STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215331	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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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 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 observations and interview, it was determined that the facility failed to ensure that the environment was in good repair. This was found to be evident in 6 (Resident rooms #239, #240, #237, #245, #235, & 242) out of 6 Resident rooms observed for the environment during the recertification survey.The findings include: During the initial tour of the [NAME] Wing conducted on 11/17/25 at 8:30 AM several resident rooms had patched up walls, stained ceiling tiles, wall damage, peeling paint, missing bed remote, broken bed remote, broken furniture, broken clock, dirt buildup on floor in front of wardrobe cabinets. During a tour of the [NAME] Wing of the facility conducted on 11/21/25 at 8:45 AM , the Surveyors and Maintenance Director (MD) observed wall damage, peeling paint, and walls patched and not painted in Resident rooms #239, #240, #237, #245, resident room [ROOM NUMBER] had a missing bed remote, resident room [ROOM NUMBER]-1 had the front of the top drawer of the night stand broken off and laying on the floor, resident room [ROOM NUMBER] - 2 bed remote did not work, the clock was not holding time, and there were stained ceiling tiles above the bed, and resident rooms #235 & #242 had a large amount of black substance that appeared to look like dirt in front of the wardrobe cabinets. The MD reported that he was not aware of the broken items. He stated that staff are to put in maintenance repair requests in a system called records where he would be notified of the broke equipment however he had not received repair requests for the broken items.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined the facility failed to ensure medications were properly stored and wasted. This was evident for 3 of 4 medication carts and 1 of 1 medication storage rooms observed during the recertification survey.The findings include:Some medications should be stored in the refrigerator until opened because cold temperatures help maintain the stability and effectiveness of their active ingredients. Improper storage can cause these medications to degrade and become less potent, which may make them ineffective. 1)On [DATE] 8:37 AM, an observation of Licensed Practical Nurse (LPN) #2 medication cart revealed 1 bottle of stored unopened eye drops for Resident #99 in a pharmacy bag labeled refrigerate until opened. 2 new unused insulin pens for Resident #71 and Resident #35 were observed being stored on the medication cart in pharmacy bags labeled refrigerate until opened. On [DATE] at 8:50 AM, interview with LPN #2 confirmed that the medications observed on the cart were unopened and were labeled with refrigerate until open on the packaging from the pharmacy. LPN#2 contacted the Director of Nursing (DON) to remove the medication from the cart. 2) On [DATE] 8: 55 AM, an observation of LPN #3 medication cart revealed 3 new unused insulin pens for Resident #76, Resident #17, and Resident #4 were observed being stored on the medication cart in pharmacy bags labeled refrigerate until opened. On [DATE] at 9:30 AM, interview with LPN #3 confirmed that the 3 insulin pens observed on the cart were unused and were labeled with refrigerate until open on the packaging. LPN #3 contacted the DON to remove the medication from the cart. 3) On [DATE] 9:45 AM, an observation of LPN #1 medication cart revealed 3 new unused insulin pens for Resident #123, Resident #74, and Resident #124 were observed being stored on the medication cart in pharmacy bags labeled refrigerate until opened. An unopened vial of Respiratory Synclinal Virus Vaccine was observed on the cart labeled for Resident #124 with instructions to refrigerate until administered. 3 vials of unopened Retacrit for Resident #123 were observed being stored on the medication cart in a pharmacy bottle labeled refrigerate until administered. 2 medication bottles brought in from home, lisinopril 40mg and metoprolol 25mg, were observed being stored on the medication cart. On [DATE] at 9:52 AM, interview with LPN #1 confirmed that the medications observed on the medication cart were unused and were labeled with refrigerate until open on the packaging. LPN #1 also confirmed that resident medications from home should not be stored on the cart and stated they should be locked up in the medication storage room until the family can pick up the medications from the facility and take them home. 4) On [DATE] 9:57 AM, an observation of the medication storage room and medication room refrigerator revealed 2 expired insulin pens observed being stored in the medication refrigerator for Resident #74 expired on [DATE] and Resident #128 expired on [DATE]. 2 vials of Prevnar pneumonia vaccine were observed being stored in the medication refrigerator for Resident #22 expired on [DATE] and Resident # 127 expired on [DATE]. On[DATE] at 10:05 AM, an interview with the Director of Nursing (DON) confirmed the medication stored in the refrigerator had expired and the DON immediately removed the insulin pens and vaccine vials from the medication storage refrigerator. At this time the DON was also made aware of the improperly stored medications observed on the 3 medication carts. On [DATE] at 1:00 PM, a record review was completed and it revealed Resident #126 was discharged on [DATE]; Resident #127 was discharged on [DATE]; and Resident #128 was discharged on [DATE]. On [DATE] at 12:30 PM, The Director of Nursing (DON) was informed of the findings and no evidence was provided to refute the finding prior to exit.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on medical record review and interviews with the resident and staff, the facility was found to have failed in ensuring the resident's right to participate in planning care. This was evident for 1 (Resident #5) of 1 resident reviewed for care plan during the annual survey.The findings include:On 11/18/25 at 1:07 PM Resident #5 reported that he/she did not receive an invitation to his/her care plan meeting. Instead, staff came to him/her room on the day of the meeting to inform her. He/she reported that the Social Worker stated the invitation had been sent to a family member who is not his/her responsible party, and that the family member received it the day after the meeting. The resident stated, I told them I am alert and oriented; why didn't you come and tell me? I'm the patient. He/she further stated, I was not happy about that, and I told the Social Worker.Review of Resident #5's medical record on 11/19/25 at 11:20 AM revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. Further review of the record revealed that the resident is his/her own responsible party for making medical decisions. On 11/19/25 at 12:07 PM an interview was conducted with the Social Services Coordinator (SSC) regarding care plan invitations. The SSC stated that invitations are sent via mail to the resident and/or the Responsible Party (RP) if the resident is capable. To verify receipt, a follow-up call is placed to the resident or family one week prior to the care plan meeting. However, for Resident #5, the invitation was sent on 10/16/25 to his/her family member, who is not the RP.On 11/19/25 at 12:20 PM the Social Services Coordinator (SSC) and the Regional Social Worker confirmed that the facility's expectation is to notify the resident of care-plan meetings unless the residents lack the capacity to make their own decisions. The SSC stated that the resident was unhappy about not being notified and apologized to him/her. The Regional Social Worker noted that notifying a family member who is not the responsible party is not the facility's practice. They further confirmed that Resident #5 is his/her own responsible party and that the invitation should have been sent to the resident, not to a family member who is not the Responsible Party.On 11/19/25 at 12:37 PM the surveyor informed the Regional Social Worker and the Social Services Coordinator of the above concern, and both acknowledged receipt.