STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215315	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Oak Manor	3415 Greencastle Road Burtonsville, MD 20866

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and interview, it was determined the facility failed to notify residents receiving Medicaid benefits to spend down when their personal account reached within $200 of the SSI resource limit. It was evident for 8 residents (Resident #12, Resident #48, Resident #54, Resident #57, Resident #62, Resident #104, Resident #108, Resident #129) out of 73 residents reviewed for personal funds. The findings include: On 4/6/26 at 11 AM, a review of the facility's [fund management company] report dated 4/3/26 revealed 8 residents with personal accounts that exceed $2500, which is the SSI resource limit. Per this report:1). Resident #12 had $2625.53 in his/her personal fund account.2). Resident #48 had $3235.99 in his/her personal fund account.3). Resident #54 had $2831.18 in his/her personal fund account.4). Resident #57 had $3045.42 in his/her personal fund account. 5). Resident #62 had $2609.96 in his/her personal fund account.6). Resident #104 had $2958.31 in his/her personal fund account.7). Resident #108 had $2923.68 in his/her personal fund account.8). Resident #129 had $2734.44 in his/her personal fund account. On 4/6/26 at 12:43 PM, Staff #24 (Business office manager) stated, When the residents approach the $2500 limit, I give them a catalog and they can order items such as clothing, toothbrushes, etc using their monies. I don't have access to move the residents' monies, so I need to contact corporate for monies to be moved to burial accounts.On 4/7/26 at 10 AM, the surveyor was given copies of Resident Fund Balance Notification letters for the 8 residents (Resident #12, Resident #48, Resident #54, Resident #57, Resident #62, Resident #104, Resident #108, Resident #129). The letter stated This letter is to notify you that your Resident fund balance is within $200 or exceeding what is allowable under Medical Assistance. Please contact your Social Worker within the next 7 days to discuss ways to assure continuance of Medicaid benefits. A review of the 8 documents revealed that each document was signed by Staff #24 and each resident. A review of each document revealed: 1). Resident #12's letter was signed in illegible handwriting. A review of Resident #12's Physician Certifications form revealed that Resident #12 was certified on 8/21/24 by Staff #22 (MD) as Unable to understand and sign admission documents and other information. A review of Resident #12's facesheet (facility document that captures information such as birthdate, address, insurance, diagnoses and emergency contacts, etc) documented a daughter as emergency contact. 2). Resident #48's letter was signed with an X. A review of Resident #48's Physician Certifications form revealed that Resident #48 was certified on 2/6/25 by Staff #22 (MD) as Unable to understand and sign admission documents and other information. A review of Resident #48's facesheet documented that Resident #48 has a Court-appointed guardian.3). Resident #54's letter was signed with an X. A review of Resident #54's Physician Certifications form revealed that Resident #54 was certified on 6/27/24 by Staff #22 (MD) as Unable to understand and sign admission documents and other information. A review of Resident #54's facesheet documented a daughter-in-law as emergency contact.4). Resident #57's letter was signed with an X. A review of Resident #57's Physician Certification of Incapacity form revealed that Resident #57 was certified on 7/17/18 by a physician as He/she is incapable of making informed decision regarding treatment. A review of Resident #57's facesheet documented a friend as emergency contact.5). Resident #62's letter was signed by the resident. A review of Resident #62's Physician Certifications form revealed that Resident #62 was certified on 11/18/22 by a physician as (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Able to understand and sign admission documents and other information. 6). Resident #104's letter was signed by the resident. A review of Resident #104's Physician Certifications form revealed that Resident #104 was certified on 1/17/23 by a physician as Able to understand and sign admission documents and other information.7). Resident 108's letter was signed with an X. A review of Resident #108's Physician Certification of Incapacity form revealed that Resident #108 was certified on 11/16/05 by a physician as He/she is incapable of making informed decision regarding treatment. A review of Resident #108's facesheet documented a spouse as emergency contact.8). Resident #129's letter was signed by his/her spouse, who resides in the room with Resident #129. A review of Resident #129's Physician Certifications form revealed that Resident #129 was certified on 6/25/23 by a physician as Unable to understand and sign admission documents and other information. A review of Resident #129's facesheet documented that Resident #129 had a power of attorney, who was not his/her spouse as emergency contact.Of note, Resident 129's spouse was documented as having a BIMS (Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition) score of 9, which was reflective of moderate cognitive impairment on a quarterly MDS (Minimum Data Set) dated 2/1/26.On 4/7/26 at 10:26 AM, Staff #24 stated that the Resident Fund Balance Notification forms were given to the 8 residents (Resident #12, Resident #48, Resident #57, Resident #62, Resident #104, Resident #108, Resident #129) on 4/2/26. When questioned regarding the residents' ability to sign the forms, Staff #24 stated, Most of these residents are alert and oriented. I deal with them all the time. No, I don't check their BIMS score. I don't even know what that is. [Resident #57] is mute but he nods his head and understands what I was saying. The ones who wrote X on the signature form are alert and oriented. All the residents signed their letter but [Resident #129] .I had [his/her loved one] sign. On 4/7/26 at 11:30 AM during the exit conference, Staff #26 (Regional nurse) stated that Staff #24 would not be expected to know the residents' BIMS score and that Staff #24 would look at the Physician Certifications form at the Certification of Ability to Comprehend Information and Make Decisions to ascertain if a resident was capable of signing a legal form.

