STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215323	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Cities Nursing & Rehabilitation Center	4409 East West Highway Riverdale, MD 20737

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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 - Some	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 observation, record review, and interview, it was determined that the facility failed to ensure that residents were served meals according to predetermined menus. This was evident for 4 (Residents #92, #34, #121 and #48) of 6 random meal trays sampled during the lunch tray line observation.The findings include: Pureed diet is a texture- modified diet consisting of smooth, moist, pudding-like food requiring no chewing. Designed for residents with swallowing difficulties. Thickened liquids are beverages or fluids with added agents (powder/gel) to increase viscosity, designed for residents with swallowing difficulties. On 2/24/2026 at 10:11 AM, Resident #1 reported frequently receiving items that do not match their meal ticket. For breakfast on 2/22/26, the resident expected orange juice, hot cereal, and milk, however received a glass of pink drink (Kool-Aid) and a bowl of oatmeal. The meal ticket for that date specified 4 oz apple juice, 2% milk, and 8 oz coffee. On 2/25/2026 at 12:02 PM, the Certified Dietary Manager (CDM) confirmed that kitchen provided apple, orange or cranberry juice, coffee or tea based on the meal tickets and that Geriatric Nurse Assistants (GNA) and the nurses distributed these with the trays. On 2/25/2026 at 12:18 PM, the surveyor conducted an observation of 6 randomly selected lunch trays with the following findings: -Resident #92's meal ticket indicated Regular- Renal, thin liquids, 4 oz chef special fried shrimp, 4 oz white rice, 4oz coleslaw, 1 2x2 cake with icing. However, apple juice cup 4 oz, milk 2%- 8 oz and coffee 8 oz were not served.-Resident #34's meal ticket indicated Pureed-Diabetic diet, thin liquids, 4 oz chef special fried shrimp (pureed), 4 oz green beans pureed, 4 oz mashed potatoes pureed and 1 2x2 cake with icing pureed. However, the cake was not pureed as ordered. Apple juice cup 4 oz, milk 2%-8 oz and coffee 8 oz were also not served.-Resident #121's meal ticket indicated Regular- honey liquids, 4 oz chef special fried shrimp, 4 oz white rice, 4 oz coleslaw, 1 2x2 cake with icing. However, apple juice cup honey 4 oz, dairy honey 8 oz and coffee honey thick 8 oz were not served.-Resident #48's meal ticket indicated Advanced- Regular, thin liquids, 4 oz chef special fried shrimp (chopped), 4 oz mashed potatoes, 4 oz green beans (soft texture), however, the 1 2x2 , cake with icing (chopped) was brought to the floor whole.On 2/26/2026 at 7:56 AM, the surveyor notified the CDM that only 3 pitchers of fruit punch and few cans of ginger ale were brought to the [NAME] Oak unit on 2/25/26, The CDM claimed that milk, juice and thickened liquids were also stocked in the unit refrigerators.On 2/26/2026 at 8:18 AM, Unit Manager (UM #6) confirmed that milk, juice and thickened liquids come from the kitchen with the food cart. The surveyor and UM #6 inspected the second-floor unit and dining room refrigerators and confirmed that they were empty.On 2/26/2026 at 8:24 AM, the Regional Dietary Manager was informed of these concerns and acknowledged the findings. The Nursing Home Administrator (NHA) was also notified at 8:40 AM.

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, it was determined that the facility failed to maintain the ice machines in a clean and sanitary manner. This was evident in 2 of 5 ice machines inspected during the recertification survey. This practice has the potential to affect all residents who consume food prepared by the facility. The findings include: On 2/24/2026 at 9:15 AM, during the initial kitchen tour with the Certified Dietary Manager (CDM), the surveyor observed the ice machine was last cleaned on 9/25/25 as indicated on the Cleaning schedule document that was found hanging on the side of the ice machine. The following information was also noted:Location- Lower level kitchenetteFilter date- 2/22/25Cleaned- (mark checked)Comments- is Good The CDM confirmed that the maintenance department should clean the machines monthly. The Regional Dietary Manager also acknowledged this observation.On 2/24/2026 at 10:42 AM, the surveyor and Licensed Practical Nurse (LPN #5) inspected the second floor Terrapin nourishment room and found that the ice machine had no cleaning log. On 2/25/2026 at 11:39 AM, during a follow up visit of the kitchen, the surveyor observed the ice machine cleaning log had been modified to reflect the monthly cleanings from 1/21/25 through 1/30/26. The Regional Dietary Manager stated that maintenance kept the logs in their office and acknowledged the concern. On 2/26/2026 at 12:26 PM, Staff #8 confirmed the facility has a total of 5 ice machines. He/she stated the machines were checked and cleaned monthly and that the practice of posting logs on the machines began in September 2025. On 2/27/2026 at 9:17 AM, a review of the Ice Machines policy dated 5/1/22 specified that all ice machines were to be inspected regularly with preventive maintenance performed monthly, quarterly and semi-annually to ensure proper and safe operation.