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews, observations, and record reviews, it was determined that the Facility failed to ensure a resident's choices were honored. This was evident for 1 (Resident #61) of 3 residents reviewed for choices during the recertification survey.The findings include: On 11/17/2025 at 11:05 AM, during an interview with Resident #61, the Resident stated can't get up, can't do anything, no GNA,I would like to get up and can't get up every day, I have not been out of bed in 2 weeks. The resident reported that when he/she requested to get out of bed, a staff member advised the facility had low staff and there was not anyone to assist the resident in getting out of bed. The Resident further reported he/she was dependent on staff to transfer him/her out of the bed and into a chair using a hoyer lift. ADL care means Activities of Daily Living care, which refers to the support provided for basic self-care tasks. This can include assistance with activities like bathing, dressing, eating, toileting, and moving around. The level of ADL care needed is determined by a person's ability to perform these fundamental tasks independently.During multiple observations conducted on 11/18/2025 at 3:00 PM and 11/19/2025 at 9:20 AM, Resident #61 was observed in bed, in a gown, and had not received ADL care. On 11/19/2025 at 10:00 AM, review of the Resident #61's 30-day ADL care look back period for showers revealed that the resident received 2 showers in 30 days: 10/21/25 and 10/28/25. On 11/19/2025 at 10:55 AM, an interview with the Assistant Director of Nursing (ADON) confirmed that if a resident missed their shower yesterday (11/18/25) due to the hot water being temporarily turned off, a makeup shower would be offered to the resident today (11/19/25). The ADON stated that if a resident refused a shower, it would be documented in the electronic record and on the shower sheet. She also went on to state it is the facility's process to have the Geriatric Nursing Assistant (GNA) report the refusal of a shower to the nurse and if it is a regular occurrence the resident would then be care planned for bed baths only. On 11/19/2025 at 11:51 AM, a review of the shower binder, kept at the nurse's station, showed only 1 shower sheet for Resident #61 for 10/07/2025 for the last 30-days. It was not documented on the sheet if a shower was completed. On 11/19/2025 at 11:53 AM, review of resident #61's care plan revealed the resident is not care planned for just bed baths or to only get out of bed on certain days. On 11/19/2025 at 1:50 PM, interview with the Licensed Practical Nurse (LPN) #2 confirmed that residents have routines that they follow. If a resident does not want to get up every day, then they have specific orders for the resident. LPN #2 explained that the facility policy is to get all bed bound residents out of bed daily unless the Resident requested to only get out of bed on certain days. Getting the residents out of bed is part of their daily routine. When LPN #2 was questioned about Resident #61, LPN #2 stated that Resident #61 does not refuse showers or care and that they are up out of bed every day. LPN #2 further stated that on Monday 11/17/25 residents were not able to get out of bed due to low staffing. During an interview conducted on 11/19/25 at 1:59 PM, the Assistant Director of Nursing (ADON) stated that it is the facility's expectation to get all residents out of bed as part of their daily routine of care. She also stated that an order was not required to get the resident out of bed however sometimes there is an order if the resident requested to get out of bed on certain days. During the continued interview, the Director of Nursing (DON) stated that if a bedbound resident refused to get out of bed the staff are expected to turn and reposition. On 11/20/2025 at 02:00 PM, Resident #61 was observed to be in their bed in a gown. On 11/21/2025 at 10:00 AM, an interview with Resident #61 confirmed they did not receive their shower on Tuesday or Wednesday. The resident stated that he/she was supposed to get a shower today and would like to receive a shower today and get out of bed. On 11/21/2026 at 10:15 AM, review of Resident #61 record for showers showed that over the last 90 days Resident #61 only received 11 showers of the 28 showers that they were scheduled to receive. There was one documented refusal in the chart for the 90-day period. 11/21/2025 at 10:20 AM, an interview with GNA # 11 confirmed she did not shower Resident #61 on 11/18/2025 or 11/19/2025. GNA #11 then stated (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would not be showering Resident #61 today on his/her scheduled shower day. She stated she does not have enough time to shower everyone and stated a good bed bath gets the resident just as clean. 11/25/2025 at 12:30 PM, The Director of Nursing (DON) was informed of the findings and no evidence was provided to refute the finding prior to exit.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record reviews and facility staff interviews, it was determined that the facility failed to ensure a resident received a beneficiary notification. This was found to be evident for 1 (Resident #16) of 3 residents reviewed for Beneficiary Notifications during the recertification survey.The findings include: The Advance Beneficiary Notice (ABN) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The Notice of Medicare Non-Coverage (NOMNC) informs the beneficiary of his or her right to file an appeal of the decision for non-covered services and their right to an expedited review of Medicare non-coverage of services. On 11/25/2025 at 08:30 AM, record review of resident # 16, confirmed that the facility had stopped billing for Medicare part A on 05/27/2025. On 11/25/2025 at 9:30 AM, information and copies for the Advanced beneficiary notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) forms were requested for Resident #16 from the facility's business Office. The Assistant Business Office Manager was unable to locate the two requested forms for Resident #16. On 11/25/2025 at 10:20 AM, the requested record for Resident #16 were reviewed using the Skilled Nursing Facility Beneficiary Protection Notification Review form (FORM CMS-20052) and found to be missing the ABN and NOMNC forms. Resident #16 was noted to not have exhausted all the Medicare Part A Services benefit Days. On 11/25/2025 at 11:15 AM, interview with Social Services Director confirmed that a NOMNC and ABN should have been issued to resident #16 when they transferred to the skilled nursing unit. The Social Services Director also confirmed that the facility does not have record of either form for Resident # 16.