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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. Based on record review and staff interview, it was determined that the facility failed to code the residents' status accurately on the Minimum Data Set (MDS) assessment. This was evident for 4 (Resident #2, Resident #31 Resident #98 and Resident #129) of 6 residents reviewed for accuracy of assessments. The findings include: The Minimum Data Set (MDS) is a federally mandated comprehensive, standardized clinical assessment tool of all residents in nursing home. Staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care that they need. 1.) On 03/30/2026 at 11:44 AM, the surveyor observed Resident #2. The resident's room had no fall mats or bed rails up. On 03/31/2026 at 9:50 AM, a review of records was conducted. Records revealed an admission MDS that was completed on 2/20/2026. MDS for restraints under section P0200, Alarms: Resident was coded for use of floor mat alarm as used less than daily. On 03/31/2026 at 10:33 AM, an interview with the unit's manager, Staff #8, and Geriatric Nurse Assistant, Staff #4, was conducted. When asked if the resident had ever used fall mats, both staff members replied no. Staff also reported that restraints have never been used on Resident #2. On 03/31/2026 at 11:16 AM, an interview with Staff #5, MDS coordinator, was conducted. She confirmed that Resident #2 had never had any orders for restraints and acknowledged that the MDS restraints section was coded inaccurately. 2.) On 04/02/2026 at 12:44 PM, a review of Resident #31's medical records was conducted. The review indicated that Resident #31 had an active order for Seroquel Tablet 25 MG (Quetiapine Fumarate) for Brief Psychotic Disorder. Seroquel (quetiapine) is an atypical antipsychotic medication primarily used to treat schizophrenia, bipolar disorder (mania and depression), and as an add-on treatment for major depression. Review of the Medication Administration Record (MAR) indicated that Seroquel was administered daily from the time of admission. Review of the admission MDS Section N0450 - Antipsychotic Medication Review, it was coded that Resident #31 had not received any antipsychotic medications. On 04/02/2026 at 1:42 PM, an interview with Staff #5 was conducted. She confirmed that the MDS was coded incorrectly, it should have been coded that the resident was taking antipsychotics. On 04/02/2026 at 4:05 PM, the facility administrator and Director of Nursing were made aware of the concerns. 3) During survey screening on 3/30/26 at 12:06 PM, Resident 98 stated, No English when the surveyor (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was trying to interview him/her. Later that day at 12:51 PM, the resident's daughter arrived for visitation. When asked, Resident #98's daughter stated that her loved one [Resident #98] only speaks a few words of English and that his/her primary language was Vietnamese. She stated that the facility typically calls the family when they want to communicate information to the resident and the family informs him/her in Vietnamese. The daughter also stated that she was not aware of the facility ever using a language line to communicate directly with the resident. A review of Resident #98's medical record on 3/31/26 at 1:30 PM revealed that the annual MDS was completed on 12/25/25. The MDS coded the resident under Section A1110 (Language) with Resident 98's preferred language documented as English and as not needing an interpreter to communicate with a doctor or health care staff. During an interview on 4/3/26 at 9:31 AM, Staff #25 (GNA) who has been assigned to care for Resident #98 for years as her aide, stated that Resident #98 does not speak English. Staff #25 stated, I have Resident #98 everyday that I work. He/he has been here for years. We figure out how to communicate. We use gestures and if he/she needs something, he/she brings the wrapper of the item (like the wrapper from a briefs packet) that he/she needs. He/she only speaks a few words of English. During an interview on 4/3/26 at 12:21 PM, Staff #5 (LPN/MDS Coordinator) stated, For the MDS, we get some information from the medical records, the resident or the resident's family. Some of the information self-populates from previous MDS forms. For Resident #98, to my knowledge there is no communication board. We call the family and ask them to relay the information to the resident. After surveyor intervention, the MDS was corrected. 4) On 4/6/2026 at 9:45 AM, a review of the facility's policy stated, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gowns and gloves use during high contact resident care activities.2. Initiation of enhanced barrier precautions: . b. An order for EBP will be obtained for residents with any of the following: .ii. Infection or colonization with a CDC-(Centers for Disease Control) targeted MDRO when Contact Precautions do not otherwise apply. 