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on facility documentation and interviews, the facility failed to have an Infection Preventionist (IP) onsite. Failure to have an Infection Preventionist has the potential to decrease compliance with infection control.The findings include:An Infection Preventionist is responsible for assessing, developing, implementing, and monitoring the Infection Prevention and Control Program of the facility to prevent and control infections.During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 2/25/26 at 12:14 PM, they both stated that the Infection Preventionist (IP) had resigned on 1/26/26. The DON stated that the facility currently have an IP from a sister facility who assists with overseeing the IP program at the facility. The DON also stated that he is not IP certified, but he collects all the required infection prevention and control data and emails them to the sister facility IP. On 2/26/26 at 09:18 AM, during an interview with the sister facility IP (Staff # 29), who stated that she/he is never in the building, but infection prevention and control information is shared via email and during the virtual attendance at the Risk and QAPI meetings.During a follow up interview with the NHA, he stated that he is aware that the facility should have an IP in-house and that there is a job posting for an IP, and he has resumes that are being reviewed for the position.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interviews, it was determined that the facility failed to provide documented evidence that all residents and/or representatives received written information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an Advance Directive (AD). This is true for 1 (Resident #166) of 4 resident records reviewed for advanced directives during the recertification survey process. Findings Included:On 02/25/2026 at 12:22 PM, the Social Worker (SW) explained the AD process, stating ADs were to be uploaded to the electronic health record upon admission. If not available, the AD was discussed during the Discharge Planning Psychosocial Assessment. The SW noted that while the assessment form included a question about offering information for initiating an AD, the form may not have been accurately, checked, or completed.On 02/25/2026 at 12:42 PM, a review of Resident #166's Discharge Planning Psychosocial Assessment indicated no existing AD, and the section regarding education about initiating AD was left unanswered/blank.On 02/25/2026 at 12:55 PM, the SW verified that Resident #166's AD was not obtained on admission. Following a chart review, the SW acknowledged there was no documented evidence that the required written AD education was provided to the resident or representative(s).On 02/25/2026 at 1:09 PM, the SW was informed of the above-mentioned findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident. This was evident for 1 (Resident #32) of 68 resident care plans reviewed during the recertification survey process.Findings Included:On 02/26/2026 at 2:21 PM, a review of Resident #32's Medication Administration Records (MAR) showed an order dated 01/29/2026 for cefTRIAXone Sodium Injection Solution Reconstituted 2 gram (Ceftriaxone Sodium), once daily for a 5-day course to treat a bacterial infection.On 02/27/2026 at 2:49 PM, a review of Resident #32's care plan revealed the facility failed to develop and implement a comprehensive person-centered care plan to address the resident's infectious disease process and antibiotic treatment needs.A further review of the resident's care plan showed the facility developed a care plan for the risk of complications related to opioid use; however, there was no documented evidence to support that the resident had orders for opioids since admission. Therefore, the Resident's care plan was not resident specific.On 02/27/2026 at 3:55 PM, the Director of Nursing (DON) confirmed that if a resident had an infection and was receiving antibiotics, the information should have been addressed on the care plan. The DON explained that Nurse Managers/Supervisors were responsible for care plan development and accuracy. The DON was notified of the above findings related to care plan development.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on record reviews, observations, and interviews, it was determined that the facility failed to ensure staff used a functional communication system to communicate personal care needs for a non-English speaking resident. This was evidenced by findings for 1 (Resident #172) of 1 resident reviewed for communication and language services during the recertification/complaint survey.Findings Included:A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment and prepared by an interdisciplinary team.On 02/24/2026 at 12:00 PM, during the initial pool phase of the annual survey process, Resident #172 (who was non-English speaking) called out to the surveyor, pointed to the perineal area.On 02/24/2026 at 12:01 PM, Staff #7 was notified of Resident #172's need for assistance. The surveyor observed Staff #7 and a housekeeper enter the