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. cite Based on record reviews and staff interviews, it was determined that the facility failed to ensure adequate monitoring for residents receiving antipsychotic medications. This was evident for 3 (Residents #14, #5 #1) out of 3 residents reviewed for Unnecessary Medications during the annual survey.The findings include:1) During the medical record review on 11/20/2025 at 6:44 AM for Resident #14, it was noted that the resident had a physician's order for busPIRone HCl 5 mg oral tablet, to give 1 tablet by mouth once daily for anxiety.2) On 11/20/25 at 10:30 AM review of Resident #5's medical record revealed a physician's order for bupropion HCl ER (XL) 300 mg oral tablet, to be administered by mouth once daily for depression.3) On 11/20/25 at 10:40 AM review of Resident #1's medical record revealed a physician's order for ARIPiprazole Oral Tablet 10 MG (Aripiprazole) Give 1 tablet via PEG-Tube one time a day for BIPOLAR DISORDER. 2) TraZODone HCl Tablet 100 MG Give 1 tablet via PEG-Tube at bedtime for DEPRESSION.Further review of the medical records on 11/20/25 at 11:00 AM for Residents #14 and #5, #1 revealed that there were no orders in place for behavior monitoring, side effect monitoring, or non-pharmacological interventions for either residents.During an interview on 11/21/25 at 9:24 AM, the Assistant Director of Nursing (ADON) stated that psychiatric and attending physicians review residents' medications and make changes as needed; families are informed; and residents are monitored through non-pharmacological interventions, behavior monitoring, side-effect monitoring documented on flow sheets, completion of AIMS assessments, and verification of medication indications by the physician On 11/21/25 at 9:34 AM the surveyor requested that ADON provide documentation of behavior monitoring, side effect monitoring, and non-pharmacological intervention assessments for Residents #14, #5, and #1.On 11/21/25 at 11:46 AM the Assistant Director of Nursing (ADON) reported that behavior monitoring, non-pharmacological interventions, and side-effect monitoring had not been initiated for Residents #14, #5, and #1, and stated that she would follow up.On 11/21/25 at 12:05 PM the surveyor notified DON and ADON of the above concerns, and both acknowledged receipt.On 11/22/25 at 4:00 PM record review revealed that orders for non-pharmacological interventions, behavior monitoring, and side effect monitoring had been added to the medical records of Residents #14, #5 and #1 after the surveyor's intervention.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that the facility failed to thoroughly investigate an allegation of abuse. This deficient practice was identified for 1 out of 1 facility-reported incidents reviewed during the annual survey.The findings include:On 11/19/2025 at 2:59 PM, this surveyor reviewed the facility-reported incident investigation regarding an allegation of sexual abuse involving Resident #101 and housekeeping staff member #19. The resident reported that the staff member had touched him/her inappropriately. Review of the file showed that during the investigation only residents on the Arcadia Unit were interviewed, and only female residents were included. There was no documentation that male residents or residents on other units were interviewed or observed for potential signs of abuse.On 11/20/2025 at 10:25 AM, this surveyor interviewed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding the scope of the investigation. During the interview, it was confirmed that the Licensed Practical Nurse (LPN) #17 who conducted the investigation interviewed only female residents. The DON explained this was done because the alleged employee was located on the female side of the unit at the time of the alleged incident.It was discussed with the DON and ADON that this approach was insufficient because the employee had clocked in earlier that morning (at 8:23am) and could have had access to male residents prior to the alleged incident time (approximately 9:30am). Additionally, it was discussed that the employee was not permanently assigned to the Arcadia Unit and worked on other floors, giving access to other residents throughout the facility.Since the investigation did not include interviews or observations of male residents or residents on other units, the facility did not ensure that all potentially affected residents were assessed for signs or symptoms of abuse and therefore did not conduct a thorough investigation. The DON and ADON acknowledged that male residents were also at risk for sexual abuse and recognized the concern raised by this surveyor.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review, staff interviews, and review of the facility's discharge practices, it was determined that the facility failed to: 1) provide the resident and/or resident representative with written notification of the bed-hold policy, and 2) notify the Ombudsman of the resident's transfer. This was evident for 1 (Resident #120) of 2 residents reviewed for hospitalization during the annual survey.The findings include:Review of the medical record for Resident #120 on 11/24/25 at 9:57 AM revealed that on 9/24/25, the resident was transferred from a nephrology appointment to the emergency room (ER) due to a change in condition. On 11/24/25 at 10:15 AM further review of the medical record revealed that on 9/24/25 at 11:59 PM, the nurse's notes documented that a call was placed to the hospital and confirmation was received that Resident #120 had been admitted with fluid overload related to congestive heart failure (CHF). No documentation was found in either the paper or electronic record to indicate that the resident or resident representative had been provided with written notice of the bed-hold policy. On 11/25/25 at 6:33 AM during an interview with the Director of Nursing (DON), she stated that she was unsure whether a bed-hold notice had been provided to the resident and that she would look for a copy. She also indicated that the notice may be kept in a location outside of the medical record. On 11/25/25 at 6:46 AM an interview was conducted with the DON regarding the process for Ombudsman notification. The DON stated, I am not sure; I will get back with you. On 11/25/25 at 8:46 AM the DON and Assistant Director of Nursing (ADON) reported that the facility failed to provide the resident and/or resident representative (RP) with the bed-hold policy notice after confirming that Resident #120 had been admitted to the hospital. On 11/25/25 at 10:12 AM the DON and ADON reported to the surveyor that there was no documentation verifying that the Ombudsman was notified. Both confirmed that the facility failed to notify the Ombudsman of the resident's transfer to the hospital. On 11/25/25 at 10:15 AM the surveyor informed both the DON and ADON of the above concerns, and both acknowledged receipt.