8. Examples of MDROs targeted by CD include: . e. Candida auris . 10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility. Table 1: Implementing Contact versus Enhanced Barrier Precautions. This table only applies to MDROs. Infected or colonized with a CD-targeted MDRO without a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained – Contact Precautions= No, Use EBP = Yes. (date revised 4/28/2025) A review of Resident #129's medical record on 4/6/26 at 9:30 AM revealed that a quarterly MDS was completed on 3/6/2026. The MDS coded the resident under Section I1700 (Active Diagnoses-Infections) as not having a multidrug resistant organism. However, a review of the physician orders on 4/6/26 at 10 AM revealed a physician order dated 3/30/26 for Enhanced Barrier Precautions to be maintained at all times MDRO (multidrug resistant organism) every shift. During an interview on 4/3/36 at 12:21 PM, Staff #5 confirmed that Resident #129's MDS had been inaccurately coded to state that the resident did not have a MDRO. After surveyor intervention, the MDS was corrected. During an interview on 4/6/26 at 12:07 PM, the DON stated that she believed the facility received an email from the Department of Public Health in 2024 notifying the facility that Resident 129 was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	positive for C. auris. The DON stated, Then we had to do a big workup, swabbing him/her and other residents. I am not sure what the source ended up being. I will look it up. On 4/6/26 at 12:17 PM, the DON furnished to the surveyor an email dated 6/13/2024 from the Maryland Prevention and Health Promotion Administration's epidemiologist stating that R129 was Candida auris positive and he/she can be on enhanced barrier precautions because C. auris is a CDC-targeted MDRO.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews and interviews, it was determined that the facility failed to educate and provide COVID-19 immunizations to the residents. This was evident for 5 (Resident #28, #57, #48, #39, #12) out of 5 residents reviewed for immunizations during the recertification survey. The findings include: On 04/06/2026 at 2:20 PM, the surveyor requested the facility to provide COVID-19 policy and proof that Resident #28, #57, #48, #39 and #12 had been educated and offered COVID 19 vaccine in 2025. On 04/06/2026 at 2:30 PM, a review of records was conducted. Review of residents' electronic records indicated that Resident #28, #12, #48 and #57 had received COVID-19 immunizations on 11/11/2024. Resident #39 was last offered COVID-19 immunization in 2023. On 04/06/2026 at 2:55 PM, a review of the facility's COVID-19 vaccination policy indicated that all residents who are eligible for immunizations were to be educated and offered the vaccine annually. On 04/06/2026 at 2:33 PM, an interview with the Director of Nursing (DON) was conducted. She confirmed that the facility offers immunizations to residents annually. She reported that she had no documentation to support the vaccines were administered or refused. DON acknowledged that the 5 residents should have been offered COVID- 19 immunizations in 2025.On 04/06/2026 at 2:40 PM, the facility administrator was notified of the concerns.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each 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 provide services to maintain communication abilities to a resident with Limited English Proficiency (LEP). This was evident for 1 (Resident #98) out of 1 resident reviewed for communication. The findings include: During survey screening on 3/30/26 at 12:06 PM, Resident 98 stated, No English when the surveyor was trying to interview him/her. Later that day at 12:51 PM, the resident's daughter arrived for visitation. When asked, Resident #98's daughter stated that Resident #98 only speaks a few words of English and that his/her primary language was Vietnamese. She stated that the facility typically calls the family when they want to communicate information to the resident and the family informs him/her in Vietnamese. The daughter also stated that she was not aware of the facility ever using a language line to communicate directly with Resident #98. A review of Resident #98 's medical record on 3/30/36 at 1:15 PM revealed that Resident #98 was admitted to the facility on [DATE]. Further review of the records revealed that on Resident #98's admission Minimum Data Set (MDS) assessment dated [DATE], Vietnamese was documented as his/her preferred language. During an interview on 4/3/26 at 9:31 AM, Staff #25 (GNA) who has been assigned to care for Resident #98 for years as her aide, stated that Resident #98 does not speak English. Staff #25 stated, I have Resident #98 everyday that I work. He/she has been here for years. We figure out how to communicate. We use gestures and if he/she needs something, he/she brings the wrapper of the item (like the wrapper from a briefs packet) that he/she needs. No, I have never seen a communication board or the language line used to communicate with Resident #98. He/she only speaks a few words of English. He/she likes to go to the Activities because he/she likes to be around people. During an interview on 4/3/26 at 3:10 PM, the DON stated that she did not believe that the staff use a communicate board to interact with Resident #98. Cross refer F641.