room. When interviewed, Staff #7 stated that communication with Spanish-speaking residents was accomplished by utilizing Spanish-speaking staff, sometimes using housekeeping staff to interpret. Staff #7 confirmed the resident expressed, via the housekeeper, a need for perineal/personal care.On 02/24/2026 at 12:14 PM, when asked by the surveyor Licensed Practical License (LPN) #27 explained that staff commonly used housekeeping and maintenance personnel to interpret Resident #172's needs. LPN #27 was unsure if the facility had an available language line.On 02/25/2026 at 1:31 PM, in an interview the social worker explained that the resident's communication needs were typically assessed upon admission. She also stated that staff sometimes used resources like Google Translate for quick communication and that the facility had a language line available for translation.On 02/25/2026 at 2:21 PM, in an interview the Director of Nursing (DON) reported that the expectations for non-English speaking residents included care planning for communication issues, providing a communication board, using Google Translate, and utilizing an interpreter phone line. The DON noted that some housekeeping staff were Spanish-speaking. When asked about the information communicated through housekeeping staff, the DON stated it included the resident's care needs (such as pain and other personal care needs). The DON identified the communication board at the nursing station or in the resident's room as the primary method used. When asked if appropriate, the DON confirmed that using ancillary staff (such as housekeeping) to interpret clinical needs was inappropriate.On 02/25/2026 at 2:38 PM, an observation of Resident #172's room with the DON revealed a basic communication board (including pictures and descriptive words) posted on the wall. However, during 5 of 5 staff interviews, staff failed to suggest the communication board as a method for communicating with non-English speaking residents.On 02/25/2026 at approximately 3:00 PM, a review of Resident #172's care plan revealed that the resident was dependent on staff and family due to language barrier and staff should utilized Spanish/ English picture chart to communicate with the resident.On 02/26/2026 at 1:00 PM, in an interview with LPN#30 she was asked about the communication method for non-English speaking residents and she explained that for Spanish speaking residents, they have Certified Nursing Assistants (CNA) and housekeepers that were Spanish speaking who help with interpreting the resident's needs. LPN #30 was asked about the facility's language line, and she reported having no knowledge of a language line.On 02/27/2026 at 3:55 PM, The DON was notified of the concern that staff routinely used ancillary staff (such as housekeepers and maintenance) to communicate residents' needs, a practice that could potentially violate resident privacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to provide an adequate smoking evaluation and safety assessment for a resident. This deficiency was evident for one (Resident #39) of two residents reviewed for safety in smoking during the recertification/complaint survey.The findings include:During the initial tour of the facility on 2/24/26 at 10:04 AM, the surveyor observed three packages of cigarettes and a lighter in Resident #39's drawer. The resident stated that the facility allowed residents to keep smoking materials (including cigarettes and lighters) in their possession.On 2/27/26 at 7:52 AM, a review of Resident #39's medical records revealed that smoking assessments were conducted upon admission [DATE]) and quarterly thereafter. The most recent quarterly assessment, dated 8/23/25, incorrectly coded the question Does the resident smoke? as No. Similarly, the Minimum Data Set (MDS) assessment dated [DATE], Section J, documented Resident #39's smoking status as No.During a follow-up interview on 2/27/26 at 8:30 AM, Resident #39 verified that he/she is an active smoker.In an interview with the Nursing Home Administrator (NHA) on 2/27/26 at 11:16 AM, the NHA confirmed that Resident #39 is a smoker. The NHA stated that residents with a Brief Interview for Mental Status (BIMS is a 0-15 point, 3-minute, standardized assessment used in long-term care to evaluate cognitive impairment. Scores of 13-15 indicate intact cognition, 8-12 suggest moderate impairment, and 0-7 indicate severe impairment) score of 10 or higher are permitted to keep their own smoking materials, while those with a score below 10 are not.The surveyor and the NHA reviewed Resident #39's recorded BIMS scores:-8/20/25: BIMS score of 10.-11/19/25: BIMS score of 7.