STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215321	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Manor Nursing and Rehabilitation Center	333 Mill Street Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interviews, the facility failed to provide dignity and respect for 1(R1) of 3 sampled residents, who preferred to have their bedpan near him/her, but instead moved it away from him/her telling them that they caused a mess while using it.Findings included: R1 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. On 4/30/26 at 10:02 a.m., a review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R1 was cognitively intact for daily decision-making. The MDS indicated that R1 required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. During an interview with R1 on 4/28/26 at 1:55 p.m., he/s stated that Geriatric Nurse Aide (GNA48) placed their bedpan out of reach. GNA48 told him he/s makes a mess when he/s uses the bedpan. R1 stated that he/s was upset by GNA48's disrespect. A telephone call to GNA48 on 4/27/26 at 2:09 p.m. and on 4/30/26 at 8:29 a.m. was not answered, and a voice message was left on the voicemail requesting a return call. In an interview with GNA3 on 4/27/26 at 12:44 p.m., she revealed that R1 reported to her that GNA48 took away his/her bedpan and placed it at a nightstand that was far from him/her. GNA3 stated that she reported the incident to her nurse. During an interview on 4/28/26 at 11:59 a.m. with the Housekeeping Assistant (HKA37), she revealed that she was delivering laundry to the resident, and R1 requested his/her bedpan, which was sitting on a nightstand away from the resident. HKA37 stated that R1 thanked her and stated that the night shift GNA48 had placed the bedpan away from him/her because he/she causes a mess. HKA37 stated that she reported the incident to the nurse. In an interview with the Director of Nursing (DON) on 4/29/26 at 9:34 a.m., she revealed that R1 likes its bedpan on the bed rail and can use it independently. The DON stated that the resident reported that the night GNA48 removed the bedpan from R1 and placed it on a nightstand out of R1's reach. The DON stated that GNA48 apologized for the incident and was suspended pending investigation and was terminated from employment. Mitigation PlanWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: -10/29/25 at 11:00 a.m. R1 told GNA3 that GNA48 took his urinal because s/he makes too much of a mess and placed it on his nightstand at the far corner of his room. -GNA3 reported the incident to LPN52, and the urinal was returned to R1 so s/he could use it. -On 10/29/26 at 1:00 p.m., the representative of R1 was made aware of the incident. -Ongoing Behavior monitoring for any changes. -R1 was seen by the psychiatry services. How other residents who have the potential to be affected by the alleged deficient practice are identified:-On 10/29/25 at 10:29 a.m., all resident interviews were conducted by social services. -Residents felt safe; reported the care was fair/good, and offered no concerns regarding care -The residents also knew who to report grievances to.How the corrective action will be monitored to ensure the deficient practice will not recur: (include re-education)-GNA3 was suspended pending the outcome of the investigation on 10/30/25 and later terminated on 11/3/25. -Maryland Board of Nursing (MBON) was notified of GNA3's deprivation of goods and services on R1.What quality assurance program will be put into place: -Abuse education was completed by RN51 on 12/10/25 for all employees. -MD20 was made aware of the incident and investigation on 10/29/25.Corrective (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	action completion date: 12/11/25. On-site validation of the mitigation plan was completed on 4/30/26. Interviews with staff across all departments at the facility confirmed that they received in-service training in treating residents with dignity and respect.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, the facility failed to prevent verbal abuse by staff for 2 (R3 and R5) of 2 sampled residents. Findings included: 1.R3 was admitted to the facility on [DATE] with diagnoses including Aftercare following joint replacement surgery and chronic pain. On 4/30/26 at 10:02 a.m., a review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] noted that R3 is cognitively intact and required extensive assistance with bed mobility, transfers, and incontinent care. On 4/30/26 at 10:02 a.m., a record review of the facility investigation record dated 12/1/25 at 10:00am showed that the allegation was investigated immediately and that Law Enforcement was notified. The facility investigation report revealed R3 reported to nursing on 12/1/25 at 9:00 a.m. about verbal abuse that occurred on 11/28/25 during the 3-11 p.m. shift perpetrated by Geriatric Nurse Aide (GNA46). The facility investigation report showed the incident occurred while R3 was receiving incontinent care by GNA46. The facility investigation report showed that GNA46 was interviewed by phone by the Director of Nursing (DON), who found GNA46 to be uncooperative during the investigation and terminated employment. In an interview with R3 on 4/27/26 at 12:06 p.m. s/he disclosed that s/he had been admitted to the facility after a hip replacement surgery and needed incontinent care. S/he disclosed that GNA46 responded to s/he's call to provide incontinent care. R3 revealed that s/he had asked GNA46 not to be rough, as s/he had come from surgery. R3 disclosed that GNA46 became verbally aggressive and talked back to her/him in a demeaning way and told R3 to hell to whatever R3 was saying regarding s/he's surgery and pain. R3 stated that s/he was hurt and upset because GNA46 was verbally aggressive for no reason. Telephone calls to the prior GNA46 on 4/28/26 at 11:02 a.m. and on 4/29/26 at 8:29 a.m. were not answered, and a voice message was recorded asking GNA46 to return the call. During an interview with the Director of Nursing (DON) on 4/29/26 at 9:31 a.m., she revealed that immediately, R3 reported verbal abuse, GNA46 was suspended and terminated after substantiation of the allegation. DON stated that the investigation showed that GNA46 had been found rude and mean toward other staff and residents in the past. In an interview with the Administrator on 4/29/26 at 11:43 a.m., he revealed that the complaint had been investigated and substantiated. He stated that GNA46 was terminated and that all staff received abuse-prevention education. Mitigation Plan:What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:-On 12/1/25, GNA46 was immediately removed from the care of residents and suspended pending investigation.