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	09/15/2025

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure that residents were served meals according to a predetermined menu that incorporated the residents' preferences. This deficient practice has the potential to affect all residents. The findings include:1) A dining observation on the 2S Wing of the 2nd floor Unit on 9/10/2025, at 12:41 PM, revealed Resident #100 eating lunch in his/her room. The Resident's tray consisted of a roast beef sandwich, Ice cream, 1 Jell-O cup, 4oz of cranberry juice, 8 oz of Iced Tea, and 1/2 cup of seasoned peas.However, the Resident's meal ticket listed the following items: 1/2 cup of no-sugar-added ice cream, 1 Jell-O cup, a chicken sandwich, 2 4-oz cranberry Juices, and 1/2 cup of seasoned peas. The Resident said, I don't know what's wrong with the kitchen. I was supposed to get a chicken sandwich, but they sent me a roast beef sandwich instead. And it happens frequently; they don't read what's on the ticket. 2) Observation of lunch on the 2W wing of the 2nd floor Unit on 9/10/2025 at 1:08 PM showed that Residents #53, #54, #92, and #121 were all to get 1/2 cup seasoned peas on their trays per their meal tickets.However, they all received corn on their meal trays instead of peas, and yet there was no indication of corn on their meal tickets.In an interview later that day, Staff #23, the Dietary Director, reported that they had run out of peas and her staff decided to serve the residents corn instead. Staff #23 added that she would ensure that the staff made extra vegetables in the future.3) During an observation of lunch on the 2W wing of the 2nd floor Unit on 09/10/2025 1:11 PM, it was noted that Resident #126 was eating lunch in his/her room. On the Resident's meal tray was a ticket that listed all the food items to be on the tray: 1/2 cup ice cream, 8oz water, 1 Ensure Plus, roast beef with w/gravy, 1/2 cup seasoned peas, and 8 oz Tea.However, the observation failed to show that Resident #126's tray contained Ensure Plus and seasoned peas. The Resident stated s/he did not receive the Ensure Plus and seasoned peas.4) Observation of Lunch on the 2S Wing of the 2nd floor Unit included Resident #85 eating Lunch in his/her room. The observation noted from the Resident's meal ticket was that s/he was to receive one pureed vanilla ice cream, 6 Fl oz of tomato soup, 4oz of apple juice, one fruit yogurt, 6oz of beef broth, and 8oz of water. However, the observation failed to show that Resident #85 received fruit yogurt on his/her tray. The Resident's family was present and stated there was no yogurt on the tray.5) During an observation of the facility's dinner tray line service on 9/11/2025, at 5:35 PM, the surveyor requested a test tray. The tray contained a meal ticket for Resident #35, with a list of food items to be served to the Resident: 1/2 cup of peaches & pears, 3oz pulled pork sandwich, 4 oz baked beans, 6oz coffee, one creamer, and 8 oz Iced tea.However, the observation failed to show that Resident #35's tray contained the portion size listed on the Resident's meal ticket for the baked beans. Staff #23 was present during the observation. She measured the baked beans with a 4-oz spoon and confirmed that it was less than 4 oz. During an interview on 9/15/2025, at 8:54 AM, staff #23 stated that her staff was serving with the right scoop on 9/11/25; however, she was not filling it to the full level. Staff #23 added that training would be provided to her staff to address all the concerns.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to ensure that: 1) food was stored in accordance with professional standards, and 2) clean dishes were stored and maintained in a manner to prevent contamination. This practice has the potential to affect all the residents in the facility.The findings include:1) During the initial tour of the kitchen, on 9/9/25 at approximately 8:30 AM, an observation was made of a large white container stored underneath a meal prep area. The container was labeled sugar, and contained a large, open bag of sugar and a serving scoop. The clear lid of the container was noted to be cracked, and the outside of the container was covered with debris. Staff #23, the Dietary Director, was present during the observation and reported that she had another lid, so she would replace it after the surveyor's intervention.2) An observation of the facility's lunch tray line service on 09/11/2025, at 12:16 PM, also showed a dome drying rack filled with covers that were being used to cover the residents' lunch. The rack was noted to have a significant amount of brownish-yellowish debris/substances on it. Staff #25, a Cook, was present and she mentioned that the drying rack was usually cleaned three times a week; however, it had not been cleaned this week. Staff #23 was also present and interviewed. She said, It looks dirty, and added she would take care of it.During a subsequent tray line service observation on 9/11/2025, at 5:34 PM, it was noted that the dome drying rack appeared clean. Staff #23 reported that it was bleached and cleaned after the surveyor's intervention. Staff #23 also added that she would educate her staff to clean the drying rack.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to ensure linens were processed appropriately to prevent cross contamination. This deficient practice had the potential to affect all residents of the facility.The findings include: The facility's laundry room was initially observed on 9/9/25 at 8:55 AM. During the observation, Housekeeping (Staff #12) was on the clean side of the laundry room folding clean linens. The laundry room's clean and soiled side was separated by a door which was observed wide open. Also present in the soiled side were 2 rolling carts full of dirty linens with no covers.On 9/9/25 at 8:58 AM, Staff #12 was interviewed about her process with laundry. During the interview, she confirmed that there were 2 carts full of dirty linens waiting to be put in the washer while she was folding on the clean side of the room. She also confirmed that the door separating the 2 sides of the room was left open.The concern with cross contamination was discussed with Staff #12 and she stated, I totally understand.On 9/9/25 at 11:39 AM, the Housekeeping Director (Staff #13) reported to the surveyor that Staff #12 was getting ready to process a load of dirty linens and invited the surveyor to observe. During the observation, Staff #12 put on disposable gloves and apron prior to sorting the dirty linens and loading them into the washer.Staff #13 was interviewed on 9/9/25 at 11:58 AM. During the interview, she reported and confirmed that the facility staff had been using disposable aprons when processing dirty linens for over 2 years now. She indicated that the facility used to supply them with isolation gowns and then switched over to using disposable equipment.An interview with the Infection Preventionist Nurse (Staff #1) was conducted on 9/10/25 at 9 AM. During the interview, the concerns with leaving the door open between the clean and soiled area of the laundry room, and the use of disposable aprons when processing soiled linens were discussed. Staff #1 reported that she had just done an infection control boot camp and indicated that it included all housekeeping staff and that part of the training was about Personal Protective Equipment (PPE). Staff #1 stated, I don't know why they would use aprons because your arms are still exposed. Staff #1 verbalized understanding and acknowledged 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observations, it was determined that the facility failed to develop person-centered, resident-specific care plans. This was evident for 1 (Resident #92) of 1 resident reviewed for insulin use and 2 (Residents #4 and #13) of 3 residents reviewed for activities.The findings include: A comprehensive care plan in long-term care is a document that outlines a person-centered roadmap for meeting a resident's unique medical, physical, emotional, and social needs, ensuring high-quality, consistent care across all settings and providers. It facilitates full health management, improves communication and coordination among the care team, prevents medical errors, and supports resident independence and quality of life by addressing their individual preferences and goals. 