concern.2) Resident #123 was a newly admitted resident of the facility. On 5/26/26 at 11:39 AM, the resident was observed receiving oxygen via nasal cannula at a rate of 3L/min.A review of Resident #123's current orders was conducted on 5/26/26 at 12:55 PM. The review revealed an order for the oxygen to be administered at a rate of 2L/min. There was no order found to indicate that the oxygen's rate of administration can be titrated.On another observation of Resident #123 on 5/27/26 at 12:06 PM, s/he was receiving oxygen therapy at a rate of 3L/min. Shortly after the Charge nurse (Nurse #20) walked in the resident's room and confirmed the resident was on oxygen at 3L/min. Nurse #20 reported that per nursing report at the beginning of her shift, the resident was supposed to receive oxygen at a rate between 2-3L/min, but would check the resident's medical record to confirm.On 5/27/26 at 12:09 AM, Nurse #20 confirmed that Resident #123's current order for oxygen therapy administration was 2L/min and that there was no order to indicate that it could be titrated. She then reported that she would adjust Resident's administration rate back down to 2L/min and would recheck his/her oxygen saturation (O2 sat) after a few minutes.On 5/27/26 at 2:59 PM, the Director of Nursing (DON) reported that they found a medical provider's note that indicated Resident #123 had an episode where his/her O2 sat decreased while receiving rehab services and the provider had ordered for the oxygen administration to be increased to 3L/min. However, the orders and the care plan were not updated.Further review of Resident #123's medical record was conducted on 5/28/26 at 9:54 AM. The review revealed a progress note by Nurse practitioner (NP #22) with an effective date of 5/20/26 at 4:29 PM, that indicated the resident's O2 sat was in the 80's and the O2 administration was increased to 4L/min to stabilize the O2 sat. The review also revealed a progress note by Physician assistant (PA #18) with an effective date of 5/25/26 at 12:47 PM that indicated the resident remained on 3L of oxygen for shortness of breath with exertion.During a subsequent interview with the DON on 5/28/26 at 3:16 PM, Resident #123's medical record was reviewed. The DON confirmed that the resident's oxygen therapy administration had changed from 2L/min to 4L/min, then finally at 3L/min. The DON reported that the medical providers had the ability and should have signed and dated new orders whenever the changes were made with the Oxygen administration. She also reported that the resident's order had been changed to 3L/min that started on 5/27/26.On 6/1/26 at 1:02 PM, the concern was discussed with the DON that the medical providers had failed to sign and date new orders during their visit with Resident #123. The DON verbalized understanding and acknowledged the concern.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and observations, it was determined that the facility failed to treat residents with respect and dignity, as evidenced by failing to knock and request permission before entering a resident's room. This was evident for one (Resident #85) of one Resident reviewed for dignity. The findings include:In an initial interview with Resident #85 on 5/26/26 at 11:36 AM, it was noted that staff sometimes failed to tell residents their names when entering their rooms to provide care, even when residents requested it. During the interview, it was observed that Resident 85 had activated the call light for help. Staff #3, a licensed practical nurse, entered Resident #85's room in response to the call light on 5/26/26 at 11:38 AM. However, the observation did not show that Staff #3 knocked on the Resident's door or requested permission before entering the room. The surveyor questioned Staff #3 at that time whether she knocked on Resident #85's door before entering the Resident's room, and she responded that she normally did; however, she did not do so when she answered Resident #85's call bell. Another observation was made on 5/27/26 at 11:33 AM regarding Staff #26, a nursing assistant, who entered Resident #85's room to answer the resident's call bell without knocking or announcing herself. In an interview with Staff #26 at that time, she said she had been in Resident #85's room earlier, so she didn't need to knock again. In a subsequent interview on 5/28/26 at 10:15 AM, the unit manager (UM) for the unit where Resident #85 resided was informed of concerns that staff members had entered a resident's room without knocking or seeking permission. The UM stated that her expectation for her staff was that they knock on residents' doors and introduce themselves before entering residents' rooms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to notify residents' representatives when a resident's status changed. This was evident for 2 related complaints (#2737149, and #2735716) for one resident (Resident #125), of 5 complaints reviewed during the annual survey.The findings include:Resident #125 was an [AGE] year-old who was admitted to the facility in October 2025 with diagnoses that included, but were not limited to, cerebral infarction (stroke), depression, and dementia. A new diagnosis of displaced fracture of the base of neck of right femur was added to the resident's list of diagnoses on 2/02/26.A review of complaints #2737149 and #2745057 revealed that Resident #125 had an unwitnessed fall on 1/23/26 at approximately 1:45 AM and the complaint alleged that the facility did not immediately notify the resident's family. On 5/28/26 at 3:23 PM a review was conducted of Resident #125's medical record. The review revealed a document, titled Change in Condition, written on 1/23/26 at 3:13 AM by Licensed Practical Nurse (LPN), Staff #29. The form indicated that the resident was found on the floor. The form had a section regarding notifications which indicated that a physician was notified at 3:13 AM, a nursing supervisor was notified at 3:15 AM, and the resident's family was notified at 7:00 AM.On 5/29/26 an interview was conducted with the Director of Nursing (DON) to review the change in condition documentation. The DON confirmed that the resident's family was not notified immediately after the fall occurred.On 6/01/26 at 2:48 PM an interview with the Nursing Home Administrator was conducted to review the survey findings, and she acknowledged the deficient practice.