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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 reviews and staff interviews, it was determined that facility staff failed to ensure the accuracy of Minimum Data Set (MDS) assessments. This was evident for 1 of 3 residents reviewed for unnecessary medications (Resident #14) during the annual survey. 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. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. An active diagnosis documented on the MDS assessment are attending provider-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. A record review was completed for Resident #14 on 11/20/25 at 6:44 AM for an Unnecessary Medications Review. The review noted that Resident #14 was admitted to the facility on [DATE]. His/her diagnoses included anxiety, as documented in the attending provider's note dated 10/24/2025 at 2:46 PM.On 11/20/25 at 7:00 AM, further review of Resident #14's Medication Administration Record (MAR) for the period of 11/1/2025-11/20/2025 revealed that the resident had an order for buspirone HCl 5 mg, to be given orally once daily for anxiety.Further review of the records on 11/20/25 at 7:15 AM revealed that the MDS assessment completed on 10/27/2025 did not include the diagnosis of anxiety in Section I - Active Diagnoses.On 11/21/25 at 12:58 PM, an interview was conducted with the MDS Coordinator, who stated that the process for diagnosis coding on the MDS assessment requires that a diagnosis be active and documented by the physician within the past 60 days. When asked how diagnoses are coded when a resident is admitted on a medication associated with a particular condition, she stated that the diagnosis is added to the admission assessment.During an interview on 11/21/25 at 1:15 PM, the surveyor requested that the MDS Coordinator verify whether the resident's diagnosis of anxiety was coded on the admission or Modification MDS assessment. She confirmed that the resident is prescribed buspirone for anxiety; however, the diagnosis of anxiety was not coded on either the admission or Modification assessment. She further stated, The diagnosis was not coded, and it was missed on both assessments.On 11/21/25 at 1:20 PM the surveyor informed the MDS Coordinator of the above concern, and she acknowledged receipt.On 11/24/25 at 12:14 PM review of the medical record revealed that the MDS assessment was modified on 11/21/25 following the surveyor's intervention.

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Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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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 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 interviews and record reviews, it was determined that the facility failed to ensure that residents requiring assistance with Activities of Daily Living (ADLs) received scheduled showers. This was evident for 1 (Resident #6) out of 1 resident reviewed for ADLs during the annual survey. The findings include: On 11/17/25 at 2:33 PM an interview with the resident's Responsible Party (RP) revealed that the resident has been in the facility since 8/4/25 and has not received a shower, only bed baths. The RP also stated that he is aware the facility has a chair that could be used to transport the resident to the shower room.Record review on 11/18/25 at 1:17 PM showed that Resident #6 had been in the facility since August 4, 2025. The Plan of Care indicated that the resident was to receive showers on Mondays and Thursdays, totaling eight showers per month, with staff assistance required. On 11/18/25 at 1:30 PM a review of GNA shower documentation for Resident #6 from 11/1/25 to 11/19/25 revealed that no showers were provided on 11/3, 11/6, and 11/13. On 11/17, the resident was marked as not available, but the medical records did not indicate the reason or whether the resident was out of the facility. On 11/19/25 at 10:00 AM an interview with the 1st Floor Unit Manager (UM) revealed that residents are scheduled for showers twice weekly and as needed, with GNAs documenting each shower in the shower book. When a resident refuses a shower, the GNA notifies the nurse, who determines the reason for the refusal, notifies the family, and ensures all actions are properly documented.On 11/19/25 at 11:11 AM an interview with GNA #18 revealed that when a resident refuses a shower, the charge nurse is notified. If the resident continues to refuse, a bed bath is offered. Refusals and interventions are documented in the Plan of Care (POC) and on the skin sheet.On 11/21/25 at 9:41 AM the ADON stated that residents are scheduled for showers twice weekly and as needed. If a resident refuses, the GNA notifies the nurse, who encourages the resident or notifies the family if the resident cannot respond. Refusals are documented, and bedbound residents receive showers using a shower bed.On 11/21/2025 at 11:34 AM, the DON and ADON confirmed that there was no documentation explaining why Resident #6 did not receive showers on the identified dates. They stated that the facility's expectation is for GNAs and charge nurses to report and document accordingly. The surveyor informed the DON and ADON of this concern, and both acknowledged receipt.

