STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215324	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Charles Village	2327 North Charles Street Baltimore, MD 21218

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the initial tour of the kitchen.The findings include:All essential kitchen equipment, including but not limited to refrigerators, mobile food carts, tray line equipment, freezers, dishwashers, ovens, stoves, and ranges, must be maintained in safe operating conditions in accordance with the manufacturer's specifications and remain accessible throughout kitchen operations.Cross-contamination means the transfer of harmful substances or disease causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw food, and then touch ready-to-eat foods. Cross-contamination can also occur when raw food touches or drips onto cooked ready-to-eat foods. On 9/29/2025 at 7:48 AM, the surveyor conducted an initial tour of the kitchen alongside the Dietary Director and noted that the following equipment and food handling practices were not in sanitary conditions:Ware Washing Area:1. The hand sink was obstructed and nonfunctional, preventing employees from washing their hands in the ware washing area.2. The hand sink was attached to an unsealed plywood wall. Exposed wood must be properly sealed to avoid moisture absorption, which may lead to bacterial proliferation and pest/insect harborage.3. The high-temperature dishwasher was found to be unclean, exhibiting visible stains and rust on both the top and exterior of the unit.4. The dishwasher drainpipes were unclean and discharged directly into the floor sink without an air gap, which should be two times the diameter of the drainpipe to prevent potential siphonage.5. The food waste grinder attached to the pre-rinse sink side of the high-temperature dishwasher was clogging the two above-ground grease trap interceptors.6. The two above-ground grease trap interceptors were overfilled to capacity and corroded.7. The 3-compartment sink gooseneck faucet was leaking, requiring employees to use a water pitcher to fill the wash vat.8. One of the 3-compartment sink drain lines was leaking gray water onto the floor.9. The dishwasher final rinse temperatures and the 3-compartment sanitizing potency levels were missing from the log sheet for the period of 9/25/2025 to the morning of 9/29/2025.10. Multiple tiles were missing at the cove base by the underground grease trap interceptor below the 3-compartment sink, leading to excessive dirt, dust, grease, and food particle buildup.11. The underground grease trap interceptor below the 3-compartment sink was filled, and the floor tiles around its perimeter were cracked, chipped, and pitted, which facilitates bacterial proliferation and pest/insect harborage.12. The wet vacuum was unclean. This unit was used to remove water from the hot holding units, which may cause possible cross-contamination. Food Service Tray Line:13. The tray line equipment, including the two hot holding machines and the plate warmer equipment, was unclean.14. The one-door reach-in refrigerator was unclean.15. A clean dish rack was placed directly beneath the wall-mounted air conditioner, which may attract dust, dirt, air contaminants, and possibly condensation leaking from the unit. Food Preparation Line (Front of [NAME] Line):16. A chef's knife was stored between the in-counter prep sink hot/cold lever handles.17. The in-counter prep sink drain line was leaking onto the bottom shelf. Cookline:18. The (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gas stove overshelf was unclean, exhibiting excessive grease buildup underneath, which inhibited proper airflow of grease, fumes, steam, and latent vapors to be removed from underneath the canopy hood system.19. The walls behind and beneath the cooking equipment were unclean.20. One of the lightbulbs on the canopy hood was burned out, providing insufficient lighting over the cookline.21. The Victory two-door reach-in refrigerator was placed adjacent to the cookline. The left door was not fully accessible due to the placement of a storage rack in front of the unit.22. The two-door reach-in refrigerator's left door gasket was in disrepair. Food Prep Sink Area:23. The drainpipes of the food prep sink were unclean and missing a floor drain cover.24. The walls behind and beneath the food prep sink were unclean.25. The deli slicer was unclean. All food equipment, utensils, and contact surfaces must be properly cleaned, sanitized, and air-dried to prevent possible foodborne illness. Ice Machine:26. The drain line of the ice machine discharged directly into the floor sink without an air gap, which should be two times the diameter of the drainpipe to prevent possible siphonage.27. The ice machine deflector shield was unclean.28. The wall-mounted ice scoop holder was unclean.29. The floor sink throughout the kitchen area was unclean. Walk-in Refrigerator/Freezer:30. A toaster oven was placed on top of a microwave in a high-traffic area, located less than two feet from the walk-in refrigerator door.31. The walk-in refrigerator door gasket was missing, which allowed a light gap at the bottom of the door.32. The shelving units, walls, floors, and ceiling were unclean.33. The compressor fans and fan covers were unclean.34. The dunnage racks were lined with torn cardboard boxes, which showed excessive dirt and debris buildup. Unapproved Equipment:35. Noncommercial-grade [NAME] ice chest coolers are not approved as kitchen equipment. This is due to their interior design lacking self-drainage and self-emptying capabilities, which