STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215328	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Pineview	9106 Pineview Lane Clinton, MD 20735

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 resident medical record reviews and staff interviews, it was determined that the facility failed to provide residents or family representatives with an opportunity to formulate an Advanced Directive. This was evident for 6 (Residents #5, #6, #18, #37, #50 and #56) out of 9 residents reviewed during the recertification survey.The findings include: On 07/31/25 at 7:22 AM, Resident #5's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 07/31/25 at 7:31 AM, Resident #6's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 07/31/25 at 7:37 AM, Resident #18's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 07/31/25 at 7:44 AM, Resident #37's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 07/31/25 at 7:53 AM, Resident #50's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 07/31/25 at 8:02 AM, Resident #56's medical record was reviewed. During the medical record review, the surveyor was unable to locate an Advance Directives or evidence that an Advance Directive was offered to the resident or family representative.On 08/05/25 at 8:28 AM, staff Social Services Director #9 was interviewed. During the interview, staff #9 stated that during the time of admission, residents or family representatives are offered an opportunity to formulate an Advance Directive. Staff #9 also stated that when the resident or family representative declines to formulate an Advance Directive, Social Services will document the resident's or family representative's refusal to formulate an Advance Directive in a progress note in the resident's medical record. Staff #9 mentioned that he/she would provide the surveyor with evidence that an Advance Directive was offered to Residents #5, #6, #18, #37, #50 and #56 or their family representatives. On 08/05/25 at 9:16 AM, Staff #9 was interviewed. During the interview, staff #9 stated that, at the time of admission, Residents #5, #6, #18, #37, #50 and #56 or their family representatives were verbally offered an opportunity to formulate an Advance Directive; however, Social Services could not locate the evidence that Residents #5, #6, #18, #37, #50 and #56 or their family representatives were offered an opportunity to formulate an Advance Directive. Staff #9 also stated that Social Services did not document that residents or their family representatives were offered an opportunity to formulate an Advance Directive.

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 observations and interviews with facility staff it was determined the facility failed to: 1) Ensure that the kitchen is clean and free of dirty dishes; 2) Ensure that the low temp dish wash machine maintained the required temperatures for the wash and rinse cycle; 3) Ensure that expired foods were discarded; 4) Remove all standing water located on the floor in the kitchen. This was found to be evident during an initial and follow-up tour of the kitchen survey has the potential to impact residents receiving food prepared in the kitchen. Findings include: An initial tour was conducted of the kitchen on 7/30/25 at 07:55 AM with the Dietary Manager (DM) Staff # 11 present. The following concerns were identified: 1. A staff member was observed washing dishes in the 3-Compartment Sink. Next to the sink there was a large puddle of water observed on the floor. A fly was observed in the area that landed on the wall inside the kitchen along with several knats flying around.During a follow-up visit to the kitchen on 8/4/25 at 11:30AM, an observation was made of a large puddle of standing water next to the entrance doorway inside the kitchen. The DM was made aware of the observation at that time. The Administrator was made aware of all identified concerns at this time as he was present in the kitchen. 2. While awaiting the dishwasher to fill with water at 8:05 AM, which takes approximately ten minutes per interview with the DM, an observation was made of the area near the dishwasher that had dirty dishes containing food particles and debris that was present on two silver carts. The DM stated that the dishes were there from the previous evening and would be washed this morning.3. At approximately 8:30AM, the DM placed a tray with coffee mugs into the dishwasher and started the dishwasher. The dishwasher ran for approximately 1 minute and the wash temperature reading was 115 degrees F and the rinse temperature reading was 130 degrees F.The DM proceeded to run the dishwasher again and the wash temperature reading was 115 degrees Fahrenheit and the rinse temperature reading was 130 degrees Fahrenheit. The DM ran the dishwasher 3 more times and the wash temperature reading was for 115 degrees Farhrenheit for each wash cycle and the rinse temperature reading was 120 degrees Fahrenheit.During a subsequent visit to the kitchen at 9:50AM, there was a staff member in the dishwash area running the dishwasher. The surveyor observed the machine, and the wash temperature reading was 138 degrees, and the rinse temperature reading was 128 degrees F.The facility provided documentation of the dishwasher being a low temp machine and was serviced on 7/3/2025 with no concerns noted at that time.4. The dry storage area had a full gallon jug of Browning and Seasoning Sauce. The container had a best buy date of April 11, 2025. The DM removed it from the shelf.5. An observation was made of the walk-in freezer and there was a long ice cycle hanging from the sprinkler. The DM began chopping away at the ice to remove it.