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interviews, it was determined that the facility failed to report an allegation of abuse in a timely manner. This was evident for 1 (Resident #139) out of 6 reviewed for abuse. The findings include: On 04/02/2026 8:00 AM, a review of incident 2685769 was conducted. Resident #139 alleged that a staff member hit them.On 4/02/2026 at 8:17 AM, a review of the facility investigation documentation was conducted. Staff #32 became aware of the incident on 12/4/2025 at 9:45 pm. The Nursing Home Administrator (NHA) became aware of the incident on 12/5/2025 at 10:30 am. The initial report submitted on 12/5/2025 at 12:40 pm.On 4/02/2026 at 10:21 AM, an interview with NHA was conducted. When asked how quickly staff should report an allegation of abuse when they are made aware. The staff should report the incident to the Director of Nursing (DON) or the NHA right away. When asked if the facility staff should have reported this incident to the NHA or DON sooner. Yes, typically they should notify Administration right away.On 4/02/2026 at 10:35 AM, a review of the facility's Abuse and Neglect Policy revealed that the facility staff are expected to report any allegation of abuse to the Administrator immediately.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff, it was determined that the facility failed to ensure appropriate provision and documentation of notice of hospital transfer and bed hold policy to residents' responsible party (RP). This was evident for or 1(Resident #7) out of 3 residents reviewed for discharge process during the facility's recertification/complaint survey. The findings include: Oxygen saturation (SpO2) measures the percentage of oxygen-carrying hemoglobin in the blood, with a normal reading for healthy individuals typically between 95% and 100%. Levels below 90% are considered low (hypoxemia), which can cause symptoms like shortness of breath, confusion, and rapid heart rate. Urgent medical attention is required if levels drop to 88% or lower. Aspiration pneumonia is a lung infection caused by inhaling food, liquid, vomit, or saliva into the lungs, often causing symptoms like fever, cough, chest pain, and shortness of breath. The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement. A BIMS score is derived from the Brief Interview for Mental Status, a brief screening tool for assessing cognitive function in long-term care settings. A score between 0 and 15, where higher scores indicate better cognitive ability, helps facilities track cognitive changes. Scores are categorized: 0–7 is severe impairment, 8–12 is moderate impairment, and 13–15 is cognitively intact. The assessment evaluates temporal orientation and short-term recall. On 03/31/2026 at 12:12 PM, a review of his/her 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 02, indicating severe cognitive impairment. On 03/31/2026 at 12:35 PM, a review of Resident #7's electronic record revealed that on 02/01/2026 at 07:08, he/she experienced a change in condition (he/she was observed with oxygen saturation level of 76%, and restless) and Nurse Practitioner Staff #29 ordered for him/her to be transferred to the hospital for further evaluation and treatment. On 03/31/2026 at 12:48 PM, further review of Resident #7's electronic record showed the nurses' follow-up note which indicated he/she was admitted to the hospital with aspiration pneumonia. On 03/31/2026 at 1:53 PM, a review of Resident #7's medical record identified a physician's certificate of incapacity dated 01/09/2026, indicating that Resident #7 was unable to comprehend information or make decisions due to dementia. On 03/31/2026 at 2:04 PM, in an interview with the Social Services, Staff #13, when she was asked if a notice of hospital transfer and bed hold policy was provided to Resident #7's responsible party (RP), she stated that it was provided and was requested to provide the surveyor with the documents. On 03/31/2025 at 2:43 PM, a copy of the notice of hospital transfer and bed hold policy was provided (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and upon review, it indicated acknowledgment of receipt with Resident #7 listed as the signer. On 03/31/2026 at 2:55 PM, during an interview, Licensed Practical Nurse (LPN) #12, when she was asked for the process of discharging residents to the hospital, she stated that when a resident is alert and oriented, the bed hold policy and notice of hospital transfer are provided by the nurse to the resident for review and signature, with copies distributed to accompany the resident to the