-Continued behavior monitoring to check for tearfulness, nervousness, and increased agitation of the residents. -On 12/3/25, Social services completed a follow-up with all residents for 72 hours s/p incident. -Resident was seen by Nurse Practitioner (NP) 49 with Psychogeriatric services on 12/11/25. -On 12/5/25, the staff involved was terminated for violating the facility abuse policy. How other residents who have the potential to be affected by the alleged deficient practice are identified:-Residents with allegations of abuse have the potential to be affected. -On 12/1/25, all residents residing in the same hallway were interviewed, and no abuse concerns were found. How the corrective action will be monitored to ensure the deficient practice will not recur:-On 12/10/25, staff were educated on reporting, recognizing, and preventing abuse. -The nurse interviewed in the investigation had completed verbal education on reporting GNA behaviors when observed. What quality assurance program will be put into place:-Facility-wide abuse education for all employees was completed on 12/10/25. Corrective action completion date: 12/11/25.On-site validation of the mitigation plan was completed on 4/30/26. Interviews with staff across all departments at the facility confirmed they received in-service training on abuse prevention and reporting by 12/10/25. Compliance date: 12/11/25. 2.R5 was admitted to the facility on [DATE] with a diagnosis including kidney disease. R5 was discharged from the facility on 4/12/26. A review on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/26 at 2:00 p.m. of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed R5 was cognitively intact and needed minimal assistance with activities of daily living. On 4/29/26 at 2:00 p.m., during record review of the facility investigation dated 2/9/26, the allegation was investigated immediately, and Law Enforcement was notified. The record review of the facility investigation showed R5 was visibly upset and crying during an interview with the Director of Nursing (DON) on 2/4/26. The facility investigation report showed that R5 reported asking the Activities Director (AD47) for a word search, and that AD47 began yelling at s/he and being mean. The facility investigation report further revealed that AD47 denied raising his voice when R5 asked for the word search. The investigation report showed that AD47 was suspended pending investigation and consequently terminated from employment.Efforts to contact AD47 through telephone calls on 4/28/2026 at 2:10 p.m. and on 4/29/26 at 11:03 a.m. were not successful. AD47 did not answer or return the calls. A record review on 4/29/26 at 4:00 p.m. of AD47's statement dated 2/4/26 during the facility investigation showed AD47 denied raising his voice but admitted denying R5 a word search because he believed R5 would continue harassing him, asking for more word searches before completing the word searches given to R5 the previous day. AD47 stated in his statement that R5 was faking crying and that R5 was not upset over the incident but was sorry about it. In an interview with Housekeeping Assistant (HKA38) on 4/28/26 at 10:05 a.m., s/he revealed that s/he was standing by the activities room on 2/4/26 at 9:15 a.m. when R5 came out of the elevator and told HKA38 that s/he needed a word search from AD47. HKA38 stated that s/he called the AD47 for R5. HKA38 stated that AD47 came to the door to speak with R5, who requested a word search. HKA38 stated that AD47 yelled out loud at R5, telling s/he was not going to give R5 any more word searches. HKA38 stated that AD47 became loud, saying and screaming that he was not going to give R5 any more word search. HKA38 stated that R5 was in tears. HKA38 stated s/he immediately reported the incident to the Unit Manager (UM12). During an interview with the Unit Manager (UM12) on 4/28/26 at 2:20 p.m., s/he stated that the incident was reported to her by HKA38 on 2/4/26 at about 9:18 a.m. UM12 revealed that s/he interviewed the staff and resident, who both reported that AD47 was rude and yelling at the resident when s/he asked for a word search. In an interview with the Director of Nursing (DON) on 4/29/26 at 9:41 a.m., s/he revealed the resident was upset and crying. The DON stated on 2/4/26 at 9:30 a.m., HKA38 reported a nursing allegation of verbal abuse on R5 when s/he was asking AD47 for a word search activity, and instead AD47 started yelling at the resident, telling s/he was not going to give her a word search. The DON revealed that AD47 was suspended and terminated following substantiation of the investigation. S/he further revealed that all staff received abuse-prevention in-service training.Mitigation Plan: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:-On 2/4/26, R5 was concerned about not having word searches. Word searches were immediately supplied to the resident. -Social Services followed up with all residents for 72 hours after the allegation and completed on 2/7/26 -Family member was made aware on 2/6/26 -No concerns found during follow-up interviews. -Continued behavior monitoring for depression. -Medical Director notified 2/4/26. How other residents who have the potential to be affected by the alleged deficient practice are identified:-Residents with allegations of abuse have the potential to be affected. -On 2/5/26, all residents residing in the same hallway were also interviewed with no concerns found. -Any other identified issues will be investigated as needed, no other identified issues. How the corrective action will be monitored to ensure the deficient practice will not recur: -On 2/6/26, the staff involved was terminated related to a violation of the Abuse policy What quality assurance program will be put into place: -Ongoing education for abuse, including preventing, recognizing, and reporting abuse. -State Facility Reported Incidents were reviewed in Quality Assurance and Performance Improvement (QAPI) meeting on 2/7/26 and again on 3/26/25. Corrective action completion date: 2/8/26.On-site validation of the mitigation plan was completed on 4/30/26. Interviews with staff across all departments at the facility confirmed they received in-service training on abuse prevention and reporting by 2/7/26. Compliance date: 2/8/26