1.) Resident #92 resides at [NAME] Manor for physical therapy and nursing care following a surgical amputation of one leg. Resident #92 has a long history of Type 2 Diabetes and associated medical conditions including heart disease and chronic kidney disease.Hypoglycemia refers to a condition where blood sugar (glucose) levels drop below normal (below 70 for diabetics). Severe hypoglycemia can occur when blood glucose levels drop below 40 mg/dL. This can lead to serious complications such as seizures, coma, and even death.Glucagon medication is used for emergency treatment of very low blood sugar (severe hypoglycemia).On 9/09/25 at 11:07 AM, the surveyor spoke with Resident #92 and asked questions about the residents' history of diabetes and whether the facility had taught them about the signs and symptoms of low blood sugar (hypoglycemia). Resident #92 stated that s/he had struggled with diabetes for years, and when they were first admitted to [NAME] Manor the facility had some difficulty getting their blood sugar straight. They reported that they were transferred to the hospital following an incident of low blood sugar.On 9/10/25 at 2:08 PM, the surveyor reviewed Resident #92's progress notes which revealed:-Nursing Progress Note dated 7/1/25 at 6:28 AM: .aide alerted nurse to resident [#92] mumbling and not making sense. BS [Blood Sugar] 37, gave glucagon 1mg injection to [Right Arm], call placed to 911. left message for MD, on-call notified.-Nurse Progress Note dated 7/1/25 at 12:46 PM: Resident [#92] returned to the facility at this time from [name of hospital]. The hospital stated that resident diagnosis was hypoglycemia [low blood sugar].-Physician Progress Note dated 7/01/25 10:09 PM: In part stated: Follow-up check on [Resident #93] who had been to the emergency room earlier because of being unresponsive with hypoglycemic [low blood sugar] incident. S/he carries a diagnosis of insulin-dependent diabetes mellitus with a hypoglycemic episode this morning.-Nurse Progress Note dated 7/2/25 at 11:28 AM: Resident #92 approached for blood sugar check at 730AM, awake and groggy. Blood sugar 39. Given chocolates and milk with sugar and cheese crackers with peanut butter. Resident was more responsive and asked what happened. [Nurse] explained to resident that their sugar had dropped again and is doing much better.On 9/10/25 at 2:30 PM, the surveyor reviewed Resident #92's current care plan dated 8/22/25 and apart from a carbohydrate-controlled diet [diabetic diet] was unable to find any interventions for the management of Resident #92's diabetes. On 9/11/25 at 9:50 AM, the surveyor interviewed the facility Director of Nursing (DON) and asked her to explain her understanding of the purpose of a care plan. She replied, It is so that the staff know what interventions are to be taken for the resident. When asked if these are general interventions, she stated, The interventions should be resident specific.The surveyor then asked what diabetic interventions would be expected to be included for a comprehensive care plan. The DON stated, The care plan should include interventions such as lab work, skin checks, blood sugar checks, vitals, medications, and that standing orders for glucagon are also included.The surveyor then asked the DON to review Resident #92's care plan and identify any diabetes related goals, interventions, or treatments. She replied that she did not see any related to Resident #92's diabetes. The surveyor expressed concern and the DON stated, these interventions should have been (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included in the care plan, and the oversight should have been caught after the transfer to the hospital.On 9/11/25 at 10:27 AM, the DON provided the surveyor with the facility policy and procedure titled Care Plan Processes, Person-Centered Care (revised 5/5/23), which in part states:The facility will develop and implement a baseline and comprehensive care plan for each resident that includes instructions needed to provide effective and person-centered care for the resident and meet professional standards of quality care.Through ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates.2.) On 9/9/25 at 8:44 AM, the Surveyor interviewed Resident #4. Resident #4 stated that they had lived in the facility for nearly four years. When asked what they do for fun, Resident #4 stated, I sometimes go to Bingo but added that they usually prefer to stay in their room. When asked if the facility provided 1:1 visits or activities of interest in their room, the resident replied, no. The surveyor did not observe any puzzles, books, or other items that could be considered entertainment, other than the television.On 9/11/25 at 3:10 PM, the Surveyor performed a review of Resident #4's activities progress notes which revealed the following:Quarterly Activities Progress Note dated 1/22/25, documented by the Activities Director (AD): [Resident #4] is alert and able to communicate [their] needs or concerns. [S/he] spends the majority of [their] day watching TV and spending time with [their] family when they are within the facility. [Resident #4] enjoys attending Bingo and monthly Resident Council meeting with peers. [S/he] has recently become more involved in group activities. Enjoys helping with baking activities. [S/he] is meeting [their] goal and will continue with plan of care until next review date.Quarterly Activities Progress Note dated 4/23/25, documented by the Activities Director:An identical note was entered on this date, reflecting the same language as above.On 9/11/25 at 3:30 PM, the Surveyor reviewed Resident #4's current activities care plan, which failed to include resident-specific interests such as those mentioned in the progress notes on 1/22/25 or 4/23/25 (Bingo, Resident Council, baking, or group activity). The care plan contained generic interventions, each with a start date of 10/26/21, including: Assist as needed in turning television to preferred network for favorite program (favorite network or program not named). Discuss items of interest while in room such as career, family, hobbies, what he/she enjoys doing for fun or pleasure (no note of what the resident enjoys). Provide supplies in room for self-directed activities as needed or requested (no mention of what activities are preferred). Provide with music of preference-invite and encourage attendance at music programs (no mention of music preferences or if the resident likes music). Staff will offer and provide reading materials of interest as needed (no mention of reading preference or if the resident likes to read).The only documented update to Resident #4's activities care plan since the start date of 10/26/21 occurred on 5/3/22, which addressed behavior issues and instructed staff to provide reassurance using calm tone of voice when these behaviors occur and alert nursing staff and to remind Resident #4 of scheduled group activities using verbal cues. There is no evidence to support that the residents care plan was updated following the AD notes dated 1/22/25 or 4/23/25. The resident's current activities care plan did not reflect their stated interests or individualized activity preferences, nor did it