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews it was determined the facility failed to: 1) accurately reflect on its facility matrix the number of residents on transmissions precautions, and/or contact precautions, and/or the number of facility acquired pressure ulcers and/or pressure ulcers acquired during a resident's admission. This was evident to be true for the three submissions of the facility matrix presented to the survey team; 2) The facility failed to document the start times on the continuous tube feeding bag. This was evident for 1 (Resident #166) of 2 residents with continuous tube feedings; 3) update residents infection control status in the electronic medical record. This was evident for 3 resident rooms (Resident #4, #14, and #162's room) out of 24 resident rooms screened on the second floor and 4) initiate an order and complete documentation for the use of resting hand splints. This was evident for 1 (Resident #4) out of 6 residents reviewed for position/range of motion. The findings include: The minimum data set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. The information collected from the MDS assessment tool drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. The facility matrix reflects the information pulled from the MDS assessments conducted by the facility. The facility matrix is used to identify pertinent patient/resident care categories for all residents within the facility. 1. On 07/30/2025 at 08:40 AM as part of the entrance conference the surveyor reviewed with the director of nursing (DON) #2 the requirement for a copy of the facility matrix. A copy of the facility matrix was provided to the surveyor within the first four hours of the entrance of the survey team. On 08/01/2025 at 08:30 AM the surveyor re-review of the facility matrix revealed that the facility had not accurately reflected the number of residents with pressure ulcers either acquired prior to admission to the facility and/or acquired after admission to the facility. Additionally, the facility matrix did not reflect the accurate number of residents on transmission-based precautions and/or contact precautions. On 08/04/2025 at 08:11 AM the surveyor informed the DON that the facility matrix presented on 07/30/25 was inaccurate and did not reflect the total number of residents on transmission precautions and/or contact isolation as well as the number of residents with pressure ulcers acquired prior to admission and/or acquired after admission to the facility. At 09:06 AM on 08/04/2025 the DON presented the surveyor with another copy of the facility matrix. On 08/05/2025 at approximately 09:30 AM the DON provided another copy of the facility matrix. The Regional Director, the two MDS coordinators (#14, 15), the second-floor Unit Manager #13, and the Regional Clinical Director (#4) and the DON #2 were present. During the conversation it was determined/revealed that the DON and unit manager had unintentionally deleted MDS information each time they updated the facility matrix per the MDS coordinators. The regional nurse was in agreement with the findings presented by the MDS coordinators. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/04/2025 at 9:40 AM, during morning observation, the surveyor observed that Resident #166 's tube feeding bag was dated and had the rate with the resident's name on it. The tube feeding bag was missing the time that it was hung. Resident's nurse, Staff #28, was outside the resident's room and was asked what should be documented on the tube feeding bag when hung. Staff #28 explained that the tube feeding bag is hung on the evening shift and should have the resident's name, date, and time that it is hung, along with the name of the product (which comes on the bag) and hourly rate. Asked Staff #28 to come to the resident's bedside and take a look at the tube feeding. Staff #28 looked at the bag and noted that there was no time on the bag for when it was hung. The surveyor spoke with the Unit Manager, Staff #13, and asked her what information should be on the tube feeding when hung. She explained that the resident's name, the date it was hung, and the time should be documented on the bag, and the type of tube feeding product, which is on the bag already, and the hourly rate. The surveyor asked Staff #13 to come to the bedside of Resident #166 and review the tube feeding bag with them. Staff #13 confirmed that the time was missing from the tube feeding bag for when it was hung. 2. On 8/05/2025 at 7:30 AM, during morning observation, it was noted that Resident #166's tube feeding bag was hanging with the date, the resident's name, and the hourly rate. The time was missing for when the tube feeding bag was started and hung. The Director of Nursing (DON) had just arrived on the unit, when the surveyor asked her to accompany