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to provide a notice of transfer to a resident's representative when the resident transferred to the hospital. This was evident for two related complaints (#2737149 and #2745057 regarding a fall for Resident #125) of 5 complaints reviewed for hospitalization.The findings include:Resident #125 was an [AGE] year-old who was admitted to the facility in October 2025 with diagnoses that included, but were not limited to, cerebral infarction (stroke), depression, and dementia. A new diagnosis of displaced fracture of the base of neck of right femur was added to the resident's list of diagnoses on 2/02/26.A review of complaints #2737149 and #2745057 revealed that Resident #125 had an unwitnessed fall on 1/23/26 at approximately 1:45 AM.On 5/28/26 at 3:45 PM a review of Resident #125's medical record was conducted which revealed a nurses note dated 1/23/26 at 9:52 AM, written by unit manager (Staff #21), that stated resident transferred to the hospital at this time for pain s/p [status post] fall via ambulance with a copy of the MOLST, capability form, physician's order, and hospital transfer summary. Resident monitored by staff until EMS [emergency medical services] arrived, [family] is aware and prepared for hospital transfer.Further review of Resident #125's electronic and paper records failed to reveal any evidence of a written notice of transfer to either the resident or the resident's representative.On 6/01/26 at 10:00 AM an interview with the Director of Nursing (DON) was conducted to review the concern that there was no notice of transfer for Resident #125's transfer to the hospital on 1/23/26, and she said that she would provide a copy of the notice of transfer.On 6/01/26 at approximately 2:00 PM, in a follow up interview with the DON, she produced evidence that a bed hold notice had been provided, but she did not provide any evidence that the facility gave a notice of transfer to the resident or the resident's RP for the resident's transfer to the hospital on 1/23/26.On 6/01/26 at 2:48 PM an interview with the Nursing Home Administrator was conducted to review the survey findings, and she acknowledged the deficient practice.

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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 within regulatory time frames to maintain current and accurate assessment records. This was evident for 3 (Residents #42, #5, #26) of 6 residents reviewed for Resident Assessment. 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 admission MDS is a comprehensive assessment for new Residents and, under some circumstances, for returning Residents. It must be completed by the end of day 14, considering the date of admission to the facility as day 1. Care Area Assessment (CAA) Completion Date: Must be completed on or before the 14th day after admission (Item V0200B2 in the MDS). The Annual MDS assessment is a comprehensive assessment for a resident that must be completed annually (at least once every 366 days) unless a Significant Change in Assessment has been completed since the most recent comprehensive assessment. The last day of the observation period is the Assessment Reference Date (ARD). It marks the end of the observation period and serves as a common reference point for all team members participating in the assessment. 1) During the initial survey process, it was noted that Resident #42 was flagged for an MDS record more than 120 days old.A review of Resident #42's electronic health record on 6/1/26 at 8:44 AM included an annual MDS assessment dated [DATE], meaning the Resident's next annual MDS was to be scheduled within 366 days of the last annual assessment, which would have been 4/22/26. Continued review showed that Resident #42's next annual MDS assessment was scheduled for 4/23/26. The MDS was completed and signed in Section Z0500B on 5/12/26, 19 days after the ARD and 5 days late, in Section V0200B2 on 5/26/26, 33 days after the ARD and 19 days late, and in Section V0200C2 on 5/26/27, 14 days after the completion date and 7 days late. An interview with staff #31 and #32, both MDS nurses, on 6/1/26 at 11:25 AM confirmed that Resident #42's annual MDS, dated [DATE], was completed late. 2) A review of Resident #5's record noted that he/she was admitted to the facility on [DATE]. The review also included an admission MDS for Resident #5, dated 4/23/26, with sections Z0500B and V0200B2 signed as complete on 5/4/26. The review noted that Resident #5's admission MDS was completed 19 days after the Resident's admission to the facility, making it 5 days late. An interview on 6/1/26 at 11:12 AM with staff #31 and #32 confirmed that Resident #5's admission MDS, dated [DATE], was completed late. 3) A review of Resident #26's medical record showed that the Resident was admitted to the facility on [DATE]. A continued review included an admission MDS assessment for Resident #26 dated 5/12/26. The MDS was due to be completed and signed in sections Z0500B and V0200B2 on 5/18/26. However, the review showed that Resident #26's admission MDS assessment was completed and signed in section Z0500B on 5/26/26, 22 days after the Resident's admission to the facility and eight days late, and in section V0200B2 on 5/27/26, nine days late. In an interview on 6/1/26 at 11:31 AM, staff #31 and staff #32 stated that Resident #26's admission MDS assessment was due within 14 days of his/her admission date on 5/5/26, so completing it on 5/27/26 was late.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days of a resident's admission to hospice care. This was evident in one (Resident #8) of six residents reviewed for Resident assessment. 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 on the MDS drives Resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. The nursing home should complete a Significant Change in Status MDS assessment within 14 days when there's a major decline or improvement in a resident's status. A record review on 6/1/26 at 10:19 AM showed an attending provider's order for a hospice care consultation for Resident #8. Continued review noted that Resident #8 was admitted to hospice care effective 5/7/26. Further review included a Significant Change in Status MDS assessment dated [DATE] for Resident #8. The MDS assessment was completed and signed in sections Z0500B and V0200B2 on 5/25/26, 18 days after admission to hospice care and 4 days late. During an interview on 6/1/26 at 1:35 PM, staff #31 and #32, both MDS nurses, confirmed that Resident #8's Significant Change in Status MDS assessment, dated 5/13/26, was completed late.