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to ensure that care and services were provided in accordance with professional standards of nursing practice for 2 of 5 residents reviewed (Residents #1 and #15). This included failure to follow accepted standards of medication administration, including the five rights of medication administration (right resident, right medication, right dose, right route, and right time) and failure to adhere to manufacturer's guidelines for medication administration.1. Resident #1 was admitted to facility on 9/20/24 with a diagnosis of diabetes.Review done on 4/28/26 at 8:52pm of Quarterly minimum data set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact with a diagnosis of diabetes and received insulin injections daily.Review done on 4/28/26 at 8:56pm of care plan initiated on 10/10/24 indicated that Resident #1 was at risk hypo/hyperglycemia related to DM2 evidenced by history of abnormal blood glucose with interventions to include but not limited to administer hypoglycemic medications per orders.Review done on 4/28/26 at 8:58pm of physician order dated 4/8/26 indicated that Resident #1 to receive Lantus Solostar U-100 insulin (insulin glargine) [antidiabetic medication] 37 units once a day subcutaneous at 8:30 am every day for diabetes.A medication administration observation was conducted on 4/28/26 at 7:45am with Staff Nurse #9. During the medication pass observation, Staff Nurse #9 retrieved an insulin pen from a zip-lock bag labeled for Resident #1, prepared the medication, and administered 37 units of insulin to Resident #1.After administration, the surveyor observed that the insulin pen used was labeled for Resident #14 and not Resident #1. Staff Nurse #9 confirmed the label and stated that they assumed the insulin pen belonged to Resident #1 based on its placement in the bag. Staff Nurse #9 acknowledged that they should have checked the label prior to administration. 2. Resident #15 was admitted on [DATE] with a recent readmission to facility on 4/26/26 with diagnosis of urinary tract infection and dysphagia.Review done on 4/28/26 at 9:32 pm of Annual MDS assessment dated [DATE] indicated that Resident #15 was cognitively impaired and on mechanically altered diet.Review done on 4/28/26 at 10:33am of physician order indicated that Resident #15 had an order for doxycycline hyclate tablet; 100mg; amount to administer: 1 tablet, oral twice a day (take doxycycline 100mg, 1 tablet by mouth twice daily for 3 days for urinary tract infection. (Doxycycline hyclate is an extended-release [enteric-coated] antibiotic)A medication administration observation was conducted on 4/28/26 at 8:24am with Staff Nurse #15. During the medication pass observation, Staff Nurse #15 administered doxycycline hyclate 100 mg by opening a capsule labeled Do Not Crush, mixing the contents with pudding, and administering it to Resident #15.Staff Nurse #15 stated that the resident was on a puree diet and would have difficulty swallowing the capsule whole.During an interview on 04/28/2026 at 8:42 AM, Staff Nurse #15 indicated that Do Not Crush meant the capsule should not be crushed but could be opened.During an interview on 04/28/2026 at 11:04 AM, Staff Nurse #9 indicated that for capsule medications, staff open capsules for administration and, if labeled Do Not Crush, they would not crush but would open them.During an interview on 04/28/2026 at 12:42 PM, Staff Nurse #14 indicated that Do Not Crush means the medication should not be altered, including crushing or opening, particularly for time-release medications, and indicated that doxycycline capsule is a time-release formulation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of facility policy and procedures, and interviews the facility failed to ensure residents were free from avoidable accidents. This was true for 2 of 3 sampled residents (Residents #10 and #14). This failure resulted in harm to Resident #10. The facility implemented a plan of correction with a compliance date of 3/23/2026.The findings include:1.Review done on 4/28/26 at 11:37 PM of the annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively impaired and had severe vision impairment. The MDS assessment also indicated Resident #10 was dependent with eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS assessment further indicated Resident #10 was dependent with rolling left and right while in bed.Review done on 4/28/26 at 11:45 PM of the care plan initiated on 4/21/25 indicated Resident #10 had a self-care performance deficit related to mild cognitive impairment, impaired visual acuity/blindness of the right eye, pain/neuropathy, and fractures of the left foot, as evidenced by the need for assistance with self-care Activities of Daily Living (ADL)s and mobility tasks. Interventions included transfers via Hoyer lift with two-person assistance, bed bath only for safety, toileting/incontinent care with one-person assistance, and bed mobility with one-person assistance.Review done on 4/28/26 at 11:50 PM of the progress note dated 3/21/26 at 1:45 PM by Staff Nurse #15 indicated, GNA called this nurse said Resident #10 rolled out of bed, upon entering room found Resident #10 on the floor laying on the left side. Resident #10 had large amount of blood and clots coming from the right side of the scalp. Pressure dressing applied. Resident #10 is complaining of left shoulder pain. Instructed staff to keep Resident #10 on the floor, MD#20 called x2 message left to call facility and 911 called.Review done on 4/28/26 at 11:50 PM of the progress note dated 3/21/26 at 6:40 PM by Staff Nurse #30 indicated Resident #10 returned from the hospital by ambulance on a stretcher and was diagnosed with a closed displaced fracture of the right clavicle due to fall. The note also indicated Resident #10 had a 1 cm x 3 cm laceration with three staples intact.Review done on 4/28/26 at 11:50 PM of the progress note dated 3/21/26 at 8:50 PM by Staff Nurse #9 indicated a skin assessment was completed due to an unwitnessed fall. The note indicated the following was found: 1 x 3 cm laceration with 3 staples intact. No drainage or odor noted. Surrounding skin is intact.Review done on 4/27/26 at 3:05 PM of the facility-reported incident report, including a statement written by the DON on 3/21/26, indicated Staff Nurse #25 notified the DON at 1:30 PM that Resident #10 fell and was going to the ER. Staff Nurse #25 stated GNA #29 was in the room with Resident #10 and went out of the room to get a towel. GNA #29 did not put the bed/floor mat back against Resident #10's bed and did not put the bed in the lowest position. Staff Nurse #15 indicated GNA #29 reported they left the room without the fall intervention in