the surveyor to Resident #166's room. The DON was asked what should be on the tube feeding bag when hung. She responded that the resident's name, the date, the time it was hung, and the rate at which it should be delivered. The DON was asked to locate the time when the tube feeding bag was hung. She was not able to locate it. The surveyor notified the DON that the Unit Manager (Staff #13) was notified yesterday of this concern and showed her the picture from the previous day. 3. Contact precautions refers to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment. On 8/4/2025 at 9:40AM, the Surveyor observed a sign on Resident #4, #14, and #162's room door indicating the residents were on contact precautions. The sign stated that everyone must: clean their hands before entering and when leaving the room. Providers and staff must also put on gloves before room entry and discard before room exit; put on gown before room entry and discard before room exit; do not wear the same gown and gloves for the care of more than one person; and use dedicated or disposable equipment and clean disinfect reusable equipment before use on another person. Enhanced Barrier Precautions (EBP) are an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms (MDROs). EBP's are used in nursing homes for residents who are infected with an MDRO, or those at risk for acquiring one, such as residents with wounds or indwelling devices. Multidrug-resistant organisms (MDROs) refer to microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents. On 8/4/2025 at 9:55AM, a review of Resident #4's electronic medical record revealed an active physician's order for enhanced barrier precautions (EBP), every shift, initiated on 2/18/2025. Continued review of Resident #14's electronic medical record revealed an active physician's order for EBP, every shift, initiated on 5/24/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of Resident #162's electronic medical record revealed an active physician's order for EBP, every shift, initiated on 12/9/2024. On 8/4/2025 at 11:18AM, during an interview with the Infection Preventionist (IP) #3 and the Director of Nursing (DON), the Surveyor was informed that Resident #4, #14, #162 were all on contact precautions due to the same MDRO. IP #3 stated that these residents are able to cohort in the same room for infection control because they have the same MDRO. The Surveyor expressed the concern that Resident #4, #14, and #162 have orders for enhanced barrier precautions in their electronic medical record and that there were no orders for contact precautions in their electronic medical record. The Surveyor, DON, and IP#3 confirmed that the residents electronic medical record should have been updated to reflect that they are on contact precautions for a specific MDRO. On 8/5/2025 at 8:00AM, during a review of Resident #4's electronic medical record, the Surveyor discovered a discontinued physician's order for EBP on 8/4/2025 and an active physician's order for contact precautions for [MDRO] initiated on 8/4/2025. During a review of Resident #14's electronic medical record, the Surveyor discovered a discontinued physician's order for EBP on 8/4/2025 and an active physician's order for contact precautions for [MDRO] initiated on 8/4/2025. During a review of Resident #162's electronic medical record, the Surveyor discovered a discontinued physician's order for EBP on 8/4/2025 and an active physician's order for contact precautions for [MDRO]. 3. Restorative Nursing Program is a program that aims to help residents in skilled nursing facilities achieve and maintain their highest possible level of independent function. The program is tailored to each resident's specific needs and abilities. Restorative interventions include range of motion exercises both active (where the resident moves their own limbs) and passive (where the staff moves the resident's limbs). Contracture is a structural change in the body's soft tissues like muscles, tendons, ligaments, or skin that causes them to stiffen and shorten. On 8/4/2025 at 9:42AM, the Surveyor observed Resident #4 in bed with contractures in both hands. On 8/4/2025 at 9:58AM, a review of Resident #4's electronic medical record failed to reveal documentation of the resident's contractures of both hands and any resident specific equipment used to meet the needs of the resident. On 8/5/2025 at 12:40PM, the Surveyor reviewed the Restorative Nursing Program Binder. Resident #4's restorative activities included in the binder as of 7/31/2025 failed to include range of motion (ROM) for the hands and interventions for the bilateral hand contractures. On 8/6/2025 at 7:45AM, the Surveyor reviewed Occupational Therapy (OT) notes from dates of service 2/18/2025-4/27/2025. OT assisted Resident #4 with bilateral upper extremity range of motion and splinting for both hands because the resident was at risk for contractures. A splint and brace program was established/trained for the restorative nursing program for right hand splint and left hand splint upon OT discharge on [DATE]. The Surveyor reviewed discharge therapy notes from dates of service 6/27/2025-7/30/2025 signed on 7/31/2025 with revisions on 8/5/2025 which OT (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisted Resident #4 with bilateral upper extremity range of motion and splint of both hands to minimize further decline. A restorative splint and brace program and range of motion program was established/trained for restorative nursing to continue splinting right and left hand and completing range of motion exercise with the resident. On 8/6/2025 at 11:20AM, the Surveyor conducted an interview with Restorative Aide/Geriatric Nursing Assistant (GNA) #31. During the interview, the Surveyor was informed that Resident #4 was a part of the Restorative Nursing Program within the facility and GNA #31 was assigned to the resident. GNA #31 was on the way to Resident #4's room to provide hand messages and to apply the resident's splints to his/her hands because his/her hands were contracted. A review of Resident #4's electronic medical record on 8/6/2025 at 12:45PM, failed to reveal a physician's order for splints to both hands for contractures until 8/5/2025 in which the order stated Splint Order: Late entry for 7/31/2025 [bilateral upper extremity, BUE] resting hand splint to be worn 4 daily for 4hrs on and 4hrd off as tolerate with skin check in between, may have splint off for ADL care. Further review failed to reveal documentation of GNA #31's completion of ROM exercises of both hands and application of splints to both hands. On 8/7/2025 at 10:50AM, during an interview with Regional Clinical Nurse #4 and restorative aid/GNA #3, the Surveyor was informed that Resident #4 had been completing range of motion exercises and placing the bilateral splints on the resident for a couple weeks. The Surveyor expressed the concern that Resident #4's electronic medical record failed to reveal an order for BUE resting hand splints until 8/5/2025 and that there was no documentation that the restorative aid/GNA #31 completed BUE range of motion or applied the splints for the resident. On 8/7/2025 at 11:30AM, the Regional Clinical Nurse #4 provide the Surveyor with a copy of Resident #4's Documentation Survey Report for August 2025 that shows the new approach/task for the restorative aid/GNA #31 to apply BUE resting hand splint to be worn 4 daily 4hrs on and 4 hours off as tolerate with skin check in between, may take splint off for ADL care, for 7:00AM-3:00PM shift. There was no documentation from 08/1/2025-8/7/2025.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview with staff, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) completed required annual in-service training timely. This was evident for 3 (GNA #16, #31, and #34) out of 4 employee records reviewed for required in-service training during the annual survey. The findings include:On 8/7/2025 at 9:15AM, the Surveyor reviewed the employee files of 4 Geriatric Nursing Assistants, GNA #16, #31, #34, and #35. A review of GNA #16, #31, and #34 employee files failed to reveal timely completion of annual in-service training courses due every 12 months for 2024 and 2025.On 8/7/2025 at 1:00PM, during an interview with Regional Clinical Nurse #4, the Surveyor requested copies of the GNA's assigned in-service courses for 2024 and 2025. A review of the Student Assignment Completion Report with a due date range of 1/1/2024 through 8/6/2025 revealed that GNA #16, #31, and #34 had incomplete required in-service training for 2024 and 2025.The Surveyor expressed the concern that the GNA's were non-compliant with completing the required in-service training for 2024 and 2025 because the trainings were past due or completed late. The Regional Clinical Nurse informed the Surveyor that the facility was working on completing all 2025 overdue in-service training by 9/30/2025.At the time of exit on 8/7/2025 at 1:30PM, no further documentation was provided to the Surveyor regarding in-service training completion for GNA #16, #31, and #34.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, it was determined that the facility failed to provide a safe environment in residents' rooms. This was evident for 3 out of 26 rooms observed during the survey.The findings include:On 7/30/25 at 8:05 AM, during the initial observation of the 3rd floor, identifiable wall damage was found in rooms [ROOM NUMBER]. There were multiple areas where the baseboard was coming off the walls, and the door protectors were cracked and peeling off the door itself.On 7/31/25 at 7:20 AM, the Director of Nursing (DON) was asked to accompany the surveyor to the 3rd floor to review the identifiable wall damage to the walls and baseboards. The DON saw the areas that needed to be repaired and stated that she would notify maintenance. The DON took pictures of all the areas reviewed with the surveyor and sent them to her team.