-2/18/26: BIMS score of 8.During a subsequent interview on 2/27/26 at 11:41 AM, the NHA stated, The Social Worker said [Resident #39's] BIMS was coded in error. It has just been corrected. The NHA then submitted a new BIMS assessment, dated 2/27/26, with a score of 13. The surveyor expressed concern that the smoking assessment had been incorrectly coded since August 2025, and that the resident's cognitive status had not been accurately reflected to ensure safety. The NHA validated these findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record reviews and staff interviews, it was determined that the facility failed to timely address and communicate significant weight changes. This deficiency was evident for two (Resident #11 and Resident #143) of six residents reviewed for nutrition during the recertification/complaint survey.The findings include:1) A review of Resident #11's medical record on 2/24/26 at 1:21 PM revealed significant and fluctuating weight changes between August 2025 and September 2025:8/05/25: 143 lbs (Wheelchair)8/12/25: 142 lbs (Wheelchair)8/15/25: 115.1 lbs (Wheelchair) - Significant Drop8/19/25: 115 lbs (Wheelchair)8/22/25: 140 lbs (Wheelchair) - Significant Increase8/26/25: 140.2 lbs (Wheelchair)8/29/25: 111.5 lbs (Wheelchair) - Significant Drop9/02/25: 115.8 lbs (Wheelchair)The resident's weight has remained at approximately 115 lbs from September 2025 to the present.A subsequent review of the resident's nutrition assessments on 2/26/26 at 9:01 AM showed entries by the Dietitian on 6/17/25 and 9/04/25. The note dated 9/04/25 identified an unplanned weight loss from 140 lbs to 111 lbs. However, there was no documentation to show that the initial weight fluctuations occurring in mid-August (the drop on 8/15/25 and the increase on 8/22/25) were investigated, re-weighed for accuracy, or addressed with interventions.During a phone interview on 2/26/26 at 10:07 AM, Staff #8 (Dietitian) stated, Since I started covering this facility after September 2025, I cannot say what was wrong with these weights. I know that significant weight changes, including gains or losses, should be addressed with interventions.2) A review of Resident #143's medical record on 2/24/26 at 1:47 PM revealed a significant weight loss. On 1/22/26, the resident weighed 147 lbs (standing). Following a hospitalization from 2/03/26 to 2/08/26, the resident weighed 132.4 lbs (mechanical lift) on 2/08/26. This represents a 14.6 lb (9.9%) weight loss in 17 days.While a nutrition assessment was completed on 2/09/26, there was no evidence in the medical record that the physician or provider was notified of this significant weight change.In a phone interview on 2/26/26 at 9:49 AM, Staff #8 (Dietitian) confirmed that weight loss upon re-admission is still categorized as a significant change. Regarding the different measurement methods (standing vs. mechanical lift), Staff #8 stated, I try to encourage using the same method to prevent weight discrepancies, but I am not sure [if they did].Staff #8 further noted that the nursing department is responsible for reporting weight changes to providers and family. When asked about the lack of notification for Resident #143, Staff #8 stated, Since the resident came back to the facility NPO (nothing by mouth), I assumed the provider caught the weight change. I cannot say it was reported.On 3/02/26 at 1:44 PM, the surveyor reviewed these findings with the Director of Nursing (DON). The DON validated the findings and the lack of documented communication regarding the weight changes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interviews, it was determined that the facility failed to provide necessary respiratory care services. This was evident for 3 (Residents #1, #3 and #171) of 6 residents reviewed for respiratory care during the recertification survey. The findings include: Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. A nasal cannula is a thin, flexible tube that delivers O2 through the nose. A humidifier in O2 therapy is a device that adds moisture to dry, concentrated O2 to prevent drying and irritation of a patient's nasal passages, throat, and lungs. These humidifiers typically consist of a bottle filled with water that attaches to an O2 concentrator. 1) On 2/24/2026 at 10:02 AM, during the initial tour of the facility, Resident #1 was observed in bed receiving O2 therapy via nasal cannula (NC), both the tubing and the humidifier bottle were unlabeled. On 2/27/2026 at 10:00 AM, a review of Resident #1's physician orders confirmed the following: Continuous Oxygen at 3-5 liters per minute via nasal cannula to keep saturation above 90% every shift Oxygen tubing change weekly on 11-7 shift every night shift every Sunday 2) On 2/24/2026 at 10:57 AM, Resident #3 was observed receiving O2 therapy with an unlabeled 02 tubing. On 2/27/2026 at 10:00 AM, a review of Resident #3's physician orders confirmed the following: Oxygen 2L via NC every shift for respiratory failure Check and change oxygen tubing weekly and as needed (PRN), Date the oxygen tubing Check and change oxygen tubing weekly and PRN every night shift every Sunday for per protocol date the oxygen tubing On 2/27/2026 at 10:41 AM, during an interview with Registered Nurse #18, he/she confirmed that the oxygen tubing were expected to be changed weekly during night shift and labeled accordingly. RN #18 noted that if O2 tubing were found undated or unchanged, the nurses were expected to address it immediately. On 2/27/2026 at 12:15 PM, the facility's Respiratory Care and Oxygen Equipment policy dated 1/29/24 requires that tubing and masks be changed weekly and as needed. On 2/27/2026 at 12:57 PM, the Director of Nursing (DON) was notified of these concerns and acknowledged the findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) During