address their expressed desire for in-room activities.3.) On 9/9/25 at 11:09 AM, the Surveyor observed Resident #13 in bed and asked about activities. Resident #13 denied participation in activities.On 9/11/25 at 12:41 PM, a review of Resident #13's medical record revealed diagnoses of depression and anxiety. The resident was documented as having lower body impairment, requiring the use of a wheelchair, and needing maximum assistance to get out of bed.On 9/11/25 at 3:05 PM, the Surveyor reviewed Resident #13's activities progress notes, which revealed the following:Quarterly Activities Progress Note dated 1/27/25, documented by the Activities Director (AD): [Resident #13] is able to communicate [their] needs or concerns. [S/he]is very pleasant. [S/he] enjoys eating [their] meals in the dining room and socializing with peers. [S/he] attends group activities of choice such as parties or socials. [S/he] enjoys puzzle books. [S/he] is meeting [their] goal and will continue with plan of care until next review date.Quarterly Activities Progress Note dated 4/29/25, documented by the Activities (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director:An identical note was entered on this date, reflecting the same language as above.On 9/11/25 at approximately 3:15 PM, the Surveyor reviewed Resident #13's current activities care plan, which failed to include resident-specific interests mentioned in the progress notes on 1/27/25 or 4/29/25 (meals in the dining room, parties and socials, and puzzle books). The care plan contained generic interventions with a start date of 7/5/24, including: Provide activity calendar and review some of the programs and available materials and equipment available for use. Staff will assist resident in participating in favorite activities such as watching TV, listening to music, or completing puzzles (no documentation of what specific TV programs or music Resident #13 enjoys).On 9/12/25 at 9:36 AM, the Surveyor interviewed the Activities Director (AD). The Surveyor asked the AD to explain the process for determining residents' personal preferences. The AD stated he uses a template that asks questions like preferred name, background, what they did for a living, music preferences, art interests, if they enjoy cooking or cleaning, and about religious preferences.The Surveyor asked how that assessment is implemented in the care plan. The AD explained that the electronic medical record (EMR) program has a template for activities in which he must manually add resident-specific interventions. He provided an example, stating that for music I could add what type of music versus just saying they like music.On 9/15/25 at 9:26 AM, the Surveyor conducted a follow-up interview with the AD. The Surveyor asked where the Activities Assistant would go to find residents' individual preferences. The AD initially responded, she would ask me. When asked if the assistant could look in the residents' care plan, the AD replied that the assistant does not have access to the EMR, but if she really needed it she could log into my account or myself or the MDS nurse could print it for her. When asked if the care plan would show specifics about residents, the AD responded, the care plan should be able to show the specifics.The Surveyor then asked the AD to look up Resident #4's care plan. The AD immediately said, she likes the newspaper. When asked how he knew that the AD responded, from her initial assessment. The Surveyor asked him to show the assessment. After opening it, the AD stated, oh wait, the assessment is blank, I didn't work here then (October 2021). He then reviewed the annual (dated 8/24/24) and stated, he/she likes her family, dog visits, and beauty shop, has no interest in painting or cooking, and likes games. The assessment did not mention the newspaper. The AD then added, Oh, her most recent annual says she doesn't like reading, but that is wrong because I know she likes the newspaper and daily chronicle.The Surveyor redirected the AD to look at Resident #4's care plan. The AD stated, I can't tell by looking at the care plan what her specifics are. When prompted to review the care plan, he confirmed that it was just the template and doesn't include resident specifics. The AD admitted , My weakness is in care planning, and stated he had been working with corporate to improve. He also reported, During our mock survey it was brought to my attention that I need to include specifics in the care plans.On 9/15/25 at 10:20 AM, the Surveyor spoke with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the lack of resident-specific care plans and evidence of updates for Residents #4 and #13. The NHA stated they were not surprised by this finding because during a mock survey that we had just completed it was identified as a concern. The DON added that a plan of correction would be initiated to address the issue.On 9/15/25 at 10:52 AM, the NHA returned with his computer and showed the Surveyor a document he described as items identified as issues during a recent mock survey. He pointed to line 20, which addressed care planning and specificity, and acknowledged, the care plan must be specific and regularly updated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record reviews, it was determined that the facility failed to reassess the effectiveness of resident care plans and revise them to address resident-specific needs. This was evident for 3 (Resident #4, #13, and #60) of 3 residents reviewed for activities. The findings include:In long-term care, a revised care plan is a modified version of a resident's original care plan that reflects a change in their needs, preferences, or medical status. Regulatory requirements mandate revisions after specific assessments, including both comprehensive and quarterly assessments, and whenever a significant change occurs, to ensure the care provided remains appropriate and effective.The resident's care plan must be reviewed after each assessment, as required by S483.20, and revised based on changing goals, preferences, and needs of the resident, and in response to current interventions.1.) On 9/9/25 at 8:44 AM, the Surveyor interviewed Resident #4 who stated that they had lived in the facility for nearly four years. When asked what they do for fun, Resident #4 stated, I sometimes go to Bingo but added that they usually prefer to stay in their room. When asked if the facility provided 1:1 visits or activities of interest in their room, the resident replied, no. The Surveyor did not observe any puzzles, books, or other items that could be considered entertainment, other than the television.On 9/11/25 at 3:10 PM, a review of Resident #4's activities progress notes revealed the following:Quarterly Activities Progress Note dated 1/22/25, documented by the Activities Director (AD): [Resident #4] is alert and able to communicate [their] needs or concerns. [S/he] spends the majority of [their] day watching TV and spending time with [their] family when they are within the facility. [Resident #4] enjoys attending Bingo and monthly Resident Council meeting with peers. [S/he] has recently become more involved in group activities. Enjoys helping with baking activities. [S/he] is meeting [their] goal and will continue with plan of care until next review date.Quarterly Activities Progress Note dated 4/23/25, documented by the Activities Director:An identical note was entered on this date, reflecting the same language as above.On 9/11/25 at 3:30 PM, the Surveyor reviewed Resident #4's current activities care plan, which failed to include resident-specific interests such as those mentioned in the progress notes dated 1/22/25 and 4/23/25 (Bingo, Resident Council, baking, or group activity).The Surveyor noted that the only update to Resident #4's