hospital, maintained by social services, and retained in the medical record. LPN #12 further stated that when a resident is unable to make decisions or has altered mental status, the responsible party (RP) was notified, and documentation is forwarded to the social worker for distribution and record retention. When asked if Resident #7 was able to understand and sign the notice of transfer and bed hold policy at the time of his/her hospital transfer on 02/01/2026, she stated that the resident could not do so. On 03/31/2026 at 3:17 PM, during an interview with the Director of Nursing (DON), when asked for the process of providing bed hold policy and notice of hospital transfer to resident, she stated that when a resident is alert and oriented, the documentation was provided for signature, and when the resident is unable due to altered mental status, the documentation was sent with the admission liaison to take to the hospital. She also added that if the residents are not their own responsible (RP), a copy was provided to the social services, who will send the documents by electronic mail or regular mail to the responsible party (RP). On 03/31/2026 at 3:20 PM, during a follow-up interview, when asked what Resident #7's cognitive status was and the reason for his/her hospital transfer, the DON confirmed the resident had a BIMS score of 02, indicating significant cognitive impairment, and added that he/she was transferred to the hospital due to low oxygen saturation and altered mental status. When asked if the resident could have signed his/her bed hold notice and understood his/her reason for hospital transfer, the DON stated Resident #7 would not have been able to understand the hospital transfer or sign the bed hold notice. When she was informed about the findings and presented with the documentation showing acknowledgment of receipt signed as self dated 03/01/2026 by Resident #7, the DON acknowledged this discrepancy as a concern.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **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 refer the residents with a serious mental disorder for a level II assessment. This was evident for 2 (Resident #1 and Resident #9) out of 3 residents reviewed for PASARR. The findings include: 1). A review of Resident #1's medical record on 4/2/26 at 1:56 PM that Resident #1 was admitted to the facility on [DATE] from a hospital with a documented diagnosis of schizoaffective disorder. Further review of Resident #1's medical record revealed a physician order on 2/2/26 for olanzapine (an atypical antipsychotic medication) 10 mg (milligrams) daily. Resident #1's admission MDS (Minimum Data Set) from 2/5/26 was coded in Section I Active Diagnoses that Resident #1 carried a diagnosis of Schizophrenia (I6000) and in Section N Medications, N0450 Review of Antipsychotic Medications coded Yes, antipsychotics were received on a routine basis. The PASARR that was initiated by the hospital on 2/1/26 at 10:07 AM contained no documentation of the schizophrenia diagnosis or the usage of antipsychotic medication for this resident with the Outcome of this PASARR evaluation stating Auto Approved- No Level II Required. During an interview on 4/3/26 at 12:33 PM, Staff #13 stated that the facility did not have an updated PASARR for Resident #1. 2). A review of Resident #9's medical record on 3/30/26 at 11:44 AM revealed Resident #9 was admitted on [DATE] with a diagnosis of bipolar disorder. Further review of Resident #9's medical record revealed a physician order on 12/18/25 for olanzapine 2.5 mg via PEG (percutaneous endoscopic gastrostomy tube- a conduit inserted into the stomach through the skin to administer food and medications to a resident) at bedtime for bipolar disorder. Resident #9's admission MDS from 12/24/25 was coded in Section I Active Diagnoses that Resident #9 carried a diagnosis of bipolar disorder (I5900) and in Section N Medications, N0415 High Risk Drug Classes that Resident #9 was taking and had indications noted for an antipsychotic medication. The PASARR that was initiated by the hospital on [DATE] at 3:19 PM contained no documentation of the bipolar disorder diagnosis or the usage of antipsychotic medication by the resident with the Outcome of this PASARR evaluation stating Auto Approved- No Level II Required. During an interview on 4/3/26 at 12:33 PM, Staff #13 stated that the facility did not have an updated PASARR for Resident #9. Staff #13 (SWS) also stated, Sometimes with PASARR, the resident comes from the hospital and the PASARR does not have a diagnosis or a med (medication) on it, so we have to resubmit. We talk about each new admission at the morning clinical meeting and the diagnoses are discussed. If there is a discrepancy, then we resubmit. During a telephone interview on 4/6/26 at 11:47 AM, Staff #23 (LCSWC, Regional SWS) stated that when a resident is admitted from a hospital with a PASARR that does not include his/her psychiatric diagnosis, the facility will update the PASARR for the resident as a new diagnosis and document in the PASARR that the facility learned of the old diagnosis including the timeline of the diagnosis. The facility cannot resubmit a new PASARR, because the system [name of the PASARR application (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system] will reject the request for a new PASARR as outcome not rendered. Staff #23 did also state that the facility is not able to see previous diagnoses from other PASARR in this system. Staff #23 stated that she would update the PASARR for the residents after the surveyor supplied their names. After Surveyor intervention, the PASARRs were amended.