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined the facility failed to ensure nursing staff maintained professional standards in regard to documention of assessments. This was found to be evident for one (Resident #39) out of one resident reviewed for side rail usage.The findings include: Review of Resident #39's medical record revealed the resident has a developmental/intellectual disability and lacks adequate decision making capacity. The resident was admitted on [DATE], arriving on the unit at 7:50 PM. Further review of the medical record revealed an Assist Bar/Side Rail evaluation, with an effective date of 5/13/26 at 8:50 PM. This evaluation was signed by Nurse #11. This evaluation was noted to have been locked on 5/14/26 at 2:36 AM indicating the documentation was completed at that time. Review of the 5/13/26 Side Rail evaluation revealed in the section for Potential risks of using enabler bar/side rail include potential for injury such as fractures, bruises, entrapment and death discussed with resident and family if resident unable to respond was marked No. The section concerning Benefits of use of enabler bar/s or side rail/s discussed with resident family was marked No. The section for Informed consent obtained was also marked No.On 5/29/26 at 11:04 AM surveyor reviewed the 5/13/26 Side Rail evaluation form with the Director of Nursing(DON) and requested a copy. The DON acknowledged the concerns identified with this assessment and indicated she would follow up with staff.On 5/29/26 at approximately 11:40 AM, surveyor reviewed the resident's paper chart and found a Consent for Use of Bed Rails which was signed by the Unit Nurse Manager #13 on 5/14/26 and indicated the consent was obtained via phone with the resident's responsible representative. On 5/29/26 at approximately 12:35 PM the surveyor again reviewed the electronic health record and discovered the 5/13/26 Assist Bar/Side Rail assessment was changed. The evaluation now indicated the risks and benefits were discussed with the resident/family and that informed consent was obtained. The signature on the evaluation was now Unit Nurse Manager #13 and was noted to be signed on 5/29/26. But the effective date and time remained 5/13/26 at 8:50 PM, indicating the consent was obtained an hour after the resident arrived on the unit.On 5/29/26 at 12:39 PM the DON reported that the Side Rail assessment was not correct and that Unit Nurse Manager #13 was doing a new assessment that day that would be accurate. Surveyor then reviewed the concern that the 5/13/26 evaluation had been changed earlier today. The DON reported that management can unlock an assessment and make changes. Surveyor reviewed the concern that the supporting documentation about the consent indicates it was not addressed with the family until the next day, which coincides with the assessment completed by the nurse on 5/14/26 at 2:36 AM, as well as the paper consent form. Surveyor and DON then reviewed the paper consent form and DON acknowledged that the form was not actually signed by the responsible representative but rather a notation that the consent was obtained via the phone on 5/14/26.On 6/1/26 at 1:29 PM the Unit Nurse Manager #13 confirmed that she was not present during the evening the resident was admitted and that she had not spoken with Nurse #11 on 5/29/26 prior to making changes to the 5/13/26 Side Rail evaluation. Surveyor reviewed the print out of the Assist Bar/Side Rail evaluation with the Unit Nurse Manager #13, who acknowledged it still had an effective date of 5/13/26 at 8:50 PM but now indicates it was completed by Unit Nurse Manager #13. The Unit Nurse Manager also confirmed that she reviewed the consent form with the responsible representative the day after admission.On 6/01/26 at 4:06 PM surveyor reviewed with the NHA the concern regarding the failure to ensure professional standards in regard to modification of a nurse's evaluation.Cross reference to F 700.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and a review of records, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received showers. This was evident for 2 (Residents #85, #8) of 6 Residents reviewed for ADLs. 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. 1) During an initial tour of the facility on 5/26/26 at 11:12 AM, Resident #85's hair was observed to be matted and greasy. Resident #85 was questioned at that time about whether he/she had received showers and responded that the surveyor should look at his/her hair and determine whether he/she had received showers. Resident #85 added that he/she had received only bed baths (washing the Resident in bed). A record review on 5/27/26 at 12:02 PM included an MDS assessment dated [DATE] for Resident #85, which indicated that the Resident did not walk, was bedbound, and relied on staff for all self-care needs. Continued review of the nursing assistants' February 2026 ADL documentation for Resident #85 showed that Resident #85 was scheduled for bed baths on Wednesdays and Sunday evenings, per his/her preference, totaling 8 bed baths per month. The review recorded 3 bed baths, 2 N/A (not applicable), 1 refusal of a bed bath, and 2 days left blank. The review also showed that on days when a bed bath was not scheduled, staff recorded N/A. In a follow-up interview on 5/28/26 at 10:19 AM with staff #4, a unit manager, she indicated that Resident #85 was previously scheduled to receive bed baths instead of showers, per his/her preference, and was also to receive bed baths on other days when nothing was scheduled. However, the earlier review did not show that Resident #85 received a bed bath on any day when one was not scheduled. During an interview with the director of nursing on 5/29/26 at 11:01 AM, she stated that she had spoken to Resident #85 after the surveyor's intervention and would schedule the Resident's showers on days when certain nursing assistants with whom the Resident was comfortable were scheduled to work, to ensure the Resident received his/her showers. 