activities care plan since the start date of 10/26/21 occurred on 5/3/22, which addressed behavior issues and directed staff to remind Resident #4 of scheduled group activities using verbal cues. There is no evidence to support that the resident's care plan was updated following the AD assessment notes dated 1/22/25 or 4/23/25, or that the resident's preference for in-room activities was addressed.2.) On 9/9/25 at 11:09 AM, the Surveyor observed Resident #13 in bed and asked about activities. Resident #13 denied participation in activities.On 9/11/25 at 12:41 PM, a review of Resident #13's medical record revealed diagnoses of depression and anxiety. The resident was documented as having lower body impairment, requiring the use of a wheelchair, and needing maximum assistance to get out of bed.On 9/11/25 at 3:05 PM, the Surveyor reviewed Resident #13's activities progress notes, which revealed the following:Quarterly Activities Progress Note dated 1/27/25, documented by the Activities Director (AD): [Resident #13] is able to communicate [their] needs or concerns. [S/he] is very pleasant. [S/he] enjoys eating meals in the dining room and socializing with peers. [S/he] attends group activities of choice such as parties or socials. [S/he] enjoys puzzle books. [S/he] is meeting [their] goal and will continue with plan of care until next review date.Quarterly Activities Progress Note dated 4/29/25, documented by the Activities Director:An identical note was entered on this date, reflecting the same language as above.On 9/11/25 at approximately 3:15 PM, the Surveyor reviewed Resident #13's current activities care plan, which failed to include resident-specific interests mentioned in the AD's notes on 1/27/25 or 4/29/25 (meals in the dining room, parties and socials, and puzzle books). The care plan contained generic interventions with a start date of 7/5/24 and no updates were added after that date.3.) Resident #60 is a paraplegic (the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inability to voluntarily move the lower parts of the body), which requires her to be dependent on others for her care, and suffers from anxiety and depression.On 9/9/25 at 9:47 AM, the Surveyor spoke with Resident #60, who stated that she does not attend activities and that they do not provide 1:1 activity in her room.On 9/12/25 at 11:44 AM, the Surveyor reviewed Resident #60's activities progress notes, which revealed the following:Quarterly Activities Progress Note dated 2/5/25, documented by the Activities Director (AD): [Resident #60] is alert and oriented. [S/he] spends the majority of [their] day watching TV and socializing with staff. [S/he] participates in room visits with Activity Staff to discuss what [s/he] is watching on TV or the weather and pet visits. [S/he] also enjoys reading the Daily Chronicle. [S/he] is meeting [their] goal and will continue with plan of care until next review date.Quarterly Activities Progress Note dated 5/7/25, documented by the Activities Director:An identical note was entered on this date, reflecting the same language as above.On 9/11/25 at approximately 3:40 PM, the Surveyor reviewed Resident #60's current activities care plan, which failed to include resident-specific interests mentioned in the AD's notes on 2/5/25 or 5/7/25 (what TV programs s/he enjoys, what in-room activities they enjoy, if they like pets, or enjoyment of the Daily Chronicle).An Evaluation note dated 8/7/25 written by Nurse #8 was included in the evaluation section of the care plan, which stated that the resident prefers to stay in her room due to pain and that she enjoys her soap opera and the Hallmark Channel and that she enjoys snacks and animals, and enjoys reading the Daily Chronicle and devotionals and prefers independent activities. The care plan was not updated to include these activities.The care plan approaches were last updated in May of 2023, and other than mentioning that she prefers to stay in her room and watch TV, it does not provide any details to help a reader understand the resident's preferences for which TV shows she likes or that she enjoys snacks, animals, or devotionals.On 9/12/25 at 9:36 AM, the Surveyor interviewed the Activities Director (AD) regarding the process for determining residents' personal preferences. The AD stated he uses an assessment template that asks questions like preferred name, background, past occupation, music and art interests, enjoyment of cooking or cleaning, and religious preferences. He explained that in the electronic medical record (EMR) system, he must manually enter resident-specific interventions. For example, instead of documenting only that a resident likes music, he could specify the type, such as country.On 9/15/25 at 9:26 AM, the Surveyor conducted a follow-up interview with the Activities Director (AD) and asked whether resident preferences are updated each quarter during care plan meetings. The AD responded, No, I only update that annually. When asked how changes in interests are identified if updates are not made quarterly, the AD stated, Well, I sometimes make changes if it is a major change, but for quarterly assessments, I largely only go by the previous care plan.The Surveyor then asked the AD to review Resident #4's care plan. The AD stated, I can't tell by looking at the care plan what her specifics are. When prompted to examine it, he confirmed that it was just the template and doesn't include resident specifics. The AD then stated, My weakness is in care planning, and stated he had been working with corporate to improve. He also reported, During our mock survey it was brought to my attention that I need to include specifics in the care plans.The Surveyor noted that many components of resident care plans had not been updated since 2021. The AD again stated that he only updates plans with major changes or during the annual review, reiterating, I am still learning.The Surveyor then asked the AD to review Resident #13's care plan, which he confirmed is not resident specific. When asked to review Resident #60's care plan, he agreed that it also lacked resident-specific information. The Surveyor expressed concern that Residents #4, #13, and #60 appeared not to have their care plans updated during their quarterly assessments. The AD responded, I am still learning and can reach out to my corporate contact for more guidance.On 9/15/25 at 10:20 AM, the Surveyor spoke with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the lack of reassessments for activities care plans for Residents #4, #13, and #60. The NHA stated they were not surprised by this finding because during a recent mock survey it was identified as a concern. The DON added that a plan of correction would be initiated to address the issue.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record review, interviews, and observations, it was determined that the facility failed to ensure that residents received their meals at an appropriate and palatable temperature. This deficient practice has the potential to affect all residents who receive meals from the facility's kitchen. The findings include:A review of the facility's grievance summary report revealed that a concern regarding the facility's food was reported to the Social Services Director on 9/4/25, stating that the facility's food was still cold. The report was reviewed by the Nursing Home Administrator and resolved on 9/5/25.Continued review of the facility's Nutrition Policies and Procedures contained a statement that Hot foods are maintained at 135 F or higher and cold foods are maintained at 40 F or below at the point of service.During a tour of the facility on 9/9/2025, Residents #4, #8, and #9 reported that the facility's food was often cold for foods that needed to be warm and warm for foods that required to be cold.During an observation of the facility's dinner tray line service on 9/11/2025, at 5:35 PM, the surveyor requested a test tray. The tray contained a pulled pork sandwich, baked beans, Peaches/Pears, Coffee, Iced Tea, and creamer. Staff #23, the Dietary Director, was present and obtained the food temperatures, which showed 127 degrees for the pulled pork, 129 degrees for the baked beans, and 59 degrees for the peaches/pears. Staff #23 indicated the acceptable temperatures should have been 135 degrees for the pork and beans, and 40 degrees for the peaches/pears.In an interview on 9/15/2025, at 11:09 AM, staff #23 indicated that they had found a 2-lid plate cover to keep the residents' meals warm after the surveyor's intervention. Staff #23 also added that she will train her staff in a new process to address concerns regarding food temperatures.