are necessary for the safe storage of ready-to-eat food, such as ice for residents.36. The plastic 3-tier storage drawer unit. All kitchen utensils, equipment, and food must be stored in or on commercial-grade shelving or dunnage racks.At 1:30 PM, a second tour of the kitchen was conducted with the Maintenance Director and the Regional Director of Operations to review the findings listed above and to verify additional concerns:37. Backflow prevention devices on all waterlines on equipment such as the ice machine, coffee maker, juice machine, and mop sink.38. The canopy hood ventilation system was insufficiently pulling air underneath the cookline when a smoke pen was used to demonstrate smoke escaping into the hood opening. The Maintenance Director stated that when the hood system was cleaned, the technician assessed the airflow. However, the surveyor asked a reevaluation of the hood airflow calculations since the kitchen door should not be kept open at all times. On 9/30/2025 at 1:10 AM, surveyors observed the ware washing area to be inaccessible during lunch preparation and service operations due to a contractor replacing two above-ground grease trap interceptors and the drainpipes attached to the high-temperature dishwasher. Surveyors also noted that the ware washing area floors were soiled with grease/sewage water, which employees subsequently tracked throughout the kitchen. A foul sewage odor permeated the kitchen. The contractor was instructed to stop any remaining dishwasher pumping repairs to prevent potential cross-contamination.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations and facility staff interview it was determined that the facility failed to provide a safe, clean, comfortable, homelike environment for Residents. This finding was found to be evident in 9 (Resident #1, 2, 4, 7, 10, 11, 29, 58, and #105) out of 9 Resident rooms and the 1st floor shower room on tours of the facility during the annual/recertification survey. The findings include: 1) On 9/30/2025 at 8:30 AM during tour of the facility the surveyor observed items in Resident rooms that were not in good repair. The following rooms were observed with items that were not in good repair: room [ROOM NUMBER] – stained ceiling tile located near window; room [ROOM NUMBER] – stained ceiling tiles located in bathroom and near window; room [ROOM NUMBER] – loose baseboard not affixed to the wall in bathroom under sink; room [ROOM NUMBER] – three ceiling tiles stained with a brown color located near bathroom; room [ROOM NUMBER] – bedside dresser with three broken drawers not affixed on the dresser tracks. TELS Platform (The Equipment Lifecycle System) helps the facility manage preventive maintenance, work orders, asset tracking, and key documentation all in one centralized system. TELS is facilities new work order system that will streamline and simplify work order creation, tracking and completion. The surveyor interviewed Registered Nurse (RN) #7 on 9/30/2025 at 8:40 AM and asked what the procedure was for reporting needed repairs in the facility. RN #7 stated that he would update the repairs needed in TELS regarding the broken dresser drawers for room [ROOM NUMBER]. In an interview with the Regional Director of Operations (RDO) at 1:45 PM on 10/3/2025 the surveyor conveyed the items that were observed in Resident rooms in need of repair (baseboards, ceiling tiles, Resident furniture). The RDO acknowledged the surveyor and stated that he was aware of the repairs that were needed in the facility, and that there was a plan going forward with the construction department of Future Care. RDO stated he knows this was a concern in the facility. At survey exit on 10/7/2025 the Licensed Nursing Home Administrator (LNHA) stated that the facility was getting new ceiling tiles. 2) Lighting - the risk of an accident increases when there is insufficient light or too much light, which often results in glare. Vision among older persons varies widely; therefore, no single level of illumination can ensure safety for all residents. Adequate lighting means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform. Comfortable lighting means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning. On 9/29/2025 at 12:05 PM, the surveyor asked Resident #58 in room [ROOM NUMBER] about preferred activities, given that the cable television was not working at the time of the survey. The resident pointed to the [NAME] novels stored on top of the dresser armoire and on top of the dresser drawer adjacent to the bed. The surveyor then asked if the lights could be turned on to view the book (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	collection. Resident #58 replied that the wall-mounted overbed light was the only available light source for reading, and it provided inadequate lighting. On 9/29/2025 at 12:10 PM, Resident #29 in room [ROOM NUMBER] stated that the wall-mounted overbed light pull string was challenging to operate and needed assistance from staff every time he/she needed to adjust the lighting. The surveyor verified that the light pull string was difficult to operate. On 10/2/2025 at 9:47 AM, Resident #10 in room [ROOM NUMBER] stated that the wall-mounted overbed light pull string was absent from their room. The surveyor observed that the light pull chain extended only one inch from the overbed light panel, making it inaccessible for the resident to comfortably adjust the light setting. On 10/3/2025 at 2:00 PM, the surveyor notified the Regional Director of Operations of the environmental concerns found in the residents' rooms. 