an observation that took place on 2/25/26 at 08:26 AM, it was noted that Resident #171 was receiving oxygen via nasal cannula at a rate of 2.5 Liters per minute. Resident #171's medical record review conducted on 2/26/26 at 11:15 AM revealed that resident was ordered 2 Liters of oxygen per minute via nasal cannula. A second observation of the oxygen administration on 03/02/26 at 11:49 AM indicated that Resident #171 continued to receive 2.5 L of oxygen via nasal canula. The surveyor asked the charge nurse (Staff #22) how much oxygen the resident should receive. Staff #22 stated that the resident is on 2L of oxygen, but sometimes the resident may remove the nasal cannula from his/her nose and if the oxygen level decreases staff will turn it up to 2.5L - 3L. The Surveyor asked if there was an order for that practice, and Staff #22 said no and that the current order is for 2L. Staff #22 subsequently decreased the resident's oxygen to 2 Liters. Further medical record review on 3/2/26 at 12:00 PM revealed no care plan for oxygen administration for Resident #171. During an interview with the DON on 3/2/26 at approximately 12:15 PM, the surveyor shared the concern about oxygen administration for Resident #171. the DON acknowledged the concerns and stated that there should have been a care plan for oxygen administration for the resident and that the oxygen setting should be set at what was ordered.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on a review of employee files and interviews with facility staff, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) demonstrated competency in essential skills and techniques prior to providing resident care. This deficiency was identified in four out of four (Staff #11, #12, #13, and #14) newly hired GNA employee charts reviewed during the recertification/complaint survey.The findings include:The American Nurses Association defines nursing competence as an expected level of performance that integrates knowledge, skills, abilities, and judgment.On 2/26/26 at 1:30 PM, the surveyor requested training records for four randomly selected GNAs. A review of these records revealed the following:-Staff #11 (Hired April 2025): Skills validation records were signed on 4/29/25. However, the form-which includes categories for general care, infection control, clinical skills, and specialized needs-was incomplete. Specific omissions included cleaning and disinfecting equipment, Transmission-Based Precautions, shower stretcher use, hearing aids, height/weight measurement, and meal services.-Staff #12 (Hired January 2025): Skills validation records were signed on 2/06/25. However, 8 of the 12 items under Equipment were left blank. Additionally, 8 of the 21 items under Clinical Skills-including falls, nail care, oral care, transfers, and vital signs-lacked verification documentation.-Staff #13 (Hired March 2025): The Skills Validation Record was signed on 3/13/25. However, the Clinical Skills section was incomplete, and the Specialized Care Needs, Documentation, and Clinical Processes sections were entirely blank.-Staff #14 (Hired October 2025): The Skills Validation Record was signed on 11/17/25. It contained significant gaps in clinical skills, including hearing aids, height and weight, oral care, orthotic devices, oxygen, restraints, scheduled activities, shaving, thickened liquids, and vital signs.During an interview on 2/26/26 at 2:17 PM, the Director of Nursing (DON) stated that GNA skills must be verified during new-hire training and that training should be completed before they begin work. Upon reviewing the files for Staff #11, #12, #13, and #14 with the surveyor, the DON validated that these competencies were not fully documented. He confirmed that no additional documentation existed to support that these GNAs' skills were verified before they began providing resident care.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, record review, and interviews, it was determined that the facility failed to identify and provide appropriate treatment and services to assist a resident in attaining their highest practicable mental health well-being. This deficiency was evident for one of one resident (Resident #111) reviewed for behavioral and emotional well-being during the recertification/complaint survey.The findings include:During an initial tour on 2/24/26 at 9:28 AM, Resident #111 was observed screaming, yelling, and crying in their room. A nursing staff member stated to the surveyor, [Resident #111] has psychological issues.In an interview on 2/24/26 at 10:31 AM, a family member of Resident #111 stated the resident had no prior history of dementia or mental health issues. The family member noted, On 12/24/25, [Resident #111] was found to have a knee fracture due to age and bone fragility. Facility staff told me the screaming and crying were due to pain. Now, they have scheduled a psychological consultation. I just have to trust the facility.On 2/27/26 at 11:59 AM, a review of Resident #111's medical record revealed an initial psychological consultation conducted on 10/15/25. At that time, the resident was identified as stable, with no evidence of self-injurious behavior or psychosis. A subsequent