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, observations, and interviews, it was determined that the facility failed to treat residents with respect and dignity during mealtime. This was evident for 3 out of 5 meal observations during the survey.The findings include:1) A record review for Resident #71 showed that s/he required physical assistance from staff with eating.An observation of breakfast on the 3rd floor Unit on 9/10/2025, at 8:35 AM, showed staff #15, an occupational therapy assistant, feeding Resident #71 in his/her room. Resident #71 was lying in bed while staff #15 was standing by the right side of the Resident's bed.Staff #15 was interviewed at that time and stated that she was aware that standing to feed a resident was undignified; however, she stood to feed Resident #71 because it was comfortable for the Resident when she stood up. A review of Resident #71's medical record later that day failed to show documentation that indicated that staff were to stand while feeding the Resident.A subsequent observation of Resident #71 on 9/11/2025, at 8:37 AM, revealed that staff #16, a geriatric nurse aid (GNA), was feeding Resident #71 breakfast. The Resident was in bed while Staff #16 was noted sitting down at the right side of the Resident's bed. Staff #16 was questioned and stated that it was comfortable for residents when staff sat down to be at the residents' level when assisting them with eating.In an interview on 9/11/2025 at 11:17 AM, the Director of Nursing (DON) reported that it was her expectation for her staff to sit down at the residents' level when assisting residents with eating their meals. However, earlier observations showed otherwise.2) An observation of breakfast on 9/11/2025 at 8:26 AM in the 3rd-floor Unit dining room showed a geriatric nurse aid, who was prepping Resident #69 for breakfast. Staff #17 placed a clothing protector on Resident #69's chest without asking.Continued observation showed that Resident #69 was talkative, alert, oriented, and able to verbalize needs. However, staff #17 did not ask the Resident before placing a clothing protector on him/her.During an interview on 9/11/2025, at 9:10 AM, staff #18, a GNA, stated that staff had to ask residents before placing clothing protectors on them to respect their dignity.In an interview on 9/15/2025, at 2:36 PM, the DON stated that staff were expected to ask residents before placing clothing protectors on them for meals. 3) During an observation of breakfast in the 3rd-floor Unit dining room on 9/11/2025 8:26 AM, Residents #69 and #70 were seated at one table while Residents #98 and #31 were also sitting at another table. The observation noted that Residents #69 and #98 had finished eating their breakfast, while Residents #70 and #31 continued to wait for theirs. Resident #30 said, I just gotta wait for my tray while others are eating, there's nothing else I can do about it.Both Residents continued to wait for their breakfast until 9:06 AM, about 30 minutes later, at which time Resident #69 wanted to return to his/her room as s/he began to feel cold in the dining area. In an interview, Staff #5, a licensed practical nurse, indicated that Residents #69, #70, #98, and #31 were typically the four residents in the dining room for breakfast almost every day. However, she could not say why their trays were not sent to the dining room at the same time. During an interview on 9/11/2025, at 11:17 AM, the DON stated that she was made aware of the concern that some residents had waited for their breakfast. The DON indicated that they addressed the situation after the surveyor's intervention.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interviews it was determined that the facility failed to ensure a sanitary and homelike environment. This was found during random observations of two residents' rooms (Resident #97 and #67) and 1 out of the 2 nursing units.The findings include:1.On 9/10/25 at 9:45 AM surveyor observed a privacy curtain that was pulled between Bed A and Bed B in Resident #97's room. Surveyor noted several dark red splotches covering an area approximately 2 inches in length on the privacy curtain. This area was noted to be at the far end of the curtain at about five feet above the floor.Review of Resident #97's medical record revealed the resident has resided at the facility for more than one year. Review of the most recent Minimum Data Set assessment, with a reference date of 7/30/25 revealed the resident is cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15.On 9/12/25 at 11:25 AM surveyor again observed the dark red splotches on the curtain between Bed A and Bed B in Resident #97's room. Resident #97 reported the stain is blood and that it has been there for months.On 9/12/25 at 11:38 AM surveyor requested that the unit nurse manager #10 come to Resident #97's room. The unit nurse manager acknowledged the stains and indicated she would notify housekeeping.On 9/12/25 at 12:45 PM surveyor reviewed the concern with the Director of Nursing (DON) that the stain on the curtain was observed earlier in the survey and that the resident reported it had been there for months. DON reports they have already cleaned it.2. On 9/12/25 at 11:25 AM surveyor observed Resident #97's bathroom. The sink was observed to have at least 7 cracks of various lengths branching out from the drain. Just below the sink counter was a board covered in laminate. The laminate was noted to be loose and a piece of silver duct tape was also noted on this board.On 9/12/25 at approximately 11:30 AM Resident #67 indicated to the surveyor a concern with the state of his/her bathroom. Observation of Resident 67's bathroom revealed the sink had more than 10 cracks branching from the drain with multiple other cracks noted in the sink basin. Observation of the drawers located in the bathroom revealed one of the drawers had two areas of laminate missing exposing the wood underneath. These areas of missing laminate were both approximately 1-inch triangles missing from the corners.On 9/12/25 at 1:12 PM the Maintenance Director #11 reported that staff can report maintenance concerns through TELS (a computer system used to track maintenance needs). When asked if he had any concerns regarding sinks, the Maintenance Director indicated concerns regarding faucets, valves and pipes.On 9/12/25 at 1:18 PM surveyor and Maintenance Director toured the facility. During this tour the bathrooms were observed in Resident #97 and #67's rooms. The Maintenance Director acknowledged the observations of the cracks in the sinks, as well as the issues with the loose/missing laminate. The Maintenance Director indicated he had not previously been made aware of a concern regarding the cracks in the sinks.3. Review of the statement of deficiencies from the previous recertification survey revealed the facility was cited for failure to maintain unit floors in a safe and sanitary