place. The DON's statement further indicated GNA #29 stated, I feel terrible. I went in to change Resident #10 and I moved the floor mat and raised the bed. I realized Resident #10's sheet was wet so I went out of the room because the linen cart was right outside the room and Resident #10 fell that quick. I know I shouldn't have done that and I feel terrible about it. When asked if GNA #29 lowered the bed before stepping away, GNA #29 responded, Yes but not all the way.Review done on 4/27/26 at 3:05 PM of ED provider notes dated 3/21/26 indicated Resident #10 had a fall after rolling out of bed, hit the head, and had a scalp laceration. The ED notes indicated no loss of consciousness, right shoulder pain, a 1 cm crescent-type laceration to the right side of the scalp with large amounts of blood in the hair, a mildly displaced distal clavicle fracture, and probably a minimally displaced right mid-rib fracture. During interview on 4/28/26 at 10:52 AM, Staff Nurse #9 indicated Resident #10 was alert to self only, blind in one eye, hard of hearing, required total assistance with activities of daily living, was not ambulatory, and was incontinent of bowel and bladder. Staff Nurse #9 confirmed Resident #10 required incontinence care to manage toileting. Staff Nurse #9 stated Resident #10 had a history of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	falls, had a bed alarm, and had fall mats on both sides of the bed. Staff Nurse #9 stated that, to their knowledge, GNA #29 was changing Resident #10 while Resident #10 was in bed, had the bed raised, left the room, and upon return, Resident #10 was on the floor.During interview on 4/28/26 at 10:52 AM, Staff Nurse #9 further indicated that upon entry to the room, Resident #10 was observed on the floor lying on the left side in a lateral position. Staff Nurse #9 indicated the floor mat was moved and Resident #10 was lying on the floor. Staff Nurse #9 stated Resident #10 was bleeding from the head and yelling loudly, saying Resident #10 was in pain. Staff Nurse #9 stated Resident #10 reported left shoulder pain. Staff Nurse #9 stated they held gauze to Resident #10's head and applied pressure until EMS arrived and transferred Resident #10 to the hospital.During interview on 4/28/26 at 12:50 PM, GNA #29 indicated Resident #10 was hard of hearing and blind, required total care, and was incontinent of bowel and bladder. GNA #29 indicated that on the day of the incident, after lunch, around 1:30 PM, they entered Resident #10's room to provide care. GNA #29 stated Resident #10 was in bed with the head of the bed slightly raised, did not have a roommate, and no one else was in the room. GNA #29 stated Resident #10 had fall mats/mattresses on the floor on either side of the bed.During interview on 4/28/26 at 12:50 PM, GNA #29 stated they moved the fall floor mat on Resident #10's left side of the bed, raised the bed to an up position, lowered the head of the bed, and pulled the top sheets to the foot of the bed to check whether Resident #10 required incontinence care. GNA #29 stated Resident #10's brief was wet and the bottom sheet was also wet. GNA #29 indicated that after noticing the entire bed was wet, they left Resident #10 in bed and left the room to get linen/sheets, which were outside the room. GNA #29 indicated they walked out of the room, and upon return, Resident #10 had rolled out of bed and was on the floor.During interview on 4/28/26 at 12:50 PM, GNA #29 confirmed the floor mat to the left side of the bed was not replaced and the bed was not lowered to the lowest position when they stepped out of the room. GNA #29 confirmed Resident #10 was on the floor on the left side of the bed. GNA #29 stated that when they left the room, Resident #10 was positioned supine in the middle of the bed and was not moving. GNA #29 stated that prior to leaving the room, Resident #10 did not show any signs of trying to get out of bed. GNA #29 stated, Resident #10 was perfectly still and I was gone two seconds and come back and Resident #10 was on the floor.During interview on 4/29/26 at 12:19 PM, the Director of Nursing (DON) indicated that GNA #29 was providing incontinence care to Resident #10 and had raised the bed to waist level and moved the mattress and fall mat. The DON indicated that when Resident #10 was turned to the left side, staff realized clean linen was needed and stepped out of the room to retrieve it from the linen cart located immediately outside the room. The DON indicated that during that time, Resident #10 fell from the bed. The DON confirmed that the bed was not lowered completely to the floor and that the fall mat was not properly in place at the time staff left the room. The DON indicated that Resident #10 had a history of falls, was very restless, and required frequent supervision, and could turn from side to side independently in bed. The DON indicated that the aide was not suspended but was educated and allowed to continue working. The DON further indicated that the facility substantiated neglect, stating that fall interventions were not in place prior to leaving the resident unattended, ensuring the bed was in the lowest position, and ensuring the floor mat was in place. The DON indicated that if the bed had been in the lowest position and fall interventions were in place, the incident would likely not have occurred.During interview on 4/29/26 at 1:25 PM, Staff Nurse #26 indicated that Resident #10 was found on the floor wedged between the bed and dresser with active bleeding from the head. Staff Nurse #26 indicated that a large amount of blood was observed and that Resident #10 was lying on the stomach with partial positioning on the left shoulder. Staff Nurse #26 indicated that Resident #10 appeared restless, was attempting to move, and verbalized distress, stating, help, help, I hit my head.Staff Nurse #26 indicated that Resident #10 was a very fast-moving resident, frequently restless, and known to move quickly in bed. Staff Nurse #26 indicated that Resident #10 required close supervision and should not be left unattended, stating, you cannot leave him for a second. Staff Nurse #26 further indicated that lowering the bed completely to the floor and ensuring the floor mat (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was in place to prevent injury. Staff Nurse #26 confirmed that the bed was not lowered to the floor and that the fall mat was away from the bed at the time of the fall and upon initial observation of Resident #10 on the floor.During interview on 4/29/26 at 2:23 PM, the Administrator indicated that GNA #29 stepped out of the room briefly and that Resident #10 fell from the bed during that time. The Administrator indicated that Resident #10 was known to move quickly and that the incident occurred within a short period of time after staff left the room.During interview on 4/30/26 at 4:51 PM, Medical Doctor #20 indicated that Resident #10 was legally blind, hard of hearing, and had advanced dementia. MD #20 indicated that Resident #10 had a history of decline MD #20 indicated that following the fall, Resident #10 sustained a clavicle fracture and head injury and was transferred to the hospital. MD #20 indicated that Resident #10 was already declining prior to the fall and was receiving hospice-level care upon readmission to the facility, and that the resident's overall condition was poor prior to the incident. 