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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 interviews, observations, and record reviews, it was determined that the facility failed to offer comprehensive activities in accordance with resident interests, physical, mental, and psychosocial well-being. This was evident for 3 (Resident #61, Resident #9, Resident # 10) of 24 residents reviewed for activities. The findings include: 1) On 11/17/2025 at 11:08 AM, resident #61 stated there are no activities for blind people, only bingo. Resident # 61 reports facility staff have never offered or brought activities in their room. Resident #61 was observed lying in bed with the TV on with no activity supplies in their room. On 11/20/2025 1:20 PM, review of resident #61 activity care plan, attends some activities daily and also pursue independent activities and watching television in his/her room. with the interventions Assist in planning/Encourage to plan own leisure-time activities; Encourage participation in group activities of interest; Provide assistant to accommodate participation in activities of choice; Provide daily Activity Flyer; Provide supplies/materials for leisure activities as needed/requested; Respect choice in regard to limited/no activity participation. On 11/20/2025 at 1:25PM a review of Resident #61 activity records for a 30-day look back period for activities was documented every day as watching TV in their room as the daily activity. On 11/20/2025 2:40 PM, an interview with the Director of Recreation was conducted. She reported that if a resident is unable to get out of their bed, they have an activities cart they go around with from room to room with different activities and supplies. On 11/21/2025 10:00 AM, an interview with Recreation Assistant #5 revealed that they have been understaffed for about a year and would like to do more 1:1 with residents, however they do not have the time. She reported the department just hired another person to assist and going forward more activities would be offered to residents including 1:1 activities. When asked about resident #61 and what activities are offered for blind residents, she stated she did not know what to offer the residents other than music or talking with them. When asked if she documents her interactions, she stated she has a form where she documents if she does a 1:1 where more than just talking with the resident occurs. She reports she does not document the encounter as an activity if she just sits and talks with the resident. 11/21/2025 10:35 AM, interview with the Director of Recreation confirmed that resident #61 were not found to have any documented 1:1 interactions for the last 90 days. When asked what the recreation department offered for resident #61 or residents who are visually impaired, she stated the resident will participate in group activities if nursing staff would get him up. She stated the recreation department has been short staffed for the last year and have recently hired more help. The Recreation Director stated that going forward more activities would be offered to residents including 1:1 activities. Director of Recreation confirmed they do not offer 1:1 activities to Resident #61 or provide activity supplies. 2) On 11/17/2025 at 12:11 PM, an interview with Resident #9 reveals their daughter brings in coloring books and activity books for the resident to do. When asked if the recreational department provides activity supplies for the resident, they stated no. Resident #9 was observed to be lying in bed coloring in a sketch pad with colored pencils. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/ 20/2025 at 1:20 PM, a review Resident #9 activity care plan, while in the facility, resident stated that it is important that he/she has the opportunity to engage in daily routines that are meaningful relative to their preferences and the resident prefers or requires 1:1 activities due to being unable or unwilling to participate in other activities with the interventions provide 1:1 activities in the room or location that is the residents preference as needed. On 11/20/2025 at 1:25 PM, a review of Resident #9 activity records for a 30-day look back period for activities was documented every day as watching TV in their room as the daily activity. On 11/21/2025 10:00 AM, an interview with Recreational Assistant #5 reports that the department has been understaffed for about a year. She stated she would like to do more 1:1 with residents, however they do not have the time. She reported the department just hired another person to assist. When asked about resident #9 and if the recreation department offered coloring or drawing supplies to the resident, the recreation assistant #5 confirmed they have not offered the resident supplies for drawing. When asked if she documents her 1:1 interactions, she stated she has a form where she documents if she does a 1:1 when more than just talking with the resident occurs. On 11/21/2025 10:35 AM, interview with Recreational Director confirmed that Resident # 9 were not found to have any documented 1:1 interactions for the last 90 days. She also confirmed they have not offered activity supplies for resident #9 to use to draw. On 11/25/2025 at 12:30 PM, the findings were presented to the Director of Nursing and the Administrator. The Administrator stated the Recreation department is fully staffed and provided a print out of the facility staffing. No further evidence was provided before the exit conference. 3) During an observation conducted on 11/18/25 at 10:07 AM, Licensed Practical Nurse (LPN) #4 and the Surveyor observed Resident #10 in bed and receiving an enteral feeding. The LPN #4 reported that the Resident was bed bound and non-verbal. During an interview conducted on 11/21/2025 at 10:00 AM, Activities Assistant #5 revealed that they have been understaffed for about a year. She stated she would like to do more 1 on 1 activities however she did not have the time. When asked what activities were offered to bedbound residents, she stated she tried to find out what the Resident liked either from the resident or family. When asked what activities had been offered for resident #10, the Activities Assistant stated she did not recognize the Resident's name. When asked if 1 on 1 activities were documented she stated she has a form where she documented the 1 on 1 activity and that the Recreational Director holds the completed forms. During an interview conducted on 11/21/2025 at 10:35 AM, the Recreational Director stated the recreation department had been short staffed for the last year and have recently hired more help. When asked about resident #10 and what was offered for bed bound residents who were cognitively impaired, the Recreational Director stated she did not recognize the name and had to search for the resident's picture in the medical record. She stated they will play music or put lotion on their hands. The Recreational Director confirmed that resident #10 was not documented to have any 1 on 1 activities with the Recreation Assistant.