note dated 2/25/26 indicated the resident was evaluated for visual hallucinations and verbal outbursts. The Psychiatric Nurse Practitioner (NP) ordered new medication to manage these symptoms. However, there was no documentation in the medical record regarding hallucinations or verbal outbursts prior to this evaluation.On 2/27/26 at 1:22 PM, Staff #19 (Unit Manager) confirmed that Resident #111 had no mental health issues when she began working at the facility. She stated the resident's verbal outbursts began approximately three weeks prior. Staff #19 added, We originally thought it was because of knee pain, but it was not. We spoke to the psychology team, and the resident was seen by the NP on 2/25/26. When the surveyor asked if staff had documented these unusual behaviors, Staff #19 stated, I believe the primary nurse documented them. However, the surveyor reviewed the records and found no documentation regarding these behaviors or any attempted interventions.On 3/02/26 at 1:44 PM, the surveyor shared these concerns with the Director of Nursing (DON), who validated the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record and interview with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was true for 3 (Residents #171, #3 and #116) of 5 residents reviewed for unnecessary medications during the recertification survey. The findings include: Clopidogrel is a prescription antiplatelet medication used to prevent serious blood clots, reducing the risk of heart attacks and strokes. Humalog sliding scale is a personalized, doctor prescribed chart that tells how much rapid-acting insulin to inject based on the blood sugar reading before a meal. Sliding means the dose changes: higher blood sugar = more insulin; lower blood sugar = less insulin. Tizanidine is a prescription medication to relax tight, stiff, and spasming muscles. 1) On 3/02/2026 at 9:34 AM, a review of Resident #3's medical records revealed medication orders that read: Clopidogrel Bisulfate Tablet 75 MG Give 1 tablet by mouth one time a day for Cerebrovascular Accident (CVA) with an order Date of 12/31/2025. Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 150 = 0 units If FS less than 70 call MD. Hypoglycemic protocol; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units IF FS 400 or above administer 10 units and call MD, subcutaneously after meals and at bedtime for Diabetes Mellitus. Administer with meals, with an order date of 7/21/2025 and a discontinued date of 12/04/2025. On 3/02/2026 at 10:16 AM, a review of the pharmacy's Medication Regimen Review (MRR) dated 10/8/2025, recommended To better stabilize glucose control and reduce the chance of medication error and to reduce the need for additional coverage, may I suggest increasing the basal dose of insulin units once weekly until sliding scale is no longer required. However, the Medication Administration Record (MAR) confirmed that insulin continued to be given until 12/4/2025 and the document was only signed by the Physician approximately 5 months later (3/2/2026) that indicated discontinue (D/C) sliding scale Insulin. Another review dated 1/5/2025, recommended Please place an adverse reaction monitoring order on the MAR to support the use of Clopidogrel. However, the physician did not address this until 01/31/2026 (26 days later), and the required monitoring was never implemented. 2) On 3/02/2026 at 11:00 AM, a review of Resident #116's medical records revealed a medication order that read: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tizanidine HCl Oral Tablet 2 MG (Tizanidine HCl) Give 1 tablet by mouth every 8 hours as needed for Muscle spasm, with an order date of 9/18/2025. On 3/02/2026 at 11: 30 AM, a review of the pharmacy's MRR dated 9/18/25 recommended discontinuing the as needed (PRN) order for Tizanidine or limiting it to 14 days per federal psychotropic medication guidelines. Although the physician ordered the discontinuation on 10/07/2025, the order remained active. The resident continued to receive the medication 37 times (10/3/25, 10/4/25, 10/8/25, 10/13/25, 10/21/25, 10/22/25, 10/24/25, 10/31/25, 11/6/25, 11/11/25, 11/13/25, 11/14/25, 11/15/25, 11/18/25, 11/19/25, 11/23/25, 11/27/25, 11/28/25, 12/2/25, 12/3/25, 12/5/25, 12/21/25, 12/30/25, 1/9/26, 1/10/26, 1/15/26, 1/16/26, 1/22/26, 1/23/26, 1/24/26, 1/29/26, 2/11/26, 2/17/26, 2/19/26, 2/24/26, 2/25/26, 2/26/26). The facility's Medication Regimen Review policy dated 1/29/24 specified that the drug regimen of each resident will be reviewed at least once per month by a licensed pharmacist. Furthermore, the policy also indicated the following: a. The consultant pharmacist will provide MMR reports to provider and Director of Nursing (DON), within 72 hours of completion. b. The physician is to review and sign the patient's individual MRR and document that he/she has reviewed the pharmacists identified irregularities within 30 days of receipt. c. When the consultant pharmacist identifies an irregularity that requires immediate or urgent action, the pharmacist will notify the DON and assigned nurse at the time the irregularity is identified. On 3/02/2026 at 11:43 AM, the Director of Nursing (DON) confirmed that the pharmacy consultant conducts monthly medication reviews and reports were sent to the Physicians and the facility. The physicians would address and signed the recommendations and sent them back to the facility, however, specific recommendations were not properly resolved. The DON was notified of the concerns and acknowledged the findings. 