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, it was determined that the facility failed to review and revise the interdisciplinary care plans to reveal accurate interventions. This was evident for 1 (Resident #129) out of 2 residents reviewed for care plans during the survey process. The findings include: A care plan is a guide that addresses the unique needs of each resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assuring the resident's needs are attended to. The care plan is to be reviewed and revised at each of the resident's quarterly assessment times to ensure the interventions on the care plan are accurate and appropriate for the resident. On 3/30/26 at 11:30 AM during screening observations, the surveyor observed that Resident #129 did not have any indwelling catheters and had wounds on his feet that were covered to contain any secretions. On 4/6/26 at 9:45 AM, the surveyor reviewed the Facility policy on Enhanced barrier precautions (EBP), which stated that EBP refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gowns and gloves use during high contact resident care activities.2. Initiation of enhanced barrier precautions: . b. An order for EBP will be obtained for residents with any of the following: .ii. Infection or colonization with a CDC-(Centers for Disease Control) targeted MDRO when Contact Precautions do not otherwise apply. 8. Examples of MDROs targeted by CD include: . e. Candida auris . 10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility. Table 1: Implementing Contact versus Enhanced Barrier Precautions. This table only applies to MDROs. Infected or colonized with a CD-targeted MDRO without a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained – Contact Precautions= No, Use EBP = Yes. (date revised 4/28/2025) On 4/6/26 at 9:30 AM, a review of Resident #129's medical record revealed a physician order dated 3/30/26 for Enhanced Barrier Precautions to be maintained at all times MDRO (multidrug resistant organism) every shift. Further review of Resident #129's medical record revealed a care plan dated 6/12/24 with a focus that stated, [Resident #129] has infection positive for Candida Auris, Candida Albicans and the assigned interventions stated, Maintain Contact precautions. The care plan had not been revised to reflect the change to Enhanced Barrier Precautions that was ordered in March 2026. On 4/6/26 at 12:17 PM, the DON furnished to the surveyor an email dated 6/13/2024 from the Maryland Prevention and Health Promotion Administration's epidemiologist stating that R129 was Candida auris positive and he can be on enhanced barrier precautions because C. auris is a CDC-targeted MDRO. Cross refer F641

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record reviews and interviews it was determined that the facility failed to maintain professional standards of practice related to oxygen orders. This was evident for 1 (Resident #49) out of 2 residents reviewed for respiratory orders. Findings include: On 03/30/2026 at 9:00 AM, an observation of Resident #49 revealed that the resident was receiving oxygen therapy. On 03/31/2026 at 9:42 AM, record review failed to reveal an active order for oxygen. On 04/01/2026 at 9:25 AM, concerns were brought up to the Director of Nursing and she indicated that she understood.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews it was determined that the facility failed to ensure that a resident had access to their call bell. This was evident for 1 (Resident #49) out of 35 observations made on call bells. The findings include: On 03/30/2026 at 8:46 AM, an observation of Resident #49 revealed the call bell was on the floor and not within reach of the resident. On 03/31/2026 at 10:37 AM, an observation of Resident #49 revealed the call bell was on the floor and not within reach of the resident. On 03/31/2026 at 12:18 PM, an observation of Resident #49 revealed the call bell was on the floor and not within reach of the resident. On 04/01/2026 at 10:20 AM, an observation of Resident #49 revealed the call bell was on the floor and not within reach of the resident. On 04/01/2026 at 10:21 AM, an interview with Geriatric Nurse Assistant (Staff #15) revealed that the expectation regarding call bells is that it should be within reach at all times. At the same time, Staff #15 revealed that Resident #49 in particular does not have a clip on her call bell cord, making it difficult for the call bell to be within reach at all times. On 04/01/2026 at 10:35 AM, an interview with the Director of Nursing revealed that the expectation regarding call bells is that they should be within reach at all times and be clipped. At the same time, the concerns were brought up with the Director of Nursing and she indicated that she understood.