condition. The deficiency included observations of cracks in the floor tile at multiple locations on both the second and third floor hallways. Visual observations made on 9/10/25 revealed similar cracks in the floor tiles, however interview with the Maintenance Director on 9/12/25 at 1:12 PM revealed the cracked areas were filled with clear epoxy. A tour conducted with the Maintenance Director on 9/12/25 at 1:18 PM validated the presence of the clear epoxy. However, in the section of tile at the entrance to the 3 East unit there was an area of approximately 1 inch X 1/8th inch where the epoxy was missing. Additionally, upon touching the area of cracks at the entrance to the 3 South unit the middle section was noted to be rough. The Maintenance Director reported he will redo the epoxy to these sections.On 9/15/25 at approximately 1:00 PM the Nursing Home Administrator (NHA) reported they filled in the spots that we deemed needed to be filled. Surveyor reviewed the concern that areas that were previously filled were found to no longer be intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, resident and staff interviews and observations, it was determined that the facility failed to ensure that the activities of Daily living needs of a dependent resident were adequately provided and documented. This was evident for 3 of 5 residents (Residents #20, #58, and #60) reviewed for ADL care. The findings include:1) On 9/12/25 at 8:30 AM, review of Intake #303291 revealed that Resident #20, a long-term resident, was interviewed by the Social Services Director (SSD)(Staff #9) on 6/27/25. Documentation showed the resident expressed concerns regarding personal hygiene and shower care. On 9/12/25 at 9:00 AM, the surveyor requested any grievance forms or documentation showing that the residents' concerns had been addressed. On 9/12/25 at 12:48 PM, the Director of Nursing (DON), reported being unable to provide any grievance form or documentation indicating the complaint had been addressed. On 9/12/25 at 1:15 PM, Resident #20 was interviewed and reported being scheduled for a shower on 9/11/25 but instead received a bed bath. The resident stated that no refusal was made and did recall previously voicing her/his concerns with personal hygiene and showers with the SSD, but she/he reported that no one followed up on his/her concerns. On 9/12/25 at 1:19 PM, Geriatric Nursing Assistant (GNA) Staff #7 was interviewed. The staff member explained the second-floor shower schedule, which uses color-coded maps. GNA staff #7 reported that Resident #20 was scheduled for a shower during the evening shift on 9/11/25. On 9/12/25 at 1:21 PM, second-floor Unit Manager (Staff #8) confirmed that Resident #20 was scheduled for a shower on the evening of 9/11/25 but received a bed bath instead. The unit manager also confirmed that Resident #20 was scheduled for two showers per week. On 9/12/25 at 2:12 PM, bathing task documentation was requested for August and September. Additional documentation for June and July was requested on 9/15/25 at 7:20 AM. On 9/16/25 at 8:00 AM, review of GNA task documentation for Resident #20 revealed the following: June 2025: 9 showers scheduled; 6 received July 2025: 9 showers scheduled; 4 received August 2025: 8 showers scheduled; 6 received September 1–11, 2025: 4 showers scheduled; 2 received On 9/12/25 at 2:26 PM, the DON was interviewed regarding staff procedures when a resident refuses a shower. The DON stated that GNAs should re-offer the shower if initially refused. If refused again, the nurse should be notified to encourage the resident and document the refusal in progress notes. The DON confirmed that no documentation of refusal was found for the 9/11/25 shower, and no evidence was provided to indicate the resident had refused showers. On 9/12/25 at 3:20 PM review of progress notes failed to reveal that Resident #20 refused showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/25 at 3:42 PM, review of the MDS (Minimum Data Set) dated 8/7/25 revealed that Resident #20 is dependent on staff for showering and bathing. On 9/15/25 at 2:18 PM, these concerns were discussed with the Administrator. No additional information was provided before the end of the survey. 2) A complaint (Intake #MD303299) submitted by a family member of Resident #58 alleged the resident was not toileted or cleaned for long periods of time, was found in soiled undergarments, not dressed in clean clothing despite clothing being available, had unwashed hair, and grooming needs were neglected. The complainant further reported that staff did not respond to concerns regarding the resident's dignity and care needs. On 09/09/2025 at 8:53 AM, Residents #58 observed; their plan of care was reviewed, as well as the facility's grievance log. The resident required the assistance of staff for ADL care. On 09/15/2025 at 9:10 AM, review of Resident #58's ADL documentation for the period 08/16/2025–09/15/2025 revealed 13 missed entries where the resident's bladder and bowel control, toileting dependence, and hygiene needs were not documented. Review of documentation from 07/01/2025 and 07/31/2025 revealed 9 additional missed entries for the same ADL care areas. On 09/15/2025 at 9:49 AM, Resident #58 was observed in bed with staff assigned to care for the resident. GNA #16 and Nurse #3 reported that both residents were incontinent, wore an incontinence brief, and required at least one-person assistance with bathing and dressing. Both staff further stated that Resident #58 was not known to refuse care. On 09/15/2025 at 10:34 AM, the Nursing Home Administrator and Director of Nursing acknowledged the deficiency related to failing to provide and document consistent ADL care that resulted in residents not receiving the care and assistance they were care planned for. 3) On 09/15/2025 at 9:25 AM, Resident #60 was observed; their plan of care was reviewed, as well as the facility's grievance log. The resident required the assistance of staff for ADL care. The record review revealed 13 missed entries between 08/16/2025 and 09/15/2025, where the resident's bladder and bowel control, toileting dependence, and hygiene needs were not documented. Review of documentation from 07/01/2025 and 07/31/2025 revealed 9 additional missed entries for the same ADL care areas. On 09/15/2025 at 9:49 AM, Resident #60 was observed in bed with staff assigned to care for the resident. GNA #16 and Nurse #3 reported that both residents were incontinent, wore an incontinence brief, and required at least one-person assistance with bathing and dressing. Both staff further stated that Resident #60 was not known to refuse care. On 09/15/2025 at 10:34 AM, the Nursing Home Administrator and Director of Nursing acknowledged the deficiency related to failing to provide and document consistent ADL care that resulted in residents not receiving the care and assistance they were care planned for.