3) During the review of Resident #171's Medication Regimen Review (MRR) on 3/2/2026 at 11:45 AM, it was noted that the pharmacist made the following recommendations on 9/08/2025, 11/7/2025, and 12/9/2025: This resident is receiving antipsychotic agent risperidone (currently missing diagnosis) but lacks an allowable diagnosis to support its use. The following DSM-IV TR are considered appropriate diagnoses/conditions: Schizophrenia. Resident #171's medical record reviewed on 3/2/2026 at 12:10 PM displayed active orders as of 10/1/2025, 11/01/2025 and 12/01/2025 listing Risperidone oral tablet 4 MG give 1 tablet by mouth 2 times a day, with an order date and start date of 7/28/2025. There was no indication for use or diagnosis of schizophrenia for the mediation. On 2/25/2026 at 1:00 PM, a review of the Medication Administration Record (MAR) had documentation at 0900 AM and 2100 PM that resident received Risperidone oral Tablet 4 MG 1 tablet two times a day for the months of 1-31 [DATE]-30 [DATE], and 1-17 [DATE]. During an interview with the Director of Nursing (DON) on 3/2/2026 at 2:15 PM, he stated that residents who are prescribed risperidone cannot have a diagnosis of schizophrenia (which would be an indication for use) for the medication until the resident had an assessment by a psychologist after (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission to the facility. A review of the Resident's record conducted on 3/2/2026 at 3:08 PM, revealed that Resident #171 had a psychological assessment for clarification for diagnosis of schizophrenia on 4/1/2025. The psychologist concluded the assessment and plan with diagnoses F20.81-schizophreniform disorder and to continue current medications and psychiatry team to monitor mood and behavior. A follow-up interview was conducted with the DON on 3/2/2026 at 3:34 PM to share the concern that Resident #171 had been receiving the risperidone medication without an indication for use, and that the pharmacist had requested to update the order with the indication for use /diagnosis of schizophrenia for 3 months. The DON acknowledged the concern and stated that the risperidone order was discontinued and re-written on 12/17/2025 with schizophrenia as the indication for use for the medication.

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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 record reviews, observations and interviews, it was determined that the facility failed to have a medication error rate of less than 5% during the medication observation facility task. This was evident for 2 of 26 medication administration opportunities which resulted in an error rate of 7.69%. Findings Included:A Percutaneous Endoscopic Gastrostomy (PEG) tube is the placement of a flexible gastric tube into the stomach. On 02/27/2026 at 10:55 AM, the surveyor observed Licensed Practical Nurse (LPN) #31 administering medications to Resident #87. LPN #31 crushed and administered acetaminophen 500mg via a gastric feeding tube. On 02/27/2026 at approximately 11:00 AM the surveyor reviewed Resident #87's medication orders and Medication administration records which revealed an order for acetaminophen 325mg Oral 2 tablets. The surveyor reviewed the medication orders with LPN #31 and she stated that she didn't know why she thought she saw 500mg on the Resident's order. On 02/27/2026 at approximately 11:00 AM, the surveyor also observed that LPN #31 administered a multivitamin 1 tablet via gastric tube; however, a review of the resident's medication revealed order for Multi-vitamin Liquid Give 15 ml via PEG-Tube one time a day for supplement. Therefore, the medication was not administered in the correct dosage form as prescribed. LPN#31 was asked the about the facility's procedure when a medication error was made and she reported that she would notify the unit manager, the Director of nursing (DON) and the Resident's physician.On 02/27/2026 at 03:55 PM, in an interview with the DON, he was notified of the surveyor's findings during medication administration facility task. The DON verbally acknowledged the findings at that time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, it was determined that the facility failed to ensure that medication was stored in a locked compartments under proper temperature controls. This was true for Resident#172's room observed during the initial tour of the facility. Findings included: On 02/24/2026 at 12:14 PM, during the initial tour of the facility, the surveyor observed prescribed skin cream on Resident #172's window ledge unattended. The medication container was prescribed to Resident #172 and had instructions to refrigerate medication. On 02/24/2026 at 12:18 PM, in an interview, Licensed Practical Nurse (LPN) #27 was asked why the resident's medication was at bedside and she stated that they recently provided personal care to the resident.On 02/24/2026 at 12:14 PM, a review of Resident's #172's Treatment Administration Record revealed that resident had an order for Greers [NAME] Cream, apply to Perineal topically two times a day for Erythema Interigo. On 02/27/2026 at 03:55 PM, in an interview with the Director of Nursing (DON), the DON was informed of the surveyor's findings and the concern was acknowledged by the DON.