3) On 09/30/25 at 10:00 AM the surveyor conducted a tour on the first floor. The surveyor observed: Bathroom in room [ROOM NUMBER]: scattered gray granular dust like debris on the vanity, a 1.5 inch whole on the top side surface of the sink, and a brown stain on ceiling tile above right side of Resident #11's bed . On 09/30/25 at 10:28 AM the surveyor conducted a tour of the shower room on first floor which revealed: A toileting stall to the left, upon entrance to the shower room, had a large 2 ft in diameter brown stain on ceiling tile; its blue privacy curtain soiled at the lower end; The window (only one) observed with black substance along the base of the top half of the window, spanned the width of the window One commode shower chair with a spotty brown substance on it. On 10/01/2025 at 8:00 AM an interview was held with the Nursing Home Administrator NHA) an the Director of Nursing DON) and the surveyor's environmental observations were discussed.

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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 observations, record reviews, and interviews, it was determined that the facility failed to ensure Resident meals were palatable and hot foods were maintained above the food danger zone of 135 degrees Fahrenheit. This was evident for 6 (Resident #2, 9, 10, 11, 13 and #87) of 6 residents interviewed during the annual survey. This failure had the potential to affect all residents receiving meals from the facility's kitchen. The findings include: 1) On 09/30/25 at 10:04 AM the surveyor conducted an initial tour on the first floor unit and Resident #11 was interviewed. During the interview it was revealed that food was served last of all three units and his/her meals are regularly cold by the time s/he receives it. An interview was held with Resident #9 on 09/30/2025 at 10:55 AM. The resident stated that breakfast is, at most times, cold and would prefer it to be hotter. During a follow up interview with Resident #11 on 10/2/25 at 11:25 AM s/he stated that their meals were now warmer than usual. During a follow up interview on 10/7/25 at 9:25 AM with Resident #9 s/he stated their food was much warmer for the past couple of days. 2) Danger Zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. On 9/29/2025 at 7:48 AM, the surveyor observed Staff #20 and Staff #21 serving breakfast at the tray line in the kitchen. The surveyor noted that the middle 3-well steam table contained two food bins filled with unshelled hard-boiled eggs and scrambled eggs. At 8:45 AM, following the breakfast service, the surveyor verified the water temperatures of the middle 3-well steam table after the food trays had been removed. The temperature measured 110 degrees F. The Certified Dietary Manager stated that the unit temperature levels had been reduced, while the first steam table visibly emitted steam. On 9/29/2025 at 12:32 PM, an interview with Resident #87 revealed that the food served was cold and lacked flavor. At 2:30 PM, an interview with Resident #13 indicated that the food served was cold and unseasoned, resulting in an unpleasant taste. On 9/30/2025 at 10:58 AM, an interview with Resident #10 disclosed that the chicken strips served for lunch on Monday, 9/29/2025, were cold and without dipping sauce. At 3:30 PM, a review of the facility's Hazard Analysis Critical Control Points (HACCP) plan showed that all potentially hazardous foods were hot-held at temperatures above 135 degrees F prior to serving. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/2025 at 7:50 AM, the surveyor verified the residents' meal tickets at the tray line in the kitchen. The Certified Dietary Manager confirmed the internal food temperatures in the steam table and acknowledged that the 3-well steam table located in the middle of the serving line was turned off. The temperatures of the food on the first steam table were as follows: 1. Grits: 179 degrees F 2. Scrambled eggs: 179 degrees F 3. Biscuit sausage sandwich: 176 degrees F At 8:27 AM, the last test tray was transported to the first-floor unit in a food cart. The Certified Dietary Manager measured the food on the plate: 1. Scrambled eggs: 128 degrees F 2. Cup of gravy: 127 degrees F 3. Biscuit sausage sandwich: 129 degrees F The Certified Dietary Manager acknowledged that food should be hot held above 135 degrees F, as stipulated in the HACCP plan. 3) On September 29, 2025 during the initial facility tour, Resident #2 was interviewed. During the interview the resident reported that the food is not always hot. They identified breakfast In particular usually being cold. They also identified that the portions were small. On October 3, 2025 while doing a follow up tour, the surveyor asked Resident #2 if their breakfast had been warm. They said it had been late and was ice cold. The Resident handed the surveyor a cup with coffee that was cold and the resident identified that they had only had their breakfast for about 15 minutes. She removed the cloche from their plate and said they were unable to eat cold eggs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment to minimize or eliminate the spread of potential cross-contamination and to implement proper hand hygiene practices to prevent the spread of possible communicable diseases and infections. This was evident in 5 of 5 infection control areas reviewed throughout the facility during the annual survey. The findings include: Hand hygiene refers to a general term that applies to hand washing, antiseptic handwash, and alcohol-based hand rub (ABHR). 