2) Resident #8 was admitted into the facility in early 2026 with diagnosis that included but was not limited to muscle weakness, muscle wasting and atrophy, and encounter for palliative care. During an interview with the resident regarding showers on 5/26/26 at 11:12 AM, s/he stated, I've only had one since I've been here and indicated that it was recent because a nurse had offered and the resident agreed. A review of Resident #8's task documentation for showers for the past 30 days was conducted on 5/27/26 at 12:26 PM. The review revealed the resident's preferred schedule was Tuesday and Friday evenings. The documentation starting from the latest entry were:a)5/8/26 documented as N/Ab)5/12/26 documented as refusedc)5/15/26 documented as N/Ad)5/19/26 documented as Yese)5/22/26 documented as refusedNo other dates/entries were found within the past 30 days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/26 at 2:11 PM, a floor nurse (Nurse #20) was interviewed about showers. Nurse #20 reported that showers are provided twice a week and the schedules are based on their room and bed placement. However, if the residents preferred a different schedule, they accommodate the change and document it in PCC. (PCC is the electronic health record used by the facility) She also explained that when residents refuse their shower, the nursing aides documents it in PCC and reports the refusal to the nurse. The nurse then makes a second attempt to offer the shower and would have to document if the resident declines again. She explained that this ensures that the nursing aides are actually offering the residents their showers as scheduled and not just marking as refused. A review of Resident #8's medical record was conducted with Nurse #20 on 5/27/26 at 2:40 PM. Nurse #20 confirmed the shower documentations listed above and reported that there was no progress notes documented to indicate that the refusals or the N/A's were reported to the nurse by the nursing aides. A subsequent review of Resident #8's medical record on 5/27/26 at 2:49 PM, revealed the most current assessment with a reference date of 5/13/26, section GG indicated that the resident needed setup or cleanup assistance from staff to complete the shower task. The Director of Nursing (DON) was interviewed on 5/27/26 at 3:02 PM. During the interview, the DON reported that she had done a full house education with nursing aides that included shower documentation within February and March 2026. The DON explained that the nursing aides should not be documenting N/A and should only be documenting yes, resident refused, or resident unavailable. On 5/28/26 at 10:11 AM, the findings were discussed with the DON, and she reported that she did expect the nurses to make a second attempt to offer showers to residents but was not expected to make a progress note about it. The DON was asked if there was any documentation to indicate that the nurses had validated the resident's shower refusal and she answered, NO The Nursing Home Administrator (NHA) was interviewed on 6/1/26 at 3:59 PM. During the interview, the concern that showers were not being provided and/or assistance were not being provided to residents requiring it was discussed. The NHA agreed that when nurses are required to offer showers to residents after they refuse it from the nursing aides, it needs to be documented otherwise there was no proof that they made the 2nd attempt. The NHA verbalized understanding and acknowledged the concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review and interviews, it was determined that the facility failed to 1.) identify and follow up on a resident's significant abnormal laboratory value and 2.) ensure orders for psychiatric medications were kept active in the absence of a plan to reduce the dosage. This was evident in 1 complaint (#2735716 related to Resident #126) of 5 complaints reviewed during the annual survey, and 1 (Resident #3) of 5 residents reviewed for unnecessary medication. The findings include: 1) A complete blood count (CBC) is a laboratory test that checks, in part, for hemoglobin. Hemoglobin is an iron-rich protein inside a person's red blood cells. Its main job is to carry and transfer oxygen to the cells in the body. Hemoglobin is measured in grams per deciliter (g/dL) of blood. Normal levels of hemoglobin are between 12.0 -17.5 g/dL. A hemoglobin level between 7.1 - 9.5 g/dL is considered moderate anemia and would cause symptoms such as noticeable weakness, pale skin, and rapid heartbeat. An anticoagulant is a medication that stops the blood from clotting too easily by slowing the body's normal clotting process. The use of anticoagulants can increase the risk of bleeding. Resident #126 was admitted to the facility in September of 2024. The resident was elderly and had diagnoses that included, but were not limited to, heart failure, atrial fibrillation, and long term use of anticoagulants. A review of complaint #2735716 was conducted on 6/01/26 at 10:37 AM and revealed an allegation of neglect that led to Resident #126 being urgently transferred to the hospital on 2/01/26. On 6/1/26 at 1:00PM Resident #126's medical records were reviewed. The review revealed failed to reveal any evidence of lack of physical care to the resident. However, a review of the resident's laboratory test history revealed a lab report of a hemoglobin level of 8.6 on 8/04/25, which indicated moderate anemia. A review of a physician progress note dated 11/23/25, written by the Medical Director revealed laboratory data, which included the hemoglobin level of 8.6 on 8/04/25, but the narrative portion of the note failed to acknowledge the abnormality or address it in any way. Further review on 6/01/26 at 1:59 PM of Resident #126's physician orders failed to reveal any order for a CBC after 8/04/25. On 6/1/26 at 2:30 PM an interview was conducted with the Director of Nursing (DON) to review the concern that Resident #126's low hemoglobin level on 8/04/25 was not recognized or followed up on, and she acknowledged the finding. On 6/1/26 at 2:48 PM an interview with the Nursing Home Administrator was conducted to review the survey findings, and she acknowledged the deficient practice. No further evidence was provided prior to the end of the survey. 2) Review of Resident #3's medical record revealed the resident was seen by the psychiatric nurse practitioner (NP #5) on 3/6/26. Review of the corresponding note revealed a diagnosis of generalized anxiety disorder and that the resident's current medications included lorazepam 0.5 mg twice a day for anxiety. No documentation was found in this note to indicate a dose reduction was planned for the twice daily lorazepam. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record (MAR) revealed the resident had orders for and received the lorazepam twice a day from 3/5/26 until it was discontinued on 4/13/26. Review of the order to discontinue the lorazepam on 4/13/26 revealed it was a verbal order given by Nurse Practitioner #16 and confirmed by Nurse #17. NP #16 is not a psychiatric provider. Further review of the medical record failed to reveal documentation to indicate why the lorazepam was discontinued on 4/13/26. No documentation was found to indicate the resident or the resident's representative were informed that the twice daily antianxiety medication was discontinued on 4/13/26. Further review of the medical record revealed the resident was seen by NP #16 on 4/17/26. Review of the corresponding note failed to reveal documentation addressing the recent discontinuation of the lorazepam. The note does indicate the resident was followed by psychiatric services. Further review of the MAR and the medication orders revealed that lorazepam 0.5 mg two times a day for anxiety was again ordered on 4/17/26 by Physician #19. No documentation was found to indicate Physician #19 saw Resident #3 on 4/17/26. No documentation was found in the nursing progress notes or the behavior monitoring documentation to indicate why the lorazepam was re-started on 4/17/26. On 5/29/26 at 3:37 PM the surveyor reviewed with the Director of Nursing (DON) that the resident did not have orders for the lorazepam between 4/13 evening and 4/17 day shift. Surveyor requested clarification from the DON regarding why this medication was stopped and then re-started a few days later. Further review of the medical record revealed the resident was seen again by the psychiatric NP #5 on 4/24/26. Review of the corresponding note failed to reveal documentation to indicate the NP #5 was aware that the resident had not received the lorazepam for more than three days earlier in the month. On 6/1/26 at 2:26 PM when asked about why the lorazepam was discontinued and then re-started three days later, the unit nurse manager #13 reported she was not sure what happened but indicated it may have been due to a supply issue. Surveyor then reviewed the Controlled Drug Administration Record which revealed that after the morning dose on 4/13/26 the resident had 3 remaining tablets in the supply. On 6/1/26 at 2:55 PM the DON reported the lorazepam was discontinued due to the order only being for 14 days, however review of the medical record with the DON at that time failed to reveal documentation to support this report. On 6/1/26 at 4:04 PM the DON reported that she had spoken with Physician #19 and that he said he restarted the medication after he saw it had been inadvertently discontinued by NP #16.

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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 observations, record review, and interviews, it was determined that the facility failed to ensure that residents with a limited range of motion received treatment and services to prevent further decline in the range of motion. This was evident for one (Resident #106) out of one resident reviewed for position and mobility. The findings include:An observation on 5/26/26 at 11:29 AM showed that Resident #106's fingers were bent at the knuckles and pressed into the left palm. The resident was unable to straighten them and had no device available. A subsequent observation on 5/27/26 at 1:57 PM showed Resident #106 sitting in the common area on the sugar loaf unit, still not wearing a device for the left-hand contracture. A record review noted a current care plan for Resident #106, initiated on 3/16/19 and revised on 10/26/22, which stated that the resident exhibits alterations in functional mobility related to contracture deformity. The care plan's goal stated that the resident will tolerate palm guard on left hand. A continued review of an occupational therapy (OT) evaluation dated 2/24/26 noted severe impairment of Resident #106's range of motion in both shoulders, the left elbow/forearm, wrist, and fingers. The OT evaluation also noted that Resident #106 was using a palm guard on the left upper extremity to manage contractures. However, earlier surveyor observations did not indicate that Resident #106 was wearing a device on the left upper extremity. In an interview on 5/27/26 at 3:06 PM, the regional director of therapy stated that therapy had recommended that Resident #106 wear a palm guard on the left upper extremity to prevent further worsening of the resident's range of motion. During a follow-up interview with the unit manager of the unit where Resident #106 resided, she indicated that Resident #106 had previously been ordered to wear a palm guard on the left upper extremity. However, the resident was transferred to the hospital, and it appeared the order was dropped during that transfer.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and observation it was determined that the facility failed to ensure informed consent was obtained prior to the initiation of side rails. This was found to be evident for one (Resident #39) out of one resident reviewed for side rail usage. The findings include:Review of Resident #39's medical record revealed the resident has an intellectual disability. The resident was admitted to the facility on [DATE], and a nursing note indicates the resident arrived at 7:50 PM. Review of the 5/15/26 Minimum Data Set assessment revealed a Brief Interview for Mental Status was not completed due to the resident being rarely or never understood. Two physicians determined that the resident lacks adequate decision-making capacity due to intellectual disabilities and developmental delay.On 5/26/26 at 10:44 AM surveyor attempted to interview Resident #39, but the resident was unable to answer questions. On 5/27/26 at 9:53 AM surveyor observed the resident had quarter side rails in the up position on both sides of the bed. Review of the electronic health record revealed an Assist Bar/Side Rail evaluation, with an effective date of 5/13/26 at 8:50 PM. This evaluation was signed by Nurse #11. This evaluation was noted to have been locked on 5/14/26 at 2:36 AM indicating the documentation was completed at that time. Review of this evaluation revealed the resident and or the