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews, and record reviews, it was determined that the facility failed to ensure that residents received oxygen therapy in accordance with physician orders for 1 (Resident #45) of 2 residents reviewed for oxygen use. The facility also failed to develop a care plan to address oxygen therapy needs and failed to ensure that residents were not connected to empty oxygen tanks. The findings include:On 03/30/2026 at 11:15 AM, Surveyor observed Resident #45 on 3L of Oxygen via Nasal Cannula. On 03/30/2026 at 11:25 AM, an interview with Resident #45 was conducted. They reported that they were supposed to be on 2L of oxygen because of pneumonia. On 03/31/2026 at 10:15 AM, Surveyor observed Resident #45 on 3L of Oxygen via Nasal Cannula. On 03/31/2026 at 11:59 AM, a review of Resident #45's medical record revealed an active order to administer Oxygen via nasal cannula at 2 L/min every shift for COPD (a chronic lung disease). Additionally, review of the care plan failed to include oxygen therapy interventions. On 03/31/2026 at 12:01 PM, Surveyor observed Resident #45 sitting on a wheelchair. Their Nasal Cannula was connected to an Oxygen tank behind the wheelchair. The oxygen tank was noted to be empty. On 03/31/2026 at 12:06 PM, an interview with Staff #11 was conducted. She reported that she was not aware that the resident was connected to an empty tank. When asked how many liters of Oxygen should be administered to Resident #45, staff stated I think 3L. On 03/31/2026 at 1:09 PM, an interview with the administrator was conducted. He reported that he had trained facility staff to always use a full tank. He acknowledged that the resident's nasal cannula should not have been connected to an empty oxygen tank. On 03/31/2026 at 1:11 PM, the Administrator and Director of Nursing were notified of oxygen concerns and associated care plan development.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interviews, it was determined that the facility 1) failed to ensure that medication was available for administration as ordered and 2) failed to administer medications on time. This was evident for 1 (Resident #31) out of 5 residents reviewed for medication administration and 1 (Resident #144) out of 3 residents reviewed for medication administration. The findings include:1) Clonazepam (brand name Klonopin) is a Schedule IV controlled substance in the United States, regulated due to risks of misuse, addiction, and physical dependence. While it has accepted medical uses for treating seizure and panic disorders, its status requires restricted, prescription-only access. On 04/02/2026 at 2:38 PM, a review of Resident #31's medical record was conducted. The review revealed an order for Clonazepam that was entered on 3/16/2026, the day the resident was admitted into the facility. The review of the Medication Administration Review (MAR) indicated that the resident was not given the medication on 3/16/20 to 3/20/2026. Review of the nurses' notes on 3/17/2026 indicated that the staff was waiting for the medication from the pharmacy. On 04/02/2026 at 2:50 PM, an interview with the Director of Nursing (DON) was conducted. When asked what the process was to obtain controlled medications for newly admitted residents, the DON reported that the provider is supposed to complete a C2 form, which is then faxed to the pharmacy. Additionally, some providers are also able to request the medications for residents electronically or alternatively call the pharmacy and give a verbal order to release the medications for the residents. The DON Acknowledged that the resident's medication should not have been delayed. She also confirmed that the facility meets in the morning to discuss any challenges or concerns for newly admitted residents. The facility staff should have discussed and addressed the lack of medication during these morning meetings. On 04/02/2026 at 3:29 PM, the facility administrator was notified of the concerns. 