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews it was determined the facility failed to: 1) develop a comprehensive care plan that addressed the resident's preference for future discharge. This was determined to be true for 1 (Resident #14) out of 34 residents reviewed for discharge planning ; 2) develop and implement a comprehensive care plan that addressed the resident's need for oral hygiene care while on a NPO status. This was evident for 1 (Resident #34) out of 2 residents reviewed for a comprehensive care plan; 3) follow the resident care plan of ensuring that a resident who is dependent on staff for assistance with transfers receives assistance out of bed. This was found to be evident for 1 (Resident # 3) of 46 residents reviewed; 4) develop a person-centered care plan for a resident who had a diagnosis of insomnia. This was evident for 1 (Resident #72) out of 9 residents reviewed during the survey. The findings include: The Minimum Data Set (MDS) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1. On 07/30/2025 at 08:30 AM the surveyor observed Resident #14 in bed. Resident #14 had a trach in place and was non-verbal, however was able to shake her head yes or no to simple questions. A review of the resident's electronic medical record revealed that the resident was capable of communicating via sign language and writing on an erasable white board. On 07/31/25 at 12:19 PM, in an interview with the resident's via phone call, Resident #14's sister stated that she would like to be assisted with placing the resident in an apartment in the community as part of the discharge plan. During the conversation Resident #14's sister stated that the option of discharge to community had not been discussed by the social worker during any care plan meetings. Resident #14's sister stated her desire was to be the resident's primary care giver while living in an apartment with the resident. On 07/31/2025 at 10:00 AM the surveyor reviewed the electronic medical record for Resident #14 and did not find a care plan related to discharge planning. On 08/01/2025 at 09:45 AM the surveyor reviewed the electronic medical record and did not find any documentation of a care plan related to discharge planning. On 08/01/2025 at 10:15 AM the surveyor spoke with the director of nursing (DON) to verify whether there was a discharge care plan in place for Resident #14. The DON stated that there was no discharge care plan currently for Resident #14. On 08/01/2025 at 11:20 AM the surveyor interviewed the Social Services Assistant, #29 and the Director of Social Services, #9 in the conference room regarding Resident #14. The social worker assistant stated that the resident's sister sometimes did participate in the care planning conference calls. Both the Social Services Assistant #29 and the Director of Social Services #9 informed the surveyor that the last care planning meeting was held on June 7, 2025. Both social services employees stated there was not any discussion with Resident #14 or the resident's sister regarding (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge planning during the June care plan meeting nor during month of July or August 2025. Additionally, both social services employees, #9 and # 29 stated there that Resident #14 would need to agree to a transition to the community as part of a discharge plan. The two social services employees acknowledged that there was no discharge planning care plan created for Resident #14 at present. The two social services employees stated that they would follow up with the resident to verify his/her agreement to follow through with exploring the discharge planning option of the waiver program and with the option to live with the resident 's sister in an apartment. The social services workers stated that they would investigate the resident's eligibility for the waiver program in the community. On 08/04/2025 at 07:51 AM The surveyor reviewed Resident #14's the electronic medical record (EMR). The surveyor did not find documentation that the nursing or the social service department had developed a discharge planning care plan for the resident. On 08/04/2025 at 08:15 AM the surveyor discussed the concern regarding the lack of a discharge planning care plan with the DON. On 08/04/2025 at 08:39 AM Resident #14 's lack of a discharge care plan was discussed with the Regional Nurse # 4. 08/04/2025 9:03 AM the Regional Director, Clinical RN #4 informed the surveyor that there was currently no discharge planning care plan for this resident present in the electronic medical record. On 08/04/2025 at 10:30 AM the surveyor reviewed the electronic medical record, and determined that the social services director had entered a note stating that a telephone interview was conducted with Resident #14 and the resident's sister stating that included a discussion occurred on 08/01/2025 regarding the exploration of the community waiver program. Both Resident #14 and the resident's sister expressed interest in finding an apartment in the community that could be shared. According to the social services employee's note, Resident#14's sister stated that she would be prepared in six months to live with the resident. The social services documented that she explained to Resident #14 and the resident's sister that the waiver application process would take a minimum of six months for processing. The deficient practice was discussed the prior to and during the exit conference on 08/07/2025 with the administrator and the DON. 6 are Plan Co[DATE] 2. On 8/01/2025 at 9:40 AM, while speaking with Resident #34, the surveyor noted the resident's breath smelled badly and their mouth was very dry, and their lips were cracked. On 8/04/2025 at 9:26 AM, the surveyor observed Resident #34 alert and smiling, and that Resident #34's lips were dry and cracked. After leaving the resident, the surveyor went to speak with the GNA who works with the resident. GNA #32 was asked if she does oral hygiene care for the residents who are NPO (nothing by mouth). GNA #32 responded that she does oral care when she does her ADLs in the morning with the resident and again in the afternoon before leaving for the day. The surveyor then went to speak with the nurse for the resident. The surveyor asked Staff #33 if they provide oral hygiene care for the resident, and he stated that they do it at least once a shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/04/2025 at 11:45 AM, the record review showed that the resident did not have an order for oral hygiene care. Review of the Treatment Administrative Record (TAR) did not show any order for oral hygiene care. Review of the Care Plan did not have any interventions for Oral hygiene care due to the resident being on NPO status long term. On 8/05/2025 at 11:30 AM, the surveyor spoke with Resident #34's nurse about oral hygiene care documentation. Nurse #25 was asked to show the order and documentation for the oral hygiene care. Nurse #25 was unable to locate the orders or the documentation for oral hygiene being completed. Nurse #25 then stated that she was going to speak with the doctor about adding the order back on. The surveyor asked for a copy of the care plan and orders from the DON, which were received around 1 pm. 3. An interview was conducted with Resident # 3 on 8/1/25 at 11:40AM and the resident was asked if they had any concerns regarding the care that they receive while at the facility. The resident stated that s/he would like to get up out of the bed and into the chair. The resident went on to say, when lying in bed for long periods of time, it causes discomfort. The resident further stated that it has been approximately two weeks since getting up to the chair after experiencing a fall when staff transferred him/her using the lift equipment. During subsequent observations on 8/1/25 at approximately 11:00AM and 8/4/25 at approximately 9:30 AM the resident was observed in bed. Review of the facility's fall investigation on 8/1/25 at 11:00AM revealed the following: On 5/9/25 during transfer of Resident # 3 using a Hoyer lift with two Geriatric Nurse Assistants (GNA's), the resident was trying to get out of the lift pad and the resident was assisted to the floor. Further review of the resident care plan revealed the resident had a fall on 5/9/25 and one of the approaches listed is to ensure the resident is calm before using the Hoyer Lift to transfer resident from chair to bed. An interview was conducted with the DON on 8/4/25 at 9:45AM and she was made aware of the observations of Resident #3 being in bed, and the resident's concerns of wanting to get up to the chair. The DON stated that she would investigate the resident concerns. The DON returned to the survey team on the same date at 11:40 AM and stated that she spoke with the staff and the resident family, and that her staff were instructed by the family not to get the resident up. The DON went on to say that the family has concerns regarding the small statue frame of the staff that uses the lift equipment and have safety concerns. The DON informed the survey team on 8/6/25, that Resident # 3 was transferred out of bed to the chair as per the resident agreement, after the DON watched the staff demonstrate compliance in use of the Hoyer Lift. The DON confirmed that staff are to follow the resident care plan and use the Hoyer lift to transfer the resident out of bed. All concerns were discussed with the Administration team at the exit conference on 8/7/25 at 1:30PM. 4. On 08/7/25 at 8:05 AM, Resident #72's medical record was reviewed. During the medical record (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review, the resident's August Medication Administration Record revealed documentation indicating that Resident #72 received 15 mg of Mirtazapine, by mouth, at bedtime for insomnia and appetite stimulation as well as 3 mg of Melatonin, by mouth, at bedtime for insomnia on August 1, 2, 3, 4, 5, and 6, 2025. On 08/7/25 at 8:28 AM, Resident #72's medical record was reviewed. During the medical record review, the resident's Minimum Data Set, dated [DATE], revealed that the resident has an Active International Classification of Diseases (ICD) diagnosis of G47.00 Insomnia, Unspecified. On 08/07/25 at 8:39 AM, Resident #72's medical record was reviewed. During the medical record review, the surveyor could not locate, in the resident's care plan, where the resident was care planned for insomnia. On 08/07/25 at 8:48 AM, staff Director of Nursing #2 was interviewed. During the interview, the surveyor made Staff #2 aware that Resident #72 had a diagnosis of insomnia; however, the surveyor could not locate in the care plan that the resident was care planned for insomnia. Staff #2 mentioned that he/she would review Resident #72's care plan to determine if the resident was care planned for insomnia. On 08/07/25 at 9:30 AM, Staff #2 was interviewed. During the interview, staff #2 informed the surveyor that Resident #72 was not care planned for insomnia although the resident has a diagnosis of insomnia.