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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 interview and observation, it was determined that the facility failed to provide quality of care to residents. This was evident for 1 (Resident #56) out of 1 resident reviewed during the annual survey.The findings include:On 11/17/2025 at 2:19 PM, this surveyor conducted an interview with Resident #56. The Resident reported he/she had pressed the call bell at approximately 11:30 AM because he/she needed assistance with being changed and cleaned. The Resident reported he/she had not yet received assistance. Resident #56 pressed the call bell again while this surveyor was present in the room.On 11/17/2025 at 2:33 PM, this surveyor was in the hallway and observed that Resident #56's call bell light remained illuminated outside the room and was visible on the nurse's station display.On 11/17/2025 at 2:34 PM, this surveyor observed Certified Nursing Assistant (CNA) #6 walking down the hallway and noted that Resident #56's call bell light was now turned off. CNA #6 then proceeded onto the elevator. Before the elevator doors closed, this surveyor asked CNA #6 if she had checked on Resident #56 prior to entering the elevator. CNA #6 confirmed that she had, but stated that she was now going on break. This surveyor asked whether she had informed another staff member that the Resident still required assistance before going on break. CNA #6 responded, hold on, exited the elevator, and notified two staff members seated at the nurse's station that she was going on break and requested that they assist Resident #56.On 11/17/2025 at 2:36 PM, two healthcare staff were observed entering Resident #56's room and closing the door.On 11/25/2025 at approximately 12:30 PM, this surveyor informed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) of the concern. It was explained that CNA #6 had acknowledged answering Resident #56's call bell but was preparing to go on break without notifying another staff member that the Resident still required assistance. This surveyor also explained that the Resident had reported waiting since approximately 11:30 AM that morning to be changed and cleaned up. The DON and ADON confirmed understanding of the concern.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to implement measures to prevent pressure ulcers. This was evident for 1 (Resident #6) of 1 resident reviewed for pressure ulcers during the annual survey. The findings include: An in-house acquired pressure ulcer is a pressure injury (also called a bedsore or decubitus ulcer) that develops or worsens while a resident is receiving care in a healthcare facility, such as a hospital, nursing home, or long-term care facility. These ulcers were not present on admission but occur due to factors such as immobility, pressure, friction, shear, or inadequate preventive care during the resident's stay.On 11/17/25 at 2:57 PM Resident #6's Responsible Party reported that the resident had no pressure ulcers upon admission to the facility but has since developed a pressure ulcer in the sacral area.During unit rounds on the first floor on 11/18/25 at 9:50 AM Resident #6 was observed lying on his/her back at 10:00 AM and remained on his/her back at 12:00 PM. On 11/19/25, the resident was lying on his/her left side at 8:00 AM and 10:00 AM, calling for help. The surveyor made the first-floor unit manager aware of these observations.On 11/21/25 at 12:00 PM review of Resident #6's medical record revealed that the resident was admitted from the hospital to the facility on 8/4/25. The admission assessment, including a skin assessment completed on 8/4/25, indicated that the resident's skin was intact with no issues. The Braden Scale, completed on 8/4/25, scored 11, indicating the resident was at high risk for developing pressure ulcers. On 11/21/25 at 12:10 PM review of Resident #6's medical record revealed that the resident was totally dependent on staff for transfers, bed mobility, and personal care, and was incontinent of both bladder and bowel, requiring full assistance with all activities of daily living (ADLs). Further review of Resident #6's medical record on 11/21/25 at 12:30 PM revealed that an At Risk assessment was completed on 8/18/25 for excoriation to the left buttock. The resident subsequently developed an in-house acquired Stage II pressure ulcer, measuring 2.5 cm x 1.5 cm x 0.1 cm, on 8/21/25.On 11/21/25 at 2:40 PM review of Resident #6's medical record revealed that on 10/2/2025, the resident's sacrum wound worsened to a Stage III pressure ulcer, measuring 4 cm x 11 cm x 0.2 cm.On 11/22/25 at 7:00 AM review of Resident #6's weekly skin observation sheets revealed ongoing documentation of a Stage III sacral pressure ulcer with the following measurements:On 10/9/25, the ulcer measured 3 cm x 4.5 cm x 0.3 cm.On 10/16/25, the ulcer measured 4.0 cm x 4.0 cm x 0.3 cm.On 10/23/25, the ulcer measured 2.0 cm x 4.0 cm x 0.3 cm.On 10/30/25, the ulcer measured 2.0 cm x 3.5 cm x 0.3 cm.On 11/6/25, the ulcer measured 0.5 cm x 0.5 cm x 0.0 cm.On 11/13/25 the ulcer measured 5.5 cm x 6.5 cm x 0.4 cm, indicating a significant increase in size compared to the prior week. On 11/24/25 at 7:30 AM review of the physician's wound notes for Resident #6 revealed the following: 8/8/25: Resident evaluated as a new admission for a comprehensive wound assessment. Skin was dry and intact with no wounds present. 8/21/2025: Resident evaluated for a new Stage II sacral pressure injury measuring 2.5 cm x 1.5 cm x 0.1 cm with 100% granulation tissue. Subsequent note indicated the wound was improving, measuring 0.5 cm x 0.3 cm x 0.1 cm with 100% granulation.10/2/25: Wound worsened to Stage III, measuring 4 cm x 11 cm x 0.2 cm, with a wound base of 70% granulation and 30% slough.10/9/25: Wound documented as improving without complications; however, wound base showed 0% granulation and 100% slough, measuring 3 cm x 4.5 cm x 0.3 cm.On 11/24/25 at 7:53 AM the surveyor reviewed Resident #6's skin assessment observation sheet with the DON and ADON, and both acknowledged that the resident's wound had worsened.On 11/24/25 at 8:36 AM the surveyor informed both the DON and ADON of the above concerns, and they acknowledged receipt.