1) On 9/29/2025 at 8:40 AM, surveyors observed Staff #11 filling residents' water cups from the hand sink faucet in the second-floor nourishment room. The staff member explained that this was a routine practice. On 9/30/2025 at 2:20 PM, the surveyor toured the facility with the Regional Director of Nursing (RDON) and the Director of Nursing/Certified Infection Preventionist (DON/CIP) to address the infection control issues found at the second-floor nourishment room. On 10/6/2025 at 10:30 AM, the Regional Clinical Services Nurse stated that the staff had received in-service training on the proper procedure for filling water cups from an appropriate area in the second-floor nourishment room. On 10/7/2025 at 10:00 AM, an interview with Staff #22 revealed that the first-floor unit receives water pitchers from the kitchen to fill residents' water cups. 2) On 9/29/2025 at 9:00 AM, the surveyor noted that the over-the-toilet commodes in rooms [ROOM NUMBERS] had rusted and damaged parts. These parts included bolts attaching the handles to the frames that could come into contact with residents' hands, as well as components in the front of the frame. The presence of rust on these bolts and joints rendered these regions difficult to sanitize between uses. At 2:30 PM, the surveyor observed that the bedside commode in room [ROOM NUMBER] was unclean and rusted. On 10/3/2025 at 1:50 PM, an interview with the Regional Director of Operations confirmed that the rusted and/or damaged over-the-toilet commodes and bedside commodes have been replaced throughout the facility. On 10/6/2025 at 12:10 PM, the surveyor noted that the over-the-toilet commode in room [ROOM NUMBER] was rusted and damaged. 3) On 9/29/2025 at 2:40 PM, an interview with Resident #37 revealed that the resident missed breakfast and lunch due to a lack of hand hygiene performed prior to eating. The resident then pointed out an empty bottle of ABHR on the bedside tray table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:45 PM, Staff #22 provided a new bottle of ABHR to Resident #37 upon the surveyor's request. On 10/3/2025 at 8:20 AM, the surveyor and the Certified Dietary Manager observed breakfast being served to residents on the first-floor unit. The staff served breakfast promptly to the residents and verified that staff used ABHR when exiting residents' rooms. However, it was not possible to verify that residents' hands were washed or cleaned prior to food service. On 10/6/2025 at 2:00 PM, the surveyor observed Resident #10 eating a plate of chef salad alone in the first-floor dining/activities room. The surveyor inquired if the resident had washed their hands prior to eating, and the resident replied, no. On 10/7/2025 at 9:00 AM, both the Administrator and the Regional Clinical Services Nurse confirmed that the facility would provide sanitizing wet naps or other hand sanitizing supplies for residents to use to clean their hands prior to eating. 4) On 9/30/2025 at 1:08 PM, surveyors observed two above ground grease trap interceptors that were previously installed at the dishwashing machine stacked on top of a dolly and located in the vestibule leading to the kitchen. At 1:10 PM, surveyors observed a makeshift barrier constructed from torn trash bags and taped to the walls leading to the ware washing area by the Maintenance Director and the Regional Director of Operations, which also obstructed access to the 3-compartment sinks during lunch service. When the surveyors asked about the duration of the contractor's work on replacing the grease trap interceptor while the kitchen was in operation, the Regional Director of Operations indicated that he had been repairing/replacing the unit and the drain lines since 12:00 PM. The contractor was asked to immediately cease the replacement of the grease trap and drain lines due to the risk of contamination from exposed sewage water splashing onto the kitchen floors. In addition, sewage water droplets could potentially become aerosolized and spread across the surfaces of kitchen food equipment, exposed cooking equipment, and food items, leading to possible cross-contamination. The surveyors also asked the Certified Dietary Manager regarding the disposal of any potentially exposed food items, to which she responded that there were no concerns regarding potential cross-contamination during lunch service while the contractor was removing and replacing the two above ground grease trap interceptors and drain lines, and she did not deem it necessary to discard any food. At 1:48 PM, a tour the kitchen was conducted alongside the RDON and the DON/CIP to highlight the infection control issues that the surveyors noted during lunch service while lunch was being prepped and served. They acknowledged that all food contact surfaces, and equipment must be thoroughly cleaned and sanitized. The hand sink by the dishwashing area must be repaired immediately. 5) On 10/6/2025 at 2:50 PM, the surveyor and the Maintenance Director observed one unwrapped/uncovered IV pole placed inside the first-floor portable oxygen tank closet. On 10/7/2025 at 9:50 AM, the surveyor observed one plastic-wrapped/covered IV pole and one unwrapped/uncovered IV pole in the first-floor clean utility room. The clean utility closet also housed clean plastic cups on a shelving unit. However, the hand sink faucet was leaking, the sink basin was unclean, storage cabinet doors were falling off their hinges, and ceiling tiles were missing. An interview with the RDON revealed that the clean IV poles were wrapped/covered in plastic to distinguish that the IV poles were sanitized between uses. Then she removed both IV poles from the clean utility closet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:10 AM, the Regional Clinical Services Nurse was notified of the findings in the first and third-floor clean utility rooms. Both the surveyor and the Regional Clinical Services Nurse verified that the Maintenance Director was present at the first-floor clean utility room to make the repairs.