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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 observation, record review, and interview with staff, it was determined that the facility failed to ensure a person-centered care plan was reviewed and revised for a resident. This was evident for 1 (Resident #4) out of 37 resident care plans reviewed during the survey.The findings include:1. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. Restorative Nursing Program is a program that aims to help residents in skilled nursing facilities achieve and maintain their highest possible level of independent function. The program is tailored to each resident's specific needs and abilities. Restorative interventions include range of motion exercises both active (where the resident moves their own limbs) and passive (where the staff moves the resident's limbs).Contracture is a structural change in the body's soft tissues like muscles, tendons, ligaments, or skin that causes them to stiffen and shorten.On 8/1/2025 at 8:11AM, Resident #4 was observed in bed with contractures in both hands. On 8/4/2025 at 10:00AM, a review of Resident #4's current care plan within the electronic medical record failed to reveal a care plan problem, goal, or approach to address the presence of contractures in both hands and interventions to include the use of resident specific equipment to meet the needs of the resident.On 8/6/2025 at 11:20AM, the Surveyor conducted an interview with Restorative Aide/Geriatric Nursing Assistant (GNA) #31. During the interview, the Surveyor was informed that Resident #4 was a part of the Restorative Nursing Program within the facility and GNA #31 was assigned to the resident. GNA #31 was on the way to Resident #4 to provide hand messages and to apply the resident's splints to his/her hands because his/her hands were contracted. On 8/6/2025 at 1:05PM, the Surveyor observed Resident #4 in bed with the head of the bed elevated about 30 degrees. The resident was observed with his/her arms stretched out in front of them with blue hand splints on both hands.On 8/6/2025 at 1:55PM, during an additional review of Resident#4's care plan within the electronic medical record, the Surveyor discover a care plan revision on 8/5/2025 for the use of bilateral resting hand splints for contractures in both hands to be worn daily, 4 hours on and 4 hours off as tolerated; remove during ADL care.On 8/7/2025 at 7:55AM, during an interview with the Director of Nursing (DON), the Surveyor confirmed that Resident #4's care plan should have been reviewed and revised to reflect bilateral hand contractures and the use of resting hand splints at the time these concerns were identified by staff. The Surveyor expressed the concern that the care plan was not revised timely. 2. Contact precautions refers to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment.Multidrug-resistant organisms (MDROs) refer to microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents.On 8/4/2025 at 9:40AM, the Surveyor observed a sign on Resident #4's door indicating the resident was on contact precautions. The sign stated that everyone must: clean their hands before entering and when leaving the room. Providers and staff must also put on gloves before room entry and discard before room exit; put on gown before room entry and discard before room exit; do not wear the same gown and gloves for the care of more than one person; and use dedicated or disposable equipment and clean disinfect reusable equipment before use on another person.On 8/4/2025 at 10:00AM, a review of Resident #4's current care plan within the electronic medical record failed to reveal a care plan problem, goal, or approach to address the resident's current contact precautions status with proper interventions for infection control.On 8/4/2025 at 11:18AM, during an interview with the Infection Preventionist (IP) #3 and the Director of Nursing (DON), the Surveyor was informed that Resident #4 was on contact precautions due to a MDRO. During a review of Resident #4's care plan on 8/5/2025 at 7:50AM, the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor discovered a care plan initiated on 8/4/2025 with a problem which stated that [Resident] is at risk for infection [related to MDRO] as evidenced by [MDRO] rectal screen.An interview was conducted with the DON and IP #3 on 8/5/2025 at 10:30AM. The Surveyor was informed that a rectal swap sample was collected on 6/3/2025 and the results released on 6/6/2025 indicated the presence of MDRO genes. Based on the results, the facility placed the resident on contact precautions. The Surveyor expressed the concern that Resident #4's care plan was not reviewed or revised to reflect the resident's current contact precaution infection control status until 8/4/2025.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and staff interviews, the facility failed to provide oral hygiene care to residents with nothing by mouth (NPO) status. This was evident for 1 (Resident #34) out of 2 residents observed during the survey.On 8/01/2025 at 9:40 AM, while speaking with Resident #34, the surveyor noted the resident's breath smelled badly and their mouth was very dry, and their lips were cracked. On 8/04/2025 at 9:26 AM, the surveyor observed Resident #34 alert and smiling, and that Resident #34's lips were dry and cracked. After leaving the resident, the surveyor went to speak with the GNA who works with the resident. GNA #32 was asked if she does oral hygiene care for the residents who are NPO. GNA #32 responded that she does oral care when she does her ADLs in the morning with the resident and again in the afternoon before leaving for the day. The surveyor then went to speak with the nurse for the resident. The surveyor asked Staff #33 if they provide oral hygiene care for the resident, and he stated that they do it at least once a shift. On 8/04/2025 at 11:45 AM, the record review showed that the resident did not have an order for oral hygiene care. Review of the Treatment Administrative Record (TAR) did not show any order for oral hygiene care. Review of the Care Plan did not have any interventions for Oral hygiene care due to the resident being on NPO status. On 8/05/2025 at 11:30 AM, the surveyor spoke with Resident #34's nurse about oral hygiene care documentation. Nurse #25 was asked to show the order and documentation for the oral hygiene care. Nurse #25 was unable to locate the orders or the documentation for oral hygiene being completed. Nurse #25 then stated that she was going to speak with the doctor about adding the order back on. The surveyor asked for a copy of the care plan and orders from the DON, which were received around 1 pm. On 8/06/2025 at 11:13 AM, the surveyor observed Resident #34 out of bed, dressed, and watching TV. Resident #34 appeared happy to be out of bed and smiled. Resident #34's mouth was visibly moist. no cracks or dryness noted.