2. Review conducted on 4/28/26 at 12:11 p.m. of the facility's policy and procedure titled Mechanical Lifts: General Guidelines, dated 5/3/23, indicated under bullet number 3.K to perform a safety check prior to lifting, including examining all hooks and fasteners to ensure they are secure and will not unhook during use. The policy further indicated to double-check the position and stability of straps and other equipment prior to lifting and to ensure that clips, latches, and bars are securely fastened and structurally sound. Under bullet number 3.L, the policy indicated to lift the resident and perform a safety check again as described above.Resident #14 was admitted to the facility on [DATE] with diagnoses including hemiplegia affecting the right dominant side. Review conducted on 4/27/26 at 8:07 p.m. of the Annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #14 was cognitively intact. The MDS assessment included a pain interview, which indicated the presence of pain occurring almost constantly, which frequently made it difficult to sleep and occasionally limited daily activities. The pain intensity was documented as 7 out of 10 during the five days prior to the assessment.Review conducted on 4/2/26 at 8:19pm of the care plan initiated on 6/11/21 indicated that Resident #14 had a self-care performance deficit related to history of CVA with hemiplegia, cognitive impairment, arthritis evidenced by need for assistance with dressing, toileting, personal hygiene and bathing with interventions to include but not limited to Transfers via Hoyer lift and 2 assist.Review conducted on 4/27/26 at 8:22 p.m. of progress notes dated 12/23/25 at 5:48 p.m., written by Staff Nurse #9, indicated that the resident experienced a witnessed fall during a transfer from the wheelchair to the bed at approximately 4:35 p.m. Upon entering the room, the nurse observed the resident partially in the wheelchair and lying on the floor with their back on the ground. The resident stated that they had pain but were unable to specify the location. The physician was notified, and the resident was sent to the hospital for further evaluation. The resident remained on the floor until Emergency Medical Services (EMS) arrived.Review conducted on 4/27/26 at 8:24 p.m. of progress notes dated 12/23/25 at 11:55 p.m., written by Staff Nurse #10, indicated that Resident #14 returned to the facility following hospital evaluation. A CT scan of the cervical spine, head, and pelvis was completed, with results negative for fracture or dislocation. There were no reports of pain at that time.Review conducted on 4/27/26 at 1:32 p.m. of the Facility Reported Incident (FRI) indicated that Resident #14 fell from a Hoyer lift while being transferred from the wheelchair to the bed. The FRI indicated that Resident #14 complained of back pain following the fall and was sent to the emergency room for evaluation.Review conducted on 4/27/26 at 1:43 p.m. of the CT scan of the pelvis dated 12/23/25 indicated that staff were attempting to transfer Resident #14 using a Hoyer lift when the resident slipped out of the transfer device and was lowered to the ground. Resident #14 reported tailbone pain. The impression indicated no definite fracture or dislocation.Review conducted on 4/27/26 at 1:48 p.m. of the emergency department (ED) provider notes dated 12/23/25 indicated that Resident #14 reported generalized body pain following a fall, which was not present prior to the incident.Review conducted on 4/27/26 at 2:01 p.m. of a written statement by GNA #7 indicated that the lift was raised while a sling hook was not secured, causing the resident to begin leaning.Review conducted on 4/27/26 at 2:06 p.m. of a written statement by (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	GNA #8 indicated that the lift was initiated under the assumption that all sling hooks were secured.Review conducted on 4/27/26 at 8:31 p.m. of the Medication Administration Record (MAR) for the period of 12/01/25 through 12/31/25 indicated no documented reports of pain prior to the incident. Review conducted on 4/27/26 at 8:32 p.m. of the MAR for January 2026 indicated documented reports of pain following the incident. During an interview on 4/17/26 at 12:47 p.m., Resident #14 indicated that staff transferred them using a mechanical lift. Resident #14 stated that they had fallen one time from the lift. Resident #14 stated that two staff members were transferring them from the wheelchair to the bed when the mechanical lift fell on them. Resident #14 stated that the wheelchair moved back and they fell down. Resident #14 stated that they were sent to the hospital. Resident #14 stated that they still had pain and indicated that, at present, they had pain, pointing to their head. Resident #14 indicated that, on a scale of 0 to 10, their pain level was 7 out of 10 and stated that they had body aches all the time.During an interview on 4/27/26 at 12:53 p.m., GNA #3 indicated that Resident #14 used a mechanical lift for transfers. At the time of observation, Resident #14 was in bed and had not been transferred out of bed that day. GNA #3 indicated that Resident #14 would be transferred if requested. GNA #3 indicated that Resident #14 was able to make their needs known, knew staff names, and was able to communicate their needs. GNA #3 indicated that Resident #14 had a history of stroke with right-sided weakness. GNA #3 indicated that Resident #14 had not complained of pain. When asked if Resident #14 had experienced a fall, GNA #3 indicated awareness of an incident involving a mechanical lift in which Resident #14 fell and indicated that they were not present at the time of the incident.During an interview on 4/28/26 at 10:43 a.m., Staff Nurse #9 indicated that Resident #14 was able to make their needs known and was alert and oriented times four, with possible difficulty related to time. Staff Nurse #9 indicated that Resident #14 was able to report pain to staff. Staff Nurse #9 indicated that on 12/23/25, they were informed that Resident #14 was on the floor. Upon entering the room, Staff Nurse #9 observed Resident #14 lying supine on the floor, with the wheelchair tilted backward. Staff Nurse #9 indicated that, when asked what had occurred, both GNA #6 and GNA #7 stated that they did not know what had happened and reported that the lift had just come down. Staff Nurse #9 indicated that GNA #6 and GNA #7 also stated that they had lowered Resident #14 to the floor. Staff Nurse #9 indicated that, upon assessment, Resident #14 denied hitting their head but reported pain and was unable to identify the location. Staff Nurse #9 indicated that Resident #14 was receiving aspirin. Staff Nurse #9 indicated that a pillow was placed under Resident #14's head and that there were no visible signs of injury. Staff Nurse #9 indicated that, due to Resident #14 being on aspirin and reporting pain, the resident was transferred to the hospital for further evaluation. Staff Nurse #9 indicated that Resident #14 remained on the floor until Emergency Medical Services (EMS) arrived.During an interview on 4/28/26 at 1:37 p.m., GNA #6 indicated that they worked with Resident #14 on the day of the incident. GNA #6 indicated that they entered Resident #14's room with GNA #7 and the mechanical lift to transfer Resident #14 from the wheelchair to the bed. GNA #6 stated that Resident #14 was in the room waiting to be transferred and had the sling underneath them while seated in the wheelchair. GNA #6 indicated that they informed GNA #7 that they were going to the supply closet to obtain gloves. GNA #6 indicated that, at the time they left the room, GNA #7 had not yet begun the transfer process.GNA #6 indicated that, upon returning to the room, GNA #7 had already started attaching the hooks of the sling to the mechanical lift. GNA #6 confirmed that neither they nor GNA #7 double-checked (in accordance with facility policy requiring safety checks prior to and during lift use) to ensure that the straps or hooks were properly secured prior to initiating the lift. GNA #6 indicated that they assumed that the hooks had been secured. GNA #6 stated that the hook under Resident #14's left shoulder had not been attached and that neither staff member had secured it. GNA #6 indicated that they could not recall who used the remote to start lifting the mechanical lift.GNA #6 indicated that, during the transfer, the lift had already been initiated when staff (GNA #6 and GNA #7) realized that Resident #14 was slipping out of the sling. GNA #6 indicated that both GNA #6 and GNA #7 attempted to reach for the wheelchair; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	however, it had already tilted backward. GNA #6 indicated that Resident #14 was already coming out of the sling and falling, and staff were unable to control the situation. GNA #6 indicated that the only option at that time was to assist in lowering Resident #14 to the floor. GNA #6 indicated that they then left the room to notify Staff Nurse #9 while GNA #7 remained with Resident #14.During interview on 4/29/26 at 11:59 AM, the Director of Nursing (DON) indicated that Resident #14 was being transferred from the wheelchair to the bed using a mechanical lift and that a clip was not secured to the lift. The DON indicated that GNA #6 and GNA #7 did not perform a safety check to ensure that all hooks were secured prior to initiating the lift. The DON indicated that staff are expected to perform a safety check prior to lifting a resident. The DON further indicated that skills competency check-offs for use of the mechanical lift were not completed upon hire or annually as expected for GNA #6 and GNA #7. The DON indicated that competency validation was conducted after the incident to ensure staff were able to safely use the mechanical lift.During interview on 4/29/26 at 2:02 PM, the Administrator indicated that two GNAs were transferring Resident #14 using a Hoyer lift and that staff believed the resident was secured in the sling but did not double-check that all loops were properly attached. The Administrator indicated that when the resident began to lean, staff lowered the resident to the floor. The Administrator indicated that staff did not verify that all loops were secured prior to initiating the transfer. The Administrator further indicated that one GNA #7 was hired on 11/11/25 and oriented from 11/12/25 through 11/19/25, with a mechanical lift competency completed on 11/16/25. The Administrator indicated that the other GNA #7 hired on 3/18/25, did not have a documented skills competency check-off upon hire but received mechanical lift training in July 2025 at the facility. The Administrator indicated that staff were not retrained immediately following the incident and stated that staff should have received one-on-one competency validation. The facility provided the following corrective action plan.The facility provided a mitigation plan dated 3/21/2026 in response to the incident involving Resident #10. The mitigation plan indicated that on 3/21/2026, the identified resident was reviewed for fall risk and that fall interventions were evaluated and validated upon return to the facility.The facility indicated that residents at risk for falls were identified as having the potential to be affected by the deficient practice and that the Director of Nursing reviewed falls from the prior seven days to validate that interventions were appropriate and in place.The facility indicated that reeducation was completed with nursing staff by 3/23/2026 regarding fall management, including ensuring fall interventions are in place at all times, and education was provided on proper use of the Accora bed.The facility indicated that ongoing monitoring would include continued review of care plans and interventions following each fall and that the Director of Nursing has observed fall interventions in place for at-risk residents since 3/21/2026.The facility indicated that an ad hoc QAPI meeting (a meeting called in response to a specific event) was held on 3/21/2026 and that falls are reviewed weekly to ensure appropriate interventions are in place and care plans are updated accordingly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to ensure proper medication labeling, storage, handling, and administration