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, record review, and interviews, it was determined that the facility failed to maintain essential equipment in proper operating conditions. This was evident for 3 of 3 pieces of equipment reviewed during the annual survey.The findings include:On 9/29/2025 at 7:50 AM, the surveyor observed that the hand sink in the ware washing area was obstructed by an open box of trash bags, with two bags draped over the sink and extending to the kitchen floor.At 7:52 AM, the Champion high-temperature dishwasher was noted to be turned off, and one of the two above-ground grease trap interceptor covers was missing, allowing for visual inspection of the grease level.At 7:54 AM, a review of the high-temperature dishwasher log sheet indicated that the wash and rinse temperatures for breakfast, lunch and dinner have not been documented since 9/24/2025.At 8:30 AM, an interview with the Certified Dietary Manager (CDM) confirmed that the dishwasher had been in use over the weekend, but staff had neglected to log the temperatures. The surveyor requested that the trash bags be removed from the hand sink and the faucet be turned on to verify hot and cold running water. The CDM confirmed that the hand sink was inoperable, with no water flowing from the faucet.At 1:40 PM, a kitchen tour was conducted with the Maintenance Director and the Regional Director of Operations. The surveyor observed that the grease level in one of the above-ground grease trap interceptors attached to the dishwasher was elevated. Both the Maintenance Director and the Regional Director of Operations confirmed that the dishwasher had been turned on and immediately shut off when the grease trap began to fill to capacity. The surveyor inquired about the location of the booster heater for the dishwasher, and the Maintenance Director confirmed its placement within the unit.On 10/3/2025 at 7:50 AM, the surveyor noted that the middle 3-well steam table was turned off. The CDM confirmed that a new unit had been ordered and would be installed as soon as possible.At 8:35 AM, the CDM started the dishwasher, and the final rinse temperatures varied between 184 degrees Fahrenheit and 138 degrees Fahrenheit. Dishwater was observed leaking from the lower edges of the side double doors onto the kitchen floor, and a significant amount of steam/vapors escaped from both ends of the unit dissipating throughout the kitchen.At 12:50 PM, an interview with the Ecolab technician revealed that the booster heater, door gaskets, and curtains from both ends required replacement for the unit to operate according to the manufacturer's specifications.Both the Chief Operating Officer and the Regional Director of Operations acknowledged the necessity of repairs for the high-temperature dishwasher.Cross-reference to F 880.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff, it was determined that the facility failed to maintain clean and effective ventilation systems, thereby impeding proper airflow throughout the premises. This was evident in 3 of 3 areas reviewed during the annual survey.The findings include:HVAC means heating, ventilation and air conditioning. Local Exhaust Ventilation ([NAME]) systems are designed/engineered to capture and remove contaminants such as excessive heat, steam, condensation, vapors, smoke, and fumes. This is achieved by calibrating the total pressure, which is determined by the sum of the static pressure exiting and entering the system, minus the velocity pressure entering the system. In addition, the fan speed, pressure, and power must be adjusted to account for the specific gravity of the contaminant being captured and removed by the [NAME] system, considering the specific size and air changes of the room.1) On 9/29/2025 at 1:50 PM, the initial facility tour concluded at the first-floor nurse's station with the Maintenance Director and the Regional Director of Operations. The surveyor raised concerns regarding multiple water-damaged ceiling tiles in several resident rooms and their restrooms, while pointing to a heavily dusted ceiling vent cover and water-damaged ceiling tiles above the first-floor nurse's station as specific examples. The Maintenance Director explained that the water-damaged ceiling tiles were a result of condensation buildup on HVAC duct systems and indicated that maintenance staff were actively replacing ceiling tiles throughout the facility. Both the Maintenance Director and the Regional Director of Operations agreed to address the root causes of the HVAC condensation buildup rather than to replace the damaged ceiling tiles.2) On 10/3/2025 at 8:35 AM, the Certified Dietary Manager started the Champion high-temperature dishwasher and noted that a significant amount of steam/vapors escaped from both ends of the unit dissipating throughout the kitchen. At 12:50 PM, an interview with the Ecolab technician revealed that the curtains at both ends, which are essential for inserting soiled dishracks and retrieving clean ones, required replacement to ensure the unit operated in accordance with the manufacturer's specifications.3) On 10/6/2025 at 2:25 PM, the surveyor observed a water-damaged ceiling tile adjacent to a vent cover when a staff