family requested the use of the enabler bars but in the section for Potential risks of using enabler bar/side rail include potential for injury such as fractures, bruises, entrapment and death discussed with resident and family if resident unable to respond was marked No. The section concerning Benefits of use of enabler bar/s or side rail/s discussed with resident family was marked No. The section for Informed consent obtained was also marked No.On 5/29/26 at 11:04 AM surveyor reviewed the 5/13/26 Side Rail evaluation with the Director of Nursing (DON) and requested a copy. The DON acknowledged the concerns identified with this assessment and indicated she would follow up with staff.Further review of the medical record revealed an Admit/Readmit Screener evaluation, also signed by Nurse #11 on 5/14/26, that indicated the use of bilateral (both sides) side rails. The sections to mark the indication for use and that consent was received were noted to not be checked.Review of the facility's Proper Use of Bed Rails policy, with a revision date of 10/27/25, revealed : It is the policy of this facility to utilize a person-Centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails.Further review of the medical record failed to reveal documentation to indicate the resident's responsible representative/family was present during the initial admission assessment or was contacted by Nurse #11 that evening.On 5/29/26 at 11:38 AM the Unit Nurse Manager #13 was interviewed about the process for use of side rails. Unit Manager #13 reported they show the resident and family the side rails and if resident/family would like to have them up then staff have to tell them all the bad things that could happen and they have to sign a consent form. If family was not here at the time of admission, they would call to go over the needed information including the side rails.Following the 5/29/26 at 11:38 AM interview, surveyor reviewed the resident's paper chart and found a Consent for Use of Bed Rails which was signed by the Unit Nurse Manager #13 on 5/14/26 and indicated the consent was obtained via phone with the residents responsible representative. On 6/1/26 at 1:29 PM Unit NUrse Manager #13 confirmed that she was not in the facility on the evening the resident was admitted and that she called the family the next day. She confirmed that she covered the side rail information with the family the next day.On 5/29/26 at 12:34 PM the Unit Manager #13 reported most of the beds have side rails and if they are not wanted she has to have maintenance take them off. She confirmed the process is usually that the rails are already on the bed and after it is determined they (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are not needed maintenance is contacted to have them removed. On 5/29/26 after the 12:34 PM interview with the unit manager, surveyor reviewed the electronic health record and discovered the 5/13/26 Assist Bar/Side Rail assessment was changed. The evaluation now indicated the risks and benefits were discussed with the resident/family and that informed consent was obtained. The signature on the evaluation was now Unit Nurse Manager #13 and was noted to be signed on 5/29/26.On 5/29/26 at 12:39 PM the DON reported that the Side Rail assessment was not correct and that Unit Manager #13 was doing a new assessment that day that would be accurate. Surveyor then reviewed the concern that the 5/13/26 evaluation had been changed and that it now indicated significant changes to the initial assessment. The DON reported that management can unlock an assessment and make changes. Surveyor reviewed the concern that the supporting documentation about the consent indicates it was not addressed with the family until the next day, on 5/14/26. Surveyor and DON then reviewed the paper consent form and DON acknowledged that the form was not actually signed by the responsible representative but rather a notation that the consent was obtained via the phone on 5/14/26.On 5/29/26 at 12:51 PM surveyor and DON observed that room [ROOM NUMBER] was currently vacant. Both the A and B bed were observed with quarter side rails in the up position.On 5/29/26 at 1:26 PM the Nursing Home Administrator (NHA) was interviewed in regard side rails. The NHA reported: I think they [side rails] should probably be removed when someone is discharged , definitely because you do not know what the next patient is going to need or not need. Surveyor requested a list of rooms currently available for new admissions. Review of this list revealed room [ROOM NUMBER] A and B beds were currently available. Surveyor informed the NHA that observation of this room with the DON earlier today revealed quarter Side Rails were in the up position for both beds.On 6/01/26 at 11:18 AM the Maintenance Director #24 reported that last year they were required to take all the side rails off and then only put them back on when requested by therapy or physician order. When asked if he was notified when a resident is discharged , he reported that he usually is before the next resident comes in and he takes the side rails off. Surveyor and Maintenance Director then went to room [ROOM NUMBER], which was currently vacant, and observed both the A and B bed had quarter side rails in the up position. At 11:27 AM, during the observation of the beds in room [ROOM NUMBER], the Maintenance Director clarified that they would lower and strap down the side rails if not needed, as opposed to removing them. And he went on the report they would do this after the resident was admitted but indicated this would occur either the day of admission or shortly after admission. On 6/01/26 at 4:06 PM surveyor reviewed with the NHA the concern regarding the failure to ensure informed consent was obtained prior to the use of side rails.Cross reference to F 658