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. cited:Based on interview and record review, it was determined that the facility failed to provide sufficient pain management. This was found to be evident for 1 (Resident #75) out of 1 resident reviewed for pain management during the annual survey. The findings include:The 0-10 pain scale is a standardized numeric rating tool used to assess a resident's level of pain. Residents are asked to rate their pain on a scale from 0 to 10, where 0 indicates no pain and 10 represents the worst pain imaginable. This scale helps staff measure the resident's subjective pain experience, monitor changes over time, and evaluate the effectiveness of pain interventions. PRN pain medication refers to analgesic medication that is ordered to be administered as needed based on the resident's reported pain level or clinical presentation. PRN pain medications must be given in accordance with the prescriber's parameters-such as pain score, frequency limits, and specific indications-and require staff to assess, document, and monitor the resident's response to ensure effective and safe pain management.On 11/18/2025 at 11:21 AM, this surveyor interviewed Resident #75, who reported having recently fallen out of bed. The resident stated he/she had pain in the left shoulder, where he/she landed on the floor during the fall. At that time, the resident was observed wincing when attempting to move the shoulder.On 11/25/2025 at 10:06 AM, record review of Resident #75's progress notes showed the fall occurred on 11/16/2025 at 5:00 PM. A progress note dated 11/17/2025 by Licensed Practical Nurse (LPN) #20 documented that the resident verbalized shoulder pain, rated 3/10, was able to move and elevate BL arms with assistance.On 11/25/2025 at 10:55 AM, record review of Resident #75's Medication Administration Record (MAR) for November 2025 showed the MAR included a 0-10 pain scale section. For 11/17/2025, LPN #20 documented a pain level of 0 out of 10. The MAR also showed the Resident did not have any PRN pain medication ordered.On 11/25/2025 at 11:35 AM, an interview was conducted with LPN #12. When asked what the expectation is when a resident reports pain but has no PRN pain medication ordered, LPN #12 stated that staff are expected to obtain an order from the physician. LPN #12 reported that pain assessments may be documented in the MAR and in progress notes.On 11/25/2025 at 11:49 AM, this surveyor interviewed the Director of Nursing (DON). When asked her expectation for a resident who experiences a fall and reports pain, the DON stated that staff are expected to assess pain using a 0-10 scale, notify the physician if no pain medication is ordered, and ensure pain medication is prescribed. The DON was informed of the concern that LPN #20 documented the resident's pain as 3/10 in the progress note on 11/17/2025, yet no pain medication was obtained for the resident at that time. The DON reported understanding the concern.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation of medication administration, review of medical records, and interviews with facility staff, it was determined that the facility failed to ensure a medication error rate of less than 5%. This was evident for 2 medication administration errors out of 25 medication administration opportunities observed which resulted in a medication error rate of 8% during the recertification survey . The findings include: During a medication administration observation conducted on 11/18/25 at 8:10 AM, Licensed Practical Nurse (LPN) #3 prepared and administered Resident #29's morning medications. The LPN administered the following medications: Breo; cholecalciferol 1000 units; losartan potassium 100 MG ; mirabegron 25 MG; acetaminophen 500 MG ; aspirin 81 MG; gabapentin 200 MG ;ipratropium bromide and albuterol sulfate 0.5mg/1mg On 11/18/2025 at 12:18 PM, a review of Resident #29 Medication Administration Record (MAR) revealed that 2 of the 8 medications were given at an incorrect time interval. Gabapentin and acetaminophen were ordered to be administered at 10:00 AM and were administered at 8:10 AM with the resident's 8:00 AM medications. The 2 medications were administered an hour and fifty minutes before they were scheduled to be administered. On 11/19/2025 at 8:30 AM, an interview with the Director of Nursing (DON) revealed that the facility's procedure for medication administration is to follow the 5 rights of medication administration and to administer medication within the hour before and hour after medication is scheduled. This surveyor discussed the observed medication error with the 10:00 AM medications being administered at 8:10 AM. The DON stated she will conduct an in-service with LPNs with medication administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation and interview, it was determined that the facility failed to (1) store food under sanitary conditions and (2) ensure food items in the nourishment refrigerators were properly labeled and dated. This was found evident during the kitchen review conducted as part of the annual survey and has the potential to affect most residents.The findings include:(1)On 11/17/2025 at 8:21 AM, this surveyor observed the kitchen freezer. There were two fans, the right freezer fan was not operating, and icicle formation was noted beneath the fan. Icicles had formed to the point of dripping onto an open box of packaged ice creams. An opened package of frozen breaded [NAME] was stored with loose pieces of fish outside of the box and exposed. Another box of frozen fish also contained loose, exposed pieces. Photographs were taken of these observations.On 11/17/2025 at 8:32 AM, this surveyor conducted a concurrent interview and observation with Head [NAME] #13. When asked about the fan, Head [NAME] #13 reported that the fan had malfunctioned and stopped working on Saturday, 11/15/2025. This surveyor showed Head [NAME] #13 the icicles formed under the fan and the icicles that had dripped into the open box of ice creams, and explained that this presented a food safety concern. This surveyor also pointed out the opened and exposed frozen beer-battered [NAME] and unbreaded fish with uncovered packaging and exposed fish pieces, and explained that this was not sanitary. Head [NAME] #13 verbalized understanding of the concerns and removed the boxes of frozen fish at that time.On 11/17/2025 at 10:09 AM, an interview was conducted with Head [NAME] #13, who confirmed that he had discarded the boxes of frozen fish.On 11/18/2025 at 3:50 PM, this surveyor conducted an interview with the Food Service Director, who confirmed that a vendor had come to the facility the previous day and repaired the freezer fan. The food safety concerns previously discussed with Head [NAME] #13 were explained to the Food Service Director, who confirmed understanding.