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards by not including diabetes-related interventions in the care plan. This was evident for 1 (Resident #92) of 1 resident reviewed for insulin use.The findings include:Resident #92 resides at [NAME] Manor for physical therapy and nursing care following a surgical amputation (removal) of one leg. Resident #92 has a long history of Type 2 Diabetes and associated medical conditions including heart disease and chronic kidney disease.Hypoglycemia refers to a condition where blood sugar (glucose) levels drop below normal (below 70 for diabetics). Severe hypoglycemia can occur when blood glucose levels drop below 40 mg/dL. This can lead to serious complications such as seizures, coma, and even death.Glucagon injection (or oral medication) is used for emergency treatment of very low blood sugar (severe hypoglycemia).On 9/09/2025 at 11:07 AM, the surveyor spoke with Resident #92 and asked questions about the resident's history of diabetes and whether the facility had taught them about the signs and symptoms of low blood sugar (hypoglycemia). Resident #92 stated that they had struggled with diabetes for years, and when they were first admitted to [NAME] Manor the facility had some difficulty getting their blood sugar straight. The Resident (#92) reported that they were transferred to the hospital following an incident of low blood sugar.On 9/10/2025 at 2:08 PM, the surveyor reviewed Resident #92's progress notes which revealed:-Nursing Progress Note dated 7/1/25 at 6:28 AM: Resident [#92] lying somewhat sideways in bed during med-pass, helped straighten him out, speaking normally, within 30 minutes aide alerted to resident mumbling and not making sense. BS [Blood Sugar] 37, gave glucagon 1mg injection to RA [Right Arm], call placed to 911. left message for MD, on-call notified.-Nurse Progress Note dated 7/1/25 at 12:46 PM: Resident [#92] returned back to the facility at this time from [name of hospital]. Resident's [spouse] transported resident. [The hospital] stated that resident diagnosis was hypoglycemia [low blood sugar].-Physician Progress Note dated 7/01/2025 10:09 PM: In part stated: Follow-up check on [Resident #93] who had been to the emergency room earlier because of being unresponsive with hypoglycemic [low blood sugar] episode. S/he carries a diagnosis of insulin-dependent diabetes mellitus with a hypoglycemic episode this morning. Monitor patient closely as they had blood glucose level of 37 was given glucagon appropriately and by the time the EMTs came s/he was 47 but would not go above that so was sent to the emergency room where s/he was given 50% dextrose [sugar water] which made them feel better. Their insulin [diabetes medication that helps to control blood sugar levels] is being decreased today.-Nurse Progress Note dated 7/2/25 at 11:28 AM: Resident #92 approached for blood sugar check at 730AM, awake and groggy. Blood sugar 39. Given chocolates and milk with sugar and cheese crackers with peanut butter. Resident was more responsive and asked what happened. [Nurse] explained to resident that their sugar had dropped again and is doing much better. Blood sugar rechecked at 751 AM and was 94. Call placed to physician and received orders to decrease glargine to 20 units at bedtime and give PBJ sandwich at bedtime.A baseline care plan is a detailed, initial plan developed for each resident within 48 hours of admission. It outlines essential care instructions needed to provide effective, person-centered care and serves as the foundation for the residents' overall care.A comprehensive care plan is a detailed, individualized document developed within 7 days after a complete assessment. It outlines a resident's goals, needs, and the services needed to achieve those goals.On 9/10/2025 at 2:30 PM, the surveyor reviewed Resident #92's baseline care plan dated 6/26/25 and current care plan dated 8/22/25 and discovered that aside from a dietary mention of a carbohydrate-controlled diet, no interventions were found for the management of Resident #92's diabetes.On 9/11/2025 at 9:50 AM, the surveyor interviewed the facility Director of Nursing (DON) and asked her to explain her understanding of the purpose of a care plan. She replied, It is so that the staff know what interventions are to be taken for the resident. When asked if these are (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	general interventions, she stated, The interventions should be resident specific.The surveyor then asked about diabetes interventions for a comprehensive care plan. The DON stated, The care plan should include interventions such as lab work like HBgA1c, skin checks, blood sugar checks, vitals, medications, and that standing orders for glucagon are also included with standard parameters for use.The surveyor then asked the DON to review Resident #92's care plan and identify any interventions included in the baseline or comprehensive care plan related to diabetes management other than a carbohydrate-controlled diet. She replied that she did not see any interventions for diabetes management.The surveyor expressed concerns that Resident #92 did not receive appropriate interventions to manage diabetes and the DON stated that she agreed and stated these interventions should have been included in both the initial and comprehensive care plan and caught after the transfer to the hospital (a change in condition).On 9/11/2025 at 10:27 AM, the DON provided the surveyor with the facility policy and procedure titled Care Plan Processes, Person-Centered Care (revised May 5, 2023), which in part states:The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care for the resident and meet professional standards of quality care.Through ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates.

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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 record review, interview and observation it was determined that the facility failed to ensure adequate supervision and staff assistance during a resident's mechanical lift transfer. This was evident for 1 (Resident #90) of 5 residents reviewed for activities of daily living during the recertification survey. The findings include:A review of Resident #90's clinical record revealed a care plan intervention that stated the resident required assistance of two staff to transfer out of bed with a mechanical lift.A review of the facility's mechanical lift policy revealed that transfers with a mechanical (Hoyer) lift required two staff.On 9/09/2025 at 9:26 AM Resident #90 was interviewed during the initial screening for the recertification survey process. S/he stated that s/he was afraid of Hoyer lift transfers, and that s/he was not sure staff used it right.On 9/11/25 at 4:21 PM Resident #90 was observed in bed as a Geriatric Nursing Assistant (GNA #14) left their room pushing a mechanical lift. Another unidentified person was observed standing in the room.On 9/11/25 at 4:23 PM an interview was conducted with Resident #90 at their bedside. The other person in the room introduced themselves as a family member. When asked, the resident and family member explained that GNA #14 used the mechanical lift alone to transfer the resident from the wheelchair and back to bed. On 9/11/25 at 4:28 PM an interview was conducted with GNA #14 in the hallway outside Resident #90's room. She was asked if she had another staff person to help her transfer Resident #90 with the mechanical lift, and she said no. She further explained that she went to ask another staff person but they were busy, so she did it by herself, and she also said that the resident's family was there in case something happened. GNA #14 acknowledged that the facility policy was to have two staff assist when a mechanical lift was used, but she had wanted to help the resident quickly.On 9/11/24 at 4:33 PM an interview with the unit manager (Staff #10) was conducted. When informed about the finding that the resident stated s/he was transferred by only one staff, and GNA #14 confirmed that she transferred Resident #90 with a mechanical lift by herself, Staff #10 said that was unacceptable. When asked if there were not enough staff to assist, the unit manager said that there were 5 GNAs working on the unit at that time when there were usually only 3 assigned, and that she was also available to help if needed. She confirmed the deficient practice.On 9/12/25 at 9:00 AM the deficiency was reviewed with the Director of Nursing who also confirmed the deficiency.On 9/15/25 at 2:10 PM - the deficiency was also reviewed with the Nursing Home Administrator. No further evidence was provided.