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 of 1 test tray temperature observation. The findings include: On 2/24/2026 at 10:11 AM, Resident #1 complained that hot foods were usually served cold. On 2/25/2026 at 12:08 PM, the surveyor conducted a lunch tray line observation and requested the Certified Dietary Manager (CDM) to include a tray on the first cart that was going to the unit. At 12:26 PM, the steel cart which contained the meal trays for the first unit with the test tray came out from the kitchen and arrived in the unit at 12:28 PM. However, there was a seven- minute delay before staff began distributing trays, and the final tray was served at 12:44 PM. Both the CDM and the [NAME] Dietary Manager (RDM) witnessed the observation. The RDM proceeded to test the food on the test tray using the facility's food thermometer and recorded the following:- fried shrimp-140 F- French fries- 134 F- coleslaw- 86 F The CDM confirmed that the facility's standards are135 F or above for hot items and 41 F or below for cold items. On 2/26/2026 at 8:40 AM, the Nursing Home Administrator (NHA) was informed of these concerns and acknowledged the findings.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review, and interviews, it was determined that the facility failed to ensure a therapeutic diet was prescribed for a resident. This deficiency affected one (Resident #57) of three residents reviewed for dietary services during the recertification/complaint survey.The findings include:During an interview on 2/24/26 at 11:30 AM, Resident #57 expressed that the provided meals did not accommodate their medical conditions. The resident stated, I am waiting for a kidney transplant. Because of that, I really need a controlled diet for diabetes and end-stage renal disease. However, the facility has been serving me foods I should not have, such as spinach, bananas, and soda.On 2/25/26 at 11:55 AM, the surveyor reviewed Resident #57's diet order, which specified a Heart-healthy diabetic diet-regular texture, thin liquid consistency. A review of the medical record confirmed diagnoses of Diabetes and End-Stage Renal Disease (ESRD). A review of progress notes dated 1/21/26 at 9:48 PM indicated that a facility nurse documented concerns from the resident and their daughter regarding daily meals. The note stated the resident could not eat certain foods due to an ESRD diagnosis. Despite these concerns being shared with staff, there was no evidence of a diet order revision.On 2/25/26 at 12:53 PM, Staff #4 (Certified Dietary Manager) stated the kitchen was aware of the resident's preferences. She noted, Resident #57 was on a diabetic diet. After I received a call from the family, I recorded the restricted foods in my personal notes, which I share with the cook. We check every meal before it is served.On 2/26/26 at 10:24 AM, Staff #8 (Dietitian) verified via phone interview that the facility offers therapeutic diets, including diabetic, renal, and heart-healthy options. When informed of Resident #57's diagnoses, Staff #8 stated, The order should be placed as a renal diet.On 3/02/26 at 1:44 PM, the surveyor discussed these findings with the Director of Nursing (DON), who validated the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to ensure staff donned appropriate personal protective equipment (PPE) for enhanced barrier precautions as required. This is evident for 1(Resident #87) of 7 Residents observed for medication administration during the facility task portion of the survey process. Findings Included:Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) (CDC website 2025).A Percutaneous Endoscopic Gastrostomy (PEG) tube is the placement of a flexible gastric tube into the stomach.Personal protective equipment (PPE)is an equipment worn such as gloves, gowns, masks, respirators, and eye protection designed to create a physical barrier between healthcare personnel and infectious materials, protecting against bloodborne pathogens and respiratory droplets. PPE is also used to reduce the risk bacteria introduction to a immunocompromised individual.On 02/27/2026 at 10:55 AM, during the medication administration task, the surveyor observed that Resident #87's room door had an Enhanced Barrier Protection (EBP) sign posted near the door frame.On 02/27/2026 at 10:57 AM, LPN #31 explained that Resident #87's medication was administered through a PEG tube, which had the potential to introduce the resident to harmful bacteria. The surveyor continued observation of LPN #31 during the medication administration process and noted that the LPN failed to use appropriate PPE (gown and gloves)during the completion of this task.On 02/27/2026 at 3:55 PM, in an interview with the DON, the DON was informed that LPN #31 failed to use appropriate PPE during medication administration via gastric tube, and the DON verbally acknowledged the concern.