member opened the first-floor portable oxygen cylinder tank storage closet to replace a nearly empty oxygen cylinder tank from behind a resident's wheelchair.At 2:45 PM, the surveyor requested the Maintenance Director to verify the [NAME] systems by placing a piece of paper towel or tissue paper on the exhaust fan covers in all three portable oxygen cylinder tank storage closets. These closets are designed to exhaust air from the nonflammable hazardous material storage areas to regulate the temperatures and the air pressures. This provided an additional opportunity to address the previously noted water-damaged ceiling tiles and dusty vent covers within the storage closet. However, the Maintenance Director confirmed that the [NAME] systems in all three portable oxygen cylinder tank storage closets were inoperable.At 3:10 PM, the Regional Director of Nursing and the Regional Clinical Services Nurse were informed of these findings.On October 7, 2025, at 8:50 AM, the Administrator and the Maintenance Director confirmed that an HVAC service technician will repair the ventilation unit on the roof in the afternoon.Cross-reference to F695.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment (#5). This was true for one of residents reviewed during the annual survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. A record review was completed on 09/29/2025 at 10:54 AM. The review noted that Resident #5 was admitted to the facility on [DATE] with diagnosis including Sepsis, Chronic Deep Vein Thrombosis and Type II Diabetes. Continued review of the record for Resident #5 revealed an MDS assessment dated [DATE]. On section N0350 for Insulin, 1 was indicated for number of days the resident received insulin injections. Next, the surveyor reviewed Resident #5's physician orders and Medication Administration Record (MAR) for August 2025. The review failed to reveal any physician's orders for insulin. On 10/02/25 at 12:30 PM an interview with the MDS Coordinator revealed that on the MDS assessment dated [DATE], under section N for Medications, N0350 was documented as 1 day for receiving insulin. The MDS Coordinator searched in the electronic record for the evidence in Resident #5's August 2025 MAR to find the insulin order and if or when it was administered and found that one injection was documented as administered which was Trulicity. Trulicity (which is a glucagon-like peptide-1 (GLP-1) receptor agonist) works by mimicking the natural hormone GLP-1 that your body produces, which helps to control blood sugar. Trulicity is not insulin. The MDS Coordinator could not locate the order for insulin but said s/he would bring any info she could find related to what information s/he used to code the resident for receiving insulin. On 10/02/25 at 1:45 PM a follow up interview was done with the MDS coordinator. During the interview s/he confirmed that s/he submitted a modified assessment on 10/2/25 which coded the number of insulin injections as 0.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on Resident interview, facility staff interview and surveyor record review, it was determined that the facility failed to revise a Resident's care plan for antipsychotic drug use timely. This finding was found to be evident for 1(Resident #14) out of 1 Resident reviewed for care plan timing and revision. The findings include:In an interview with Resident #14 on 9/30/2025 at 9:20 AM the surveyor asked Resident about care plan meeting. Resident #14 stated I don't attend care plan meeting, and I don't want to attend the meeting. Resident #14 was alert and oriented to person, place and time.A care plan is a formal document or a set of notes that outlines a person's healthcare needs, treatment goals, and the specific interventions required to meet those goals, ensuring personalized and consistent care. It serves as a guide for healthcare providers and Residents, detailing medications, test results, and care strategies while promoting collaboration between the Resident, their family, and the care team.Antipsychotic drug is a class of medication used to treat mental health conditions characterized by psychosis. They help to reduce the symptoms of psychosis such as hallucinations, delusions, and disorganized thinking.The surveyor conducted a record review of Resident #14's medical record on 10/1/2025 at 12:05 PM. Review of the medical record revealed that Resident #14 had antipsychotic drug use addressed on the care plan as of 5/22/2023 with a revision date of 7/31/2024. Further review of the medical record, specifically the physician orders for Resident #14 revealed that Seroquel, an antipsychotic medication, was discontinued on 2/27/2025 due to non-use. However, Resident #14's current care plan still had antipsychotic drug use addressed on the care plan.In an interview with the Director of Nursing (DON) at 2:30 PM on10/3/2025 the surveyor reviewed Resident #14's current care plan and physician orders with the DON. The surveyor conveyed to the DON that the Seroquel, an antipsychotic medication, was discontinued on 2/27/2025; however, antipsychotic drug use remained on Resident #14's current care plan. Resident #14's care plan was not revised when the Seroquel was discontinued on 2/27/2025. The DON acknowledged the surveyor and stated that she would update Resident #14's current care plan. On 10/3/2025 the DON provided a copy of the revised care plan dated 10/3/2025, and on 10/6/2025 the Regional Clinical Service Nurse provided a copy of the discontinued Seroquel order dated 2/27/2025 to the surveyor.