practices in accordance with pharmacy services policies and procedures and manufacturer's guidelines for 2 of 5 residents reviewed (Residents #1 and #15). This resulted in the administration of medication labeled for another resident and improper alteration of medication despite Do Not Crush instructions.1. Resident #1 was admitted to facility on 9/20/24 with a diagnosis of diabetes.Review done on 4/28/26 at 8:52pm of Quarterly minimum data set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact with a diagnosis of diabetes and received insulin injections daily.Review done on 4/28/26 at 8:56pm of care plan initiated on 10/10/24 indicated that Resident #1 was at risk hypo/hyperglycemia related to DM2 evidenced by history of abnormal blood glucose with interventions to include but not limited to administer hypoglycemic medications per orders.Review done on 4/28/26 at 8:58pm of physician order dated 4/8/26 indicated that Resident #1 to receive Lantus Solostar U-100 insulin, insulin glargine (antidiabetic medicine) 37 units once a day subcutaneous at 8:30 am every day for diabetes.A medication administration observation was conducted on 4/28/26 at 7:45am with Staff Nurse #9. During the medication pass observation, Staff Nurse #9 stated that Resident #1 had a physician's order to receive 37 units of Lantus (insulin glargine). Staff Nurse #9 retrieved a zip-lock bag labeled with the name Resident #1 from the top shelf of the medication cart. From this bag, Staff Nurse #9 removed an insulin pen, applied a needle, and stated the intent to prime the pen prior to administration. Staff Nurse #9 observed priming and dialing the insulin pen. Upon request, Staff Nurse #9 turned the insulin pen in the direction of the surveyor. The surveyor did not handle the insulin pen, as it had been opened with the needle exposed, in accordance with infection control precautions. The surveyor was able to observe that the insulin pen was dialed to 37 units; however, the label on the pen could not be fully visualized at that time because it was partially obscured while being held by Staff Nurse #9.After administration, Staff Nurse #9 returned to the medication cart, removed the needle, disposed of it in the sharps container, and replaced the cap on the insulin pen. The surveyor then requested to inspect the insulin pen. Upon inspection, the surveyor observed that the insulin pen was labeled Resident #14, not Resident #1. The pen was documented as opened on 04/27/2026. The surveyor also noted approximately 260 units of insulin remaining in the pen.Staff Nurse #9 confirmed that the label on the insulin pen indicated Resident #14. Staff Nurse #9 stated that the insulin pen had been stored inside a zip-lock bag labeled for Resident #1 and acknowledged that they assumed the pen belonged to Resident #1 based on its placement in the bag. Staff Nurse #9 further stated that they should have verified the label on the insulin pen prior to administration. Staff Nurse #9 was unable to verify whether the insulin pen labeled for Resident #14 had been previously used.During an interview on 04/28/2026 at 8:10 AM, Staff Nurse #14 stated that on 04/27/2026, Staff Nurse #13 removed a new Lantus (insulin glargine) pen for Resident #14 from the refrigerator in the medication room at the end of the day shift. Staff Nurse #14 indicated that the insulin pen was not administered to Resident #14. Staff Nurse #14 reported that a new insulin pen contains 300 units and that approximately 260 units remained in the pen observed. Staff Nurse #14 further stated that although the insulin pen was labeled for Resident #14, it had not been used on any resident other than Resident #1. Staff Nurse #14 acknowledged that while the medication was correct, it was labeled for the wrong resident.During an interview on 04/28/2026 at 8:21 AM, Staff Nurse #13 confirmed that on 04/27/2026 at approximately 2:30 PM, they removed a new Lantus insulin pen labeled for Resident #14 from the refrigerator in the medication room. Staff Nurse #13 stated that Resident #14 still had insulin remaining in a current pen that was nearing depletion and the new pen was obtained in preparation. Staff Nurse #13 indicated that the new insulin pen was placed in Resident #14's designated medication storage bag and stated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that they did not place the insulin pen in Resident #1's bag. 2. Resident #15 was admitted on [DATE] with a recent readmission to facility on 4/26/26 with diagnosis of urinary tract infection and dysphagia.Review done on 4/28/26 at 9:32 pm of Annual MDS assessment dated [DATE] indicated that Resident #15 was cognitively impaired and on mechanically altered diet.Review done on 4/28/26 at 10:33am of physician order indicated that Resident #15 had an order for doxycycline hyclate tablet; 100mg; amount to administer: 1 tablet, oral twice a day (take doxycycline 100mg, 1 tablet by mouth twice daily for 3 days for urinary tract infection. (Doxycycline hyclate is an extended-release [enteric-coated] antibiotic)A medication administration observation was conducted on 4/28/26 at 8:24am with Staff Nurse #15. During the medication pass observation, Staff Nurse #15 administered doxycycline hyclate 100 mg 1 capsule to Resident #15. The physician's order indicated tablet; however, the medication was supplied in a bubble pack labeled Do Not Crush.Review conducted on 4/28/26 at 11.27am of pharmacy services policies and procedures section 4.1 crushing of medication for oral administration dated with complete manual revision 4/17/24 indicated that All orally administered medications which do not lose effectiveness or produce side effects when crushed, may be crushed per prescriber's order for residents who have difficulty swallowing. A physician order is required to crush medications. The facility should have Do Not Crush list accessible to all nurses. Medications which are enteric coated, extended release, sublingual or otherwise noted by manufacturer as inappropriate for crushing, may not be crushed. The authorized staff or licensed nurse should review the Do Not Crush list prior to opening capsules for administration orally or via tube. If the prescriber/physician orders the crushing of a Do Not Crush medication, he/she must document in the medical record that the benefits outweigh the risk of crushing the medication. The Care Plan must reflect the IDT and staff's determination and/or the resident's preference to have orally administered medications crushed and administered together.During the observation on 