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	09/15/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interviews, it was determined that the facility failed to have an effective process to ensure that medication recommendations made by the pharmacist were delivered to the physician for review. This was evident for 1 (Resident #10) of 5 residents reviewed for unnecessary medications during a survey. The findings include:On 9/10/25 at 1:07 PM, a review of Resident #10's revealed a monthly pharmacy review note dated 12/11/24. The note referenced Omeprazole 20 mg BID for GERD, administered at 0800 and 2000. The pharmacist recommended reviewing and considering a time change to administer the medication either 1 hour before or 2 hours after other medications and food. No other recommendations were noted. On 9/10/25 at 2:02 PM, an interview was conducted with the Director of Nursing (DON) regarding the monthly pharmacy medication review. The DON reported that when the pharmacist made a recommendation, a hard copy was delivered to the facility with the next pharmacy delivery. The document was first received by the DON, who then gave it to the appropriate nurse manager. The nurse manager was responsible for providing the recommendation to the physician. After the physician reviewed and signed it, the hard copy was returned to the DON. On 9/10/25 at approximately 11:30 AM, during another interview, the DON reported not receiving the December pharmacy recommendations mentioned in the progress note dated 12/11/24. As a result, the recommendation was not reviewed by the physician. On 9/11/25 at 11:30 AM, a document titled Consult Pharmacist Summary Report (provided by the DON) was reviewed. Review of the documents listing all recommendations made between 12/01/24 and 12/31/24 did not include the recommendation noted in the progress notes. On 9/11/25 at 9:05 AM, the DON confirmed that Omeprazole was discontinued along with all other medications on 1/11/25 when the resident was hospitalized . The DON also confirmed that the physician did not receive or review the pharmacist's recommendation and acknowledged that the recommendation documented in the progress notes was not followed up on. On 9/15/25 at 2:18 PM, these concerns were discussed with the Administrator. No additional information was provided before the end of the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on records review and interviews, it was determined that the facility failed to ensure residents were free from unnecessary medications. This was evident for 1 (Resident #8) of 5 residents reviewed for unnecessary medications.The findings include: Resident #8 was admitted into the facility in early 2025 with diagnosis that include hypertension. Hypertension, also known as high blood pressure, is a long-term medical condition in which the blood pressure in the arteries is persistently elevated. High blood pressure usually does not cause symptoms itself. It is, however, a major risk factor for stroke, coronary artery disease, heart failure, atrial fibrillation, peripheral arterial disease, vision loss, chronic kidney disease, and dementia.Blood pressure is classified by two measurements, the systolic (first number) and diastolic (second number) pressures.A review of Resident #8's medication orders was conducted on 9/12/25 at 1:09 PM. The review revealed medications that treat hypertension that include:1) Carvedilol, to be taken 2x a day with instructions to hold if systolic blood pressure (SBP) was <120 or heart rate <60.2) Losartan, to be taken at bedtime with instructions to hold if SBP was <120 or heart rate <60.A review of Resident #8's electronic Medication Administration Record (eMAR) for September 2025 was conducted on 9/12/25 at 2:01 PM. The review revealed the following concerns:1) Carvedilol was administered on 9/1at 6 PM with a SBP of 118, 9/4 at 9 AM with a SBP of 107, 9/5 at 6 PM with a SBP of 110, 9/6 at 9 AM with a SBP of 112, and on 9/11 at 6 PM with a SBP of 109.2) Losartan was administered on 9/1 at 9 PM with a SBP of 118 and on 9/11 with a SBP of 109.The Director of Nursing (DON) was interviewed on 9/12/25 at 2:37 PM. Resident #8's eMAR for September was reviewed with the DON and she confirmed that Carvedilol and Losartan were administered on the dates stated above and indicated that they should have been held. The concern was discussed that the medications were administered outside the parameters and the DON agreed and acknowledged the concern.

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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. Based on observation, interview and review of medical records it was determined that the facility failed to ensure medication error rate of less than 5% as evidenced by 3 errors out of 29 opportunities. These errors were identified for 2 (Resident #73 and #10) out of the three residents observed during the medication administration observation task. The findings include: 1)On 9/09/25 at 8:30 AM surveyor observed Nurse #2 prepare and administer medications for Resident #73. One of the medications prepared was Clear Lax which is a laxative that comes in a powder form that needs to be mixed with a liquid. The active ingredient in Clear Lax is polyethylene glycol 3350.Nurse #2 was observed to use the lid of the Clear Lax to measure the powder. The lid was observed to be purple with an inner white section. The nurse filled the powder to approximately 3/4 of the way up the white part of the lid. The nurse then proceeded to mix the powder with water in one of the disposable cups kept on the medication cart. The nurse reported this was a 120 ml cup (120 ml is approximately 4 ounces).On 9/9/25 at approximately 12:00 noon review of the medical record revealed an order for the Miralax (polyethylene glycol 3350) powder 17 grams, mix with 8 ounces of H2O (water) or juice.Review of drugs.com information for Clear Lax revealed the following instructions: fill to top of white section in cap which is marked to indicate the correct dose (17 g).On 9/09/25 at 1:06 PM after viewing the measuring cup portion of the Clear Lax with a flashlight, Nurse #2 acknowledged the powder should be to top of the white portion and confirmed the dose administered was a little under what was ordered for Resident #73.2) On 9/9/25 at 9:42 AM surveyor observed Nurse #3 prepare and administer ten medications for Resident #10. One of the medications prepared was Clear Lax. The nurse was observed pouring the Clear Lax powder into the measuring cup portion of the lid, but the powder did not appear to fully cover the white section of the cup, the nurse then mixed the powder with water. At the end of the observation Nurse #3 confirmed that 10 medications were administered.On 9/9/25 at approximately 12:00 noon review of Resident #10's medical record revealed an order for a multivitamin to be given once a day. Review of the Medication Administration Record (MAR) revealed this medication was scheduled to be given at 9:00 AM. Nurse #3 had documented on 9/9/25 at 9:54 AM that the vitamin was not administered due to being unavailable. The other 10 medications that were observed were documented as administered on the MAR. Further review of the medical record also revealed an order for Miralax 17 grams.On 9/09/25 at 1:11 PM Nurse #3 confirmed the vitamin was not administered, reporting that she only had a vitamin with iron on the medication cart during the med pass observation. Nurse #3 went on to report that she had since obtained the multivitamin and proceeded to show the surveyor a bottle from the medication cart containing a multivitamins. When asked if she had since administered the multivitamin to the resident, Nurse #3 responded: no, because she had already documented it as not given.Also, during the 9/9/25 interview at 1:11 PM surveyor and Nurse #3 observed the lid to the Clear Max. Nurse #3 reported she fills to the line, pointing to the grove in the cup approximately 1/2 to 3/4 the way up the white section. After further observation the nurse confirmed the dose administered to Resident #10 was less than what was ordered. On 9/09/25 at 2:43 PM surveyor informed the Director of Nursing and the Nursing Home Administrator of the medication error rate above 5% based on the three errors: two with wrong dose of the Clear Lax and one of omission related to a vitamin.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record reviews and interviews, it was determined that the facility failed to ensure education was provided to residents and/or responsible parties (RP) regarding the benefits and potential risks associated with the COVID 19 vaccine. This was evident for 1 (Resident #31) of 5 residents reviewed for immunizations.The findings include: Resident #31 had been a resident of the facility since 2023. A quick look into the resident's medical record indicated an intact cognitive function.A review of Resident #31's immunization record was conducted on 9/10/25 at 1:25 PM. The review revealed the resident's preventive healthcare documentation that indicated the resident had declined the COVID 19 vaccine dated 8/8/23. However, the designated area at the bottom of the document to indicate if education was provided to the resident/family/power of attorney, was left unanswered.The finding was discussed with the Infection Preventionist (IP) Nurse (Staff #1) on 9/10/25 at 2:50 PM. Staff #1 indicated that she would review Resident #31's medical record.On 9/10/25 at 3:21 PM, Staff #1 reported that Resident #31 had been refusing the Covid 19 vaccine but was not able to find documentation to indicated that the resident was provided information on the benefits and risks of the vaccine. Staff #1 verbalized understanding of the regulation and indicated that the preventive health documentation was done prior to her becoming the IP nurse. She further reported that moving forward, she would ensure that education will be provided and documented for all declined immunizations.