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations and interviews, it was determined that the facility failed to provide activities to meet the needs and preferences of residents. This was evident for 2 (Resident #13 and #119) of 2 residents interviewed for activities during the annual survey.The findings include:On 9/29/2025 at 2:30 PM, the surveyor observed 14 residents on the first-floor dining/activities room and noted that eight residents were sitting in their wheelchairs, and six residents were sitting in the Geri chairs, where two residents have fully extended their recliner seats positioned to elevate their legs. When the surveyor asked to speak with resident #13, five other residents had to rearrange their chairs out of the dining/activities room to allow the resident to exit from the corner of the limited spaced dining/activities room.On 10/2/2025 at 9:30 AM, the surveyor observed five residents on the second-floor dining/activities room and noted that three residents were sitting in front of the large screen TV while two other residents were staring out the windows.On 10/3/2025 at 2:15 PM, the surveyor observed 16 residents on the first-floor dining/activities room and noted that two other residents were sitting on their wheelchairs just outside the room in front of the employee bathroom door while other residents were participating in coloring activities at the table. Due to the limited space of the room, the two residents could not participate in the activities.On 10/6/2025 at 12:06 PM, an interview with the resident #119 from the third floor revealed that there were no activities to participate in at the second and third floor dining/activities rooms. All monthly scheduled activities on the calendar were held on the first-floor dining/activities room only. The resident also added that the facility did not provide activities that meet their interest and had a difficult time getting down to the first floor to participate in the activities that started from 10 AM to 2:30 PM.At 3:00 PM, an interview with Staff #3 and Staff #18 confirmed that the activities were only held in the first-floor dining/activities room. The first activity started at 10 AM and the last activity ended at 3:30 PM. At 3:15 PM, the Regional Director of Nursing and the Regional Clinical Services Nurse acknowledged that the room had limited space for all residents to participate in the activities. They both agreed that the issue will be brought up at the next Quality Assurance and Performance Improvement (QAPI) meeting.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, medical record review and interviews with residents, residents' family members and facility staff, it was determined that the facility failed to: 1) ensure ordered splints were in place, 2) failed to get an X-ray and the appropriate higher level of care for a resident who had sustained a fall that had resulted in a hip fracture in a timely manner, 3) failed to get a resident who was experiencing abdominal pain and had made multiple request for the facility to call 911 transported to the hospital in a timely manner. This was evident for 2 (Resident #2 and #15) of 2 residents reviewed for neglect during the annual survey.The findings include:1) Surveyor completed a tour of the facility and multiple observations of Resident #2 on 9/2/2025. During these observations Resident #2 was observed lying in his/her bed without any noticeable splints or braces in place. Upon review of the Medication Administration Record (MAR), it was discovered that the nurse had signed off that the splints had been applied but failed to do so. The Director of Nursing (DON) was notified.2) During the initial pool interviews on 9/29/2025, Resident #2 stated that his/her care at the facility was so-so stating that in January 2025 she had fallen and that they had experienced a lot of pain In their leg for a long time before going to the hospital. After reviewing the medical record, the surveyor discovered that the resident had been left on the toilet unsupervised while the Geriatric Nursing Assistant was getting supplies and had fallen while attempting to get up. The resident is paraplegic. The fall occurred on 1/8/2025 at approximately 9:00 pm. The resident was assessed by the nurse and an order for an X-ray was written at 11:00 pm. The order was not written as a STAT order and consequently the X-ray was not completed until 2:41 pm on 1/9/2025. The x-ray results that indicated the resident had a broken hip were not made available until 4 pm and the resident was not transferred to the hospital until 6:33 pm where they underwent emergency surgery. This was approximately 21 hours after they had sustained the injury.3)While investigating a complaint made by a family member, the family member and the resident informed the surveyor that in January 2025 the resident had experienced abdominal pain, had made the facility staff aware of her pain and requested multiple times to have 911 called and be taken to the hospital and was told that the staff check on her. The family member had stated that on 1/19/2025 at approximately 9am her mother had complained of abdominal pain after eating breakfast. The resident had spoken to her sister (the mother's sister) about the pain and reported that she had vomited. The sister had called the nurse's station and requested that they check on the resident which they did. The resident reports that the pain was so severe that they had requested that the facility call 911 and that she had been told they would continue to check on her. The resident reported that they continued to use the call bell and request that 911 be called throughout the day. At approximately 6pm the resident's roommate called 911 and the resident was transported to John Hopkins Hospital (JHH) ER. It was determined there that the resident had a bowel obstruction caused by adhesions and the resident was admitted and had a surgical procedure performed to remove the obstruction. A medical record review confirmed that the facility staff had been aware of the resident's pain and that a nursing assessment had been done. On 10/2/2025, the surveyor interviewed the DON and made her aware of the concerns. The DON stated that the nursing staff had assessed the resident and were providing care. There was no progress note regarding care beyond the initial nursing assessment or any pain medication given beyond the resident's standing order for Acetaminophen.