2) On 4/06/2026 at 10:17 AM, a review of Complaint 2701933 and an interview with the complainant was conducted. The complainant alleged that the facility did not administer Resident #144's eye medication on time. On 4/06/2026 at 10:31 AM, a review of the Medication Administration Audit Report was conducted. Resident #144 was ordered Timolol Maleate Ophthalmic Solution 0.5 % 1 drop in both eyes two times a day. Timolol Maleate was given over an hour late 22 times from 12/6/2025 to 12/21/2025 by multiple nurses. On 4/06/2026 at 11:00 AM, an Interview with the Director of Nursing (DON) was conducted. This surveyor confirmed the late administrations of Timolol with the DON. When asked when medications should be given, The DON stated medications should be given at the time they were ordered to be given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimal standard of practice for timely medication administration is that medications that are not time sensitive are to be given in the window of 1 hour before and 1 hour after the ordered administration time.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interviews and record reviews, it was determined that the facility failed to provide physical therapy services as ordered. This was evident for 1 (Resident #6) out of 6 residents reviewed for therapy services during the recertification survey. The findings include: On 03/30/2026 at 8:36 AM, an interview with Resident #6 was conducted. They reported that they were supposed to receive Physical Therapy (PT) services 3 times a week, however, this rarely happened. On 04/01/2026 at 8:25 AM, a review of physical therapy notes revealed that in February Resident #6 had 3 PT sessions (17th, 18th, and 26th) and 5 sessions in March (11th, 12th, 20th, 24th, and 26th). Review of Resident #6's care plan revealed an intervention that indicated that the resident should receive physical therapy evaluation and treatment as per orders. Further review of records revealed an active order for the resident to continue skilled Physical Therapy 3-5 times per week for 90 days for therapeutic exercises. The review of a recent PT recertification completed on 3/19/26 indicated that Resident #6 should continue PT services 3-5 days a week for therapeutic exercise, Neuro re-education, therapeutic activities, gait training and wheelchair management and mobility. On 04/01/2026 at 10:20 AM, an interview with Staff #33, PT Director, was conducted. He reported that even though the resident is ordered for 3-5 PT sessions per week, since the resident is considered a long-term resident, the facility does its best to accommodate the sessions, at times that can be one or two sessions per week. On 04/01/2026 at 12:00 PM, an interview with Staff #34, Regional PT Director, was conducted. She reported that the resident's order should include as needed because Resident #45 had plateaued but could not be discharged from PT services. On 04/01/2026 at 12:20 PM, the facility administrator was made aware of the concerns.

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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 observations, interviews and record reviews, it was determined that the facility failed to ensure that staff adhered to enhanced barrier precautions when providing care to residents. This was evident for 1 (Resident # 87) out of 6 residents reviewed for infection control practices during the recertification survey. The findings include: Enhanced Barrier Precautions (EBP) are an infection control strategy for nursing homes, requiring gowns and gloves during high-contact resident care to prevent the spread of Multidrug-Resistant Organisms (MDROs).A PICC line (peripherally inserted central catheter) is a long, thin, flexible tube inserted through a vein in the upper arm and advanced to a large vein near the heart. This tube is used to give intravenous (IV) medications to a patient. On 04/03/2026 at 08:30 AM, the surveyor observed Staff #31 give Resident #87 Fluticasone IV medication through a PICC line. Staff #31 was not wearing a gown, only gloves. Resident #87's door had a yellow sign that indicated EBP precautions to be followed when providing care or providing medications via the PICC line. On 04/03/2026 at 08:40 AM, an interview with Staff #31 was conducted. When asked if she was aware that the resident was on EBP precautions, the nurse replied no, no one had told her that information. When asked if she knew how the facility identified the residents who were on EBP, the nurse stated she was an agency nurse, and that it was her first day at the facility and that she had not been provided with training yet. On 04/03/2026 at 08:45 AM, Staff #31 was notified of the concern, and the proper personal protection equipment was reviewed with the surveyor. On 04/03/2026 at 08:49 AM, a review of Resident #87's medical record was conducted. The review confirmed that the resident had an order for EBP to be maintained at all times for PICC line use every shift for preventive measures.On 04/03/2026 at 12:33 PM, an interview with the Director of Nursing (DON) was conducted. She reported that the facility requires all staff to adhere to EBP precautions and must wear gowns and gloves when taking care of PICC lines. At this time, the DON was notified of the infection prevention concerns observed. On 04/03/2026 at 2:40 PM, the facility administrator was made aware of the concerns.