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review and interview it was determined that the facility failed to ensure pain medications were administered within the ordered parameters. This was found to be evident for one (Resident #3) out of five residents reviewed for unnecessary medications. The findings include: On 5/28/26 review of Resident #3's medical record revealed an order, in effect on 3/4/26 for oxycodone (an opioid pain medication) 5 mg to be given every 6 hours as needed for pain rated greater than 6 out of 10 on a numeric pain scale. Review of the Medication Administration Record (MAR) revealed documentation that the oxycodone was administered on 3/4/26 for pain at a level of 4. Further review of the MAR revealed that from 3/10-3/17/26 there was an order for oxycodone 5 mg to be given every 6 hours as needed for pain rated greater than 6 out of 10 on a numeric pain scale. Review of the Medication Administration Record (MAR) revealed documentation that the oxycodone was administered on 3/13 for a pain level of 2; on 3/14 for a pain level of 3; on 3/15 for a pain level of 5; and on 3/16 for a pain level of 4. Further review of the MAR revealed that at the same time the oxycodone was administered, the nursing staff had offered Non-pharmacological interventions that were documented as being effective. Further review of the medical record revealed a current order, in effect since 3/20/26, for tramadol (an opioid pain medication) 50 mg to be given every 8 hours as needed for pain rated greater than 7 out of 10. Review of the April MAR revealed that on 4/24/26 the resident had pain at a 2 and that the tramadol was administered. Review of the May MAR revealed that on 5/10/26 the resident had pain at a 0 and that the tramadol was administered. On 5/29/26 at 3:37 PM surveyor reviewed the concern with the Director of Nursing regarding the administration of opioid pain medication outside of the ordered parameters. On 6/01/26 at 2:25 PM the unit nurse manager #13 confirmed she was aware of the concern regarding the administration of the opioid outside of the ordered parameters and reported that she had no additional documentation to provide regarding this concern.

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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 staff interview, the facility failed to ensure medication refrigerator temperatures were consistently monitored and documented to verify that medications requiring refrigeration were stored within appropriate temperature ranges. This deficient practice was observed in 1 (Sugarloaf Unit) of 2 medication storage refrigerators reviewed.The findings include:On 5/28/26 at 10:00 AM, following a medication administration observation, the surveyor conducted a review of the medication storage room on the Sugarloaf unit with Licensed Practical Nurse (LPN) #4. During the observation, LPN #4 opened the medication room and unlocked the medication refrigerator.On 5/28/26 at 10:05 AM, the surveyor requested to review the refrigerator temperature log. The unit manager stated that the temperature log was not maintained near the medication refrigerator in the medication storage room and left the area to retrieve it. After a few moments, LPN #4 returned with the temperature log and held it in front of the surveyor for review.Review of the May 2026 medication refrigerator temperature log revealed missing documented refrigerator temperatures for 7 dates during the month of May 2026, including:5/6/265/8/265/10/265/16/265/17/265/18/265/20/26On 5/28/26 at 10:05 AM, LPN #4 stated that daily refrigerator temperature checks were part of night-shift unit rounds and that the temperature log was maintained in a book kept on the unit.The surveyor requested a copy of the refrigerator temperature log from LPN #4. LPN #4 initially refused to provide a copy and stated that permission from facility leadership was required before providing requested documentation to a surveyor.On 5/28/26 at 10:25 AM, after approximately 18 minutes, LPN #4 returned and provided the surveyor with a copy of the refrigerator temperature log. At that time, LPN #4 stated that refrigerator temperatures were documented by night shift. The surveyor asked LPN #4 whether she acknowledged the 7 dates with missing documented refrigerator temperatures and how it was ensured refrigerated medications were stored under appropriate conditions. LPN #4 did not provide an answer.On 5/29/26 at 2:45 PM, the Director of Nursing was made aware of concerns regarding missing refrigerator temperature documentation for the medication refrigerator located in the Sugarloaf unit medication storage room.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and review of facility documentation it was determined that the facility failed to have a qualified food service director. This was found to be evident for the one out of one food service director at the facility. The findings include On 5/26/26 at 8:15 AM while conducting the initial tour of the kitchen, Staff #6 was asked if she was the Food Service Director. Staff #6 referenced her name tag which stated Account Manager but indicated she was the person in charge. Staff #6 reported she was currently in training to become a Certified Dietary Manager but confirmed she did not at present have that certification.Review of the list of key personnel that was provided by the facility identified the Food Service Director as Staff #6.On 5/27/26 at approximately 1:00 PM surveyor interviewed Registered Dietitian (RD) #9 in the office of the main kitchen. RD#9 reported she is at the facility 3 days a week and another RD is in the building on Fridays. When asked if she acts as a kitchen supervisor, RD #9 reported only when specifically asked to assist. If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. Full-time means working 35 or more hours a week. In States that have established standards for food service managers or dietary managers, the director of food and nutrition services must meet the State requirements for food service managers or dietary managers.The state of Maryland requires in a nursing home with more than 50 beds, overall supervisory responsibilities for the food service department and food production shall be assigned to a full-time qualified dietetic service supervisor.