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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 surveyor observation, facility staff interview, and surveyor record review it was determined that the facility failed to follow appropriate respiratory care and services. This was found to be evident in 1 (Resident #30) out of 2 Residents reviewed for respiratory care and services.The findings include:On tour of Unit 3 on 9/29/2025 at 2:35 PM the surveyor observed Resident #30 in bed with an oxygen concentrator in the room in use. There was not an oxygen signage posted on Resident #30's room door upon entry to the room.The surveyor conducted a record review of Resident #30's medical record on 10/2/2025 at 7:45 AM. Review of the medical record revealed that Resident #30 had a current physician order dated 6/3/2025 for oxygen via nasal cannula at 3 liters/minute every shift for shortness of breath.Additionally, the surveyor reviewed the nursing home facility's Respiratory Therapy: Oxygen Therapy Policy and Procedure on 10/2/2025 at 8:15 AM. The policy indicated that oxygen will be delivered in a safe manner.In an interview with the Unit Manager on Unit 3 at 11:10 AM on 10/2/2025 the surveyor asked what the expectation was for oxygen signage to be posted on the Resident room door when oxygen was in use in the Resident room. The Unit Manager stated that an oxygen sign should be posted on the Resident room door when oxygen was in use. The surveyor conveyed that Resident #30 had an oxygen concentrator in use in the Resident room; however, there was not an oxygen signage posted on the Resident room door. The Unit Manager acknowledged the surveyor and stated that an oxygen sign should be posted on Resident #30's room door and further stated that we will do a better job with this.No additional information was provided by the facility at the time of survey exit.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observations, record review, and interviews, it was determined that the facility failed to provide sufficient physician-ordered thickened drinks to maintain resident hydration needs and preferences. This deficiency was evident for 1 (Resident #13) of 1 resident reviewed during the annual survey.The findings include:On 9/29/2025 at 2:30 PM, the surveyor observed Resident #13 in the dining/activities room without a hydration cup at the table. The surveyor requested to escort the resident back to their room for a private conversation, whereupon the resident requested a cup of water.On 9/30/2025 at 9:40 AM, the surveyor observed Resident #13 with a therapist; however, no hydration cup was present next to the bedside tray table or dresser drawer.On 10/2/2025 at 10:20 AM, the surveyor observed Resident #13 with a therapist; however, no hydration cup was present next to the bedside tray table or dresser drawer.On 10/3/2025, at 12:49 PM, a record review indicated that the resident was on a regular diet, level 7, and level 2 mildly thick consistency liquid, with no straws and no ice, effective 9/8/2025.At 1:20 PM, the surveyor interviewed Resident #13 regarding hydration needs and preferences, and the resident stated that he/she was thirsty. At 1:22 PM, the surveyor notified the Regional Director of Nursing (DON) of the four-day observations and the resident's hydration status. The Regional DON confirmed that the resident was prescribed thickened liquids but did not have a hydration cup by their bedside table.On 10/7/2025 at 9:00 AM, the Certified Dietary Manager and the DON presented a new plan to store pitchers of thickened hydration liquid in the nourishment room refrigerators to meet residents' hydration needs and preferences.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff, it was determined that the facility failed to provide a call bell system accessible to residents in the restrooms. This was evident for 3 of 3 restroom call bell systems reviewed during the annual survey.The findings include:On 9/29/2025 at 11:00 AM, the surveyor observed that the restroom call bell cords in rooms [ROOM NUMBERS] were wrapped around the toilet handrails making them inaccessible to residents if they were on the restroom floors.On 10/3/2025 at 1:40 PM, the Regional Director of Operations was informed of these findings and confirmed that the call bell cord would be extended to the restroom floors to ensure resident accessibility.On 10/6/2025 at 12:05 PM, the surveyor noted an additional restroom call bell cord in room [ROOM NUMBER] wrapped around the toilet handrail making it inaccessible to residents if they were on the restroom floor.The Administrator, Regional Director of Nursing (DON), Regional Clinical Services Nurse, and the DON were notified of the deficient practices during the exit conference on October 7, 2025.