4/28/26 at 8:24am, Staff Nurse #15 removed the medication from the bubble pack and opened the capsule prior to administration. Staff Nurse #15 stated that the resident was on a puree diet and would have difficulty swallowing the capsule whole, indicating concern for choking. Staff Nurse #15 opened the capsule, poured the contents into a medicine cup, mixed it with pudding and administered via mouth.During an interview on 04/28/2026 at 8:42 AM, Staff Nurse #15 was asked what Do Not Crush means. Staff Nurse #15 indicated that it meant that the capsule should not be crushed, but could be opened.During an interview on 04/28/2026 at 11:04 AM, Staff Nurse #9 indicated that for capsule medications, staff open capsules for administration. Staff Nurse #9 further indicated that if a medication is labeled Do Not Crush, staff would not crush it but would open it.During an interview on 04/28/2026 at 12:42 PM, Staff Nurse #14 indicated that Do Not Crush means you do not want to crush the capsule or its contents. Staff Nurse #14 indicated that crushing could alter the medication, particularly for antibiotics or time-release formulations. Staff Nurse #14 further indicated that time-release medications should not be opened; however, expressed belief that doxycycline could be opened if needed. Staff Nurse #14 indicated that the facility has a Do Not Crush list and showed the surveyor the 2024 reference list, which indicated doxycycline capsule as a time-release formulation.During an interview on 4/29/26 at 12:30 PM, the Director of Nursing (DON) stated that the facility has a back-up system in the medication room and staff would use available back-up medications. The DON stated that if a medication is not available, the physician is contacted. The DON further stated that staff are not allowed to open or crush medications, as it changes the release rate. The DON indicated that the medication was a capsule and staff may have thought it should have been labeled as extended release.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews the facility failed to ensure that the medication error rate was less than 5% for 5 residents reviewed during medication pass observations. Administration of insulin to Resident #1 using an insulin pen labeled for another resident (wrong resident medication), and alteration of medication for Resident #15 by opening a medication labeled Do Not Crush (improper administration), were observed. This was evidenced by 2 medication errors out of 29 opportunities observed (6.89%), which exceeds the allowable error rate of 5%.1. Resident #1 was admitted to facility on 9/20/24 with a diagnosis of diabetes.Review done on 4/28/26 at 8:52pm of Quarterly minimum data set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact with a diagnosis of diabetes and received insulin injections daily.Review done on 4/28/26 at 8:56pm of care plan initiated on 10/10/24 indicated that Resident #1 was at risk hypo/hyperglycemia related to DM2 evidenced by history of abnormal blood glucose with interventions to include but not limited to administer hypoglycemic medications per orders.Review done on 4/28/26 at 8:58pm of physician order dated 4/8/26 indicated that Resident #1 to receive Lantus Solostar U-100 insulin (insulin glargine) [antidiabetic medication] 37 units once a day subcutaneous at 8:30 am every day for diabetes.A medication administration observation was conducted on 4/28/26 at 7:45am with Staff Nurse #9. During the medication pass observation, Staff Nurse #9 stated that Resident #1 had a physician's order to receive 37 units of Lantus (insulin glargine). Staff Nurse #9 retrieved a zip-lock bag labeled with the name Resident #1 from the top shelf of the medication cart. From this bag, Staff Nurse #9 removed an insulin pen, applied a needle, and stated the intent to prime the pen prior to administration. Staff Nurse #9 observed priming and dialing the insulin pen.Upon request, Staff Nurse #9 turned the insulin pen in the direction of the surveyor. The surveyor did not handle the insulin pen, as it had been opened with the needle exposed, in accordance with infection control precautions. The surveyor was able to observe that the insulin pen was dialed to 37 units; however, the label on the pen could not be fully visualized at that time because it was partially obscured while being held by Staff Nurse #9.Staff Nurse #9 administered the insulin to Resident #1.After administration, Staff Nurse #9 returned to the medication cart, removed the needle, disposed of it in the sharps container, and replaced the cap on the insulin pen. The surveyor then requested to inspect the insulin pen. Upon inspection, the surveyor observed that the insulin pen was labeled Resident #14, not Resident #1. The pen was documented as opened on 04/27/2026. The surveyor also noted approximately 260 units of insulin remaining in the pen.Staff Nurse #9 confirmed that the label on the insulin pen indicated Resident #14. Staff Nurse #9 stated that they assumed the pen belonged to Resident #1 based on its placement in the zip-lock bag labeled for Resident #1. Staff Nurse #9 acknowledged that they should have verified the label prior to administration. 2. Resident #15 was admitted on [DATE] with a recent readmission to facility on 4/26/26 with diagnosis of urinary tract infection and dysphagia.Review done on 4/28/26 at 9:32 pm of Annual MDS assessment dated [DATE] indicated that Resident #15 was cognitively impaired and on mechanically altered diet.Review done on 4/28/26 at 10:33am of physician order indicated that Resident #15 had an order for doxycycline hyclate tablet; 100mg; amount to administer: 1 tablet, oral twice a day (take doxycycline 100mg, 1 tablet by mouth twice daily for 3 days for urinary tract infection. (Doxycycline hyclate is an extended-release [enteric-coated] antibiotic)A medication administration observation was conducted on 4/28/26 at 8:24am with Staff Nurse #15. During the medication pass observation, Staff Nurse #15 administered doxycycline hyclate 100 mg 1 capsule to Resident #15. The physician's order indicated tablet; however, the medication was supplied in a bubble pack labeled Do Not Crush.During the observation on 4/28/26 at 8:24am, Staff Nurse #15 removed the medication from the bubble pack and opened the capsule prior to administration. Staff Nurse #15 stated that the resident was on a puree diet and would have difficulty swallowing the capsule whole. Staff Nurse #15 opened the capsule, poured the contents into a medicine cup, mixed it with pudding and administered via mouth.