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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. Based on observations and interviews with residents, the facility failed to prepare meals that were attractive, flavorful, and appetizing to the residents. This was evident for 2 (Resident #59 and #151) residents out of 5 interviewed for meals during survey. On 7/30/2025 at 11:31 AM, the surveyor spoke with Resident #151 about the food at the facility. Resident #151 stated that the food just isn't that good. I don't eat most of my meals. Resident #151 was unable to provide examples of what they meant. On 8/01/2025 at 1:45 PM, Resident #59 was interviewed about the food at the facility. Resident #59 complained that the food is terrible, with no taste. Resident #59 also stated that they (the facility) need someone better to cook the food. It's either not cooked enough or overcooked. On 8/05/2025 at 12:26 PM, the surveyor visited Resident #151 to find that they were not happy with their lunch. They stated that they always get the same stuff that they don't like. It doesn't look appetizing or taste good. I get the alternative lunch most times. A salad or a PBJ sandwich. The surveyor observed that the resident had not eaten the lunch provided. They had already eaten the salad and some of the broccoli. Resident #151 stated that the broccoli was too hard to eat, especially since they do not have many teeth. On 8/5/2025 1:05 PM, the surveyor revisited Resident #59 about their lunch for the day. Resident #59 complained that today they had country-fried steak that was tough and slightly burnt. The mashed potatoes did not have any gravy on them, and the broccoli was hard and not cooked enough. On 8/05/2025 at 1:13 PM, the surveyor sampled a lunch tray. The tray was a Regular diet: it consisted of a smothered pork chop in gravy, mashed potatoes without gravy, and broccoli. The pork chop was tough, hard to cut, and very chewy. The broccoli was not cooked thoroughly, hard when chewing, and had no taste. Mashed potatoes also had no taste.

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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, record reviews, and interviews it was determined that the facility failed to ensure infection control and prevention policies and procedures were carried out by its employees. This was determined to be true for one (Resident #86) out of six residents reviewed for infection control and prevention during the survey. The findings include: On 07/31/2025 at 1:55 PM, Resident #8 and Resident #86 were observed lying in their beds. The surveyor observed during a tour of the 2nd floor clinical unit that Resident# 86's door was open and that an employee was engaged in conversation with Resident #86. The surveyor observed that there were two isolation signs posted on room door. The posted signs were contact isolation and enhanced barrier precautions. The surveyor observed that Staff #26, physical therapy assistant, was not wearing an isolation gown while speaking to Resident #86 and was observed touching the resident's linens during the conversation. Staff #26 came to the open doorway of the room and asked if she could assist the surveyor before returning to the bedside of the resident. The surveyor introduced herself to staff #26 and advised her that the surveyor was making observations of resident rooms. A review of the electronic medical record revealed that both Resident #8 and #86 were on contact and enhanced barrier precautions. On 07/31/2025 At 2:00 PM the surveyor spoke with the DON regarding the observation of the occupational therapist assistant, staff #26's non-compliance with wearing an isolation gown while in contact with a resident who on contact and/or enhanced barrier precautions. DON #2 stated that she would contact the supervisor of Staff #26 and would provide clinical staff education related to infection control and isolation policies and procedures.This deficient practice was discussed with the DON and the administrator prior to the exit interview on 08/07/2025.