[See S0790].Review of the definitions section of the state regulations revealed: Dietetic service supervisor means a person who: (a) Is a qualified dietitian; (b) Is a graduate of a dietetic technician program approved by the American Dietetic Association; (c) Is a certified dietary manager who has successfully completed the required course and maintains certification as required by the certifying board for the Dietary Managers Association; (d) Is a graduate of a State-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or (e) Has training and experience in food service supervision and management in a military service equivalent in content to (b) and (d) of this regulation.On the afternoon of 5/29/26 surveyor requested the Food Service Director's credentials. The facility provided a ServSafe Certification for Staff #6. This certification does not meet the federal or state requirements for a qualified dietetic supervisor.On 5/29/26 at 2:45 PM surveyor informed the Director of Nursing that the credentials provided for the Food Service Director do not meet the regulatory requirements.On 5/29/26 at 2:59 PM the Nursing Home Administrator (NHA) and the food services contractor District Manager #7 reported that they have RD#9 for 32 hours per week. District Manager #7 reported that the registered dietitian does sanitation audits and reviews menus. Surveyor informed the NHA and District Manager #7 that RD #9 had reported earlier in the survey that she worked here 3 days a week and had denied regular supervisory duties. Surveyor indicated she would review any additional documentation the facility provided regarding the registered dietitians' role.Review the additional documentation provided by the facility, which consisted of the food service contractor's job description for Registered Dietitian. This description did not indicate if the position was full time or part time. No contract information was provided for RD #9. No documentation was provided to support the actual hours of work per week the dietitians were providing in the facility.On 6/01/26 at 11:00 AM surveyor reviewed with the NHA the concern that based on the federal and state regulations the facility does not meet the requirement for qualified dietetic supervisor.As of time of survey exit on 6/1/26 at 5:00 PM no additional documentation was provided regarding the hours of service provided by the registered dietitians or additional credentials for Staff #6.Cross reference F 812

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation and review of menus it was determined that the facility failed to ensure menus were followed as posted. This was found to be evident for one (Resident #76) out of one resident included in the sample for review of food. The findings include: During an interview on 5/26/26 at 8:55 AM regarding food, Resident #76 reported: you get choices but sometime they serve me something else. On 5/27/26 at 5:28 PM surveyor observed staff deliver Resident #76's dinner tray to the resident. The tray included: two egg salad sandwiches; broccoli, and potato salad. No dessert was observed on this tray. Review of the Resident Meal Change ticket revealed the resident had requested the B meal. One of the B meal items was egg salad sandwich with chips. No chips were observed on the resident's tray. The resident expressed concern that no peach parfait was included on the tray. Surveyor observed that there was no dessert on the tray. Review of the menu posted in the hallway revealed the alternative meal items for this dinner were: egg salad sandwich, broccoli salad and macaroni salad. Chilled Peach Parfait was included on the menu but did not have an alternative listed. The menu also included milk, but this item was not included on the resident's tray. On 5/27/26 at 5:40 PM the Nursing Home Administrator (NHA) reviewed the posted menu and the resident's tray with the surveyor. In the presence of the resident, the NHA confirmed that the resident should of received the dessert, the chips and the milk. The resident then indicated to the NHA that s/he would like the parfait and the chips but that s/he did not want the milk. The NHA indicated she would follow up regarding the resident's requests.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview it was determined that the facility failed to ensure the psychiatric providers notes were accurately documented. This was found to be evident for one (Resident #3) out of five residents reviewed for unnecessary medications. The findings include: On 5/28/26 review of Resident #3's medical record revealed an order, in effect since 3/2/26 for Sertraline (an antidepressant) to be given one time a day for depression. Review of the Medication Administration Records (MAR) revealed the medication was being administered daily as ordered since 3/2/26. Further review of the medical record revealed the resident was seen by the psychiatric nurse practitioner (NP #5) on 3/6/26. Review of the corresponding note revealed the resident was being seen to evaluate for agitation, anxiety and depression. The diagnosis included adjustment disorder with mixed anxiety and depressed mood. Review of the list of active medications failed to include the use of the Sertraline or any other antidepressant medication. Review of the Assessment and Plan section of the note failed to include documentation to indicate the resident was currently receiving, or needed to receive, an antidepressant medication. Further review of the medical record revealed the resident was seen again by the psychiatric nurse practitioner (NP #5) on 4/24/26. Review of the corresponding note revealed the resident was being seen to evaluate for anxiety, depression and adjustment issues. The diagnosis included adjustment disorder with mixed anxiety and depressed mood. Review of the list of active medications failed to include the use of the Sertraline or any other antidepressant medication. Review of the Assessment and Plan section of the note failed to include documentation to indicate the resident was currently receiving, or needed to receive, an antidepressant medication. On 5/29/26 at 9:11 AM interview with NP #5 who reported she reviews the medications the resident is currently on before she sees the resident. The NP had her computer with her during the interview and consulted it when asked which psychiatric medications the resident was currently on. The NP included the sertraline for depression when listing the resident's current medications. Surveyor provided a copy of the 3/6/26 and 4/24/26 notes for the NP to review and she acknowledged the sertraline was not included in the documentation. When asked if she had reviewed the use of the sertraline, the NP stated: I'm sure I have. The NP went on to report the anti-depressant is a medication the resident should be receiving and indicated she would correct her notes. On 5/29/26 at approximately 10:30 AM surveyor informed the Director of Nursing of the concern regarding the psychiatric NP failure to document the use of an antidepressant in either of her eval notes.