(2)On 11/20/2025 at 2:25 PM, this surveyor observed the nourishment refrigerator for the Congressional Unit. A container of food in Tupperware was noted without a label or date. Another Tupperware container was labeled but did not include a date.On 11/20/2025 at 2:26 PM, this surveyor conducted an interview with Licensed Practical Nurse (LPN) #4. When asked about expectations for the nourishment refrigerators, LPN #4 stated that when families or residents bring food in, the expectation is that items are labeled with a name, date, and sometimes a room number. She stated that it is the responsibility of the nurses and Geriatric Nursing Assistants (GNAs) to ensure this is done.On 11/20/2025 at 2:33 PM, this surveyor conducted a concurrent observation of the nourishment refrigerator with LPN #4. This surveyor pointed out the Tupperware containers that were unlabeled or missing dates. LPN #4 acknowledged the concern and stated she would address it immediately. She removed the containers from the refrigerator during the interview.On 11/20/2025 at 2:45 PM, LPN #4 reported that she had disposed of the undated food items from the nourishment refrigerator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, it was determined that the facility failed to accurately document resident records. This was evident for 1 (Resident #75) of 1 resident reviewed for pain management during the annual survey.The findings include:The 0-10 pain scale is a standardized numeric rating tool used to assess a resident's level of pain. Residents are asked to rate their pain on a scale from 0 to 10, where 0 indicates no pain and 10 represents the worst pain imaginable. This scale helps staff measure the resident's subjective pain experience, monitor changes over time, and evaluate the effectiveness of pain interventions. On 11/18/2025 at 11:21 AM, this surveyor interviewed Resident #75, who reported having recently fallen out of bed. The resident stated he/she had pain in the left shoulder, where he/she landed on the floor during the fall. On 11/25/2025 at 10:06 AM, record review of the resident's progress notes showed the fall occurred on 11/16/2025 at 5:00 PM. A progress note dated 11/17/2025 by Licensed Practical Nurse (LPN) #20 stated that the resident verbalized shoulder pain, rated 3/10, was able to move and elevate BL arms with assistance.On 11/25/2025 at 10:55 AM, review of the Medication Administration Record (MAR) for November 2025 showed a designated section for pain assessment using the 0-10 scale. For 11/17/2025, LPN #20 documented the resident's pain level as 0 out of 10. On 11/25/2025 at 11:35 AM, an interview was conducted with LPN #12. When asked about expectations for documenting pain assessments, he stated that pain assessments are documented in the MAR and may also be included in progress notes.On 11/25/2025 at 11:49 AM, this surveyor interviewed the Director of Nursing (DON). When asked her expectation for documenting resident pain, she stated that staff are expected to assess and document pain using the 0-10 scale. The DON was informed that LPN #20 documented the resident's pain level as 3/10 in the progress note on 11/17/2025, yet documented 0/10 for the same date in the MAR, creating a discrepancy in the resident's medical record. The DON reported understanding of the concern.

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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 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 observation, interview and record review, it was determined that the facility failed to maintain proper infection prevention and control practices by (1) failing to maintain sanitary and safe practices related to the resident care environment and supplies, and (2) failing to ensure staff were wearing required personal protective equipment (PPE). This was found evident during the Infection Control review conducted during the annual survey and has the potential to affect most residents.The findings include: (1) On 11/21/2025 at 8:33 AM, this surveyor observed visibly soiled linens placed on the floor of Resident #15's room. Resident #15 was observed lying on the bed without sheets, directly on a bare mattress. Photographs of these observations were taken at this time.At approximately 8:34 AM, an interview was conducted with Resident #15 in his/her room. The Resident reported that a staff member had cleaned him/her, removed the soiled linens, placed them on the floor, and left the Resident lying on the uncovered mattress without clean sheets.On 11/25/2025 at 12:30 PM, this surveyor met with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to discuss the concerns. The infection control issues regarding soiled linens placed on the floor and the Resident lying on an uncovered mattress were reviewed. Photographs were shown to the DON and ADON, and they acknowledged the concerns.(2)On 11/21/2025 at 12:23 PM, this surveyor conducted an interview with the Infection Control Preventionist (ICP). The ICP stated that employees who have not yet received the seasonal influenza vaccine are expected to wear a mask during flu season, which per Centers for Medicare & Medicaid Services (CMS) guidance is October 1 through March 31.On 11/21/2025 at 1:30 PM, a record review of the employee flu binder provided by the ICP showed that Certified Nursing Assistant (CNA) #7 had not yet received the influenza vaccine.On 11/20/2025 at 2:35 PM, this surveyor observed CNA #7 in the hallway on the second floor and at the nurse's station on the Arcadia Unit without wearing a mask.On 11/21/2025 at 2:28 PM, this surveyor conducted a follow-up interview with the ICP. She confirmed that CNA #7 had not yet been vaccinated for influenza. The surveyor informed the ICP of the observation made the previous day of CNA #7 not wearing a mask. The ICP acknowledged the concern and stated that the issue would be addressed immediately.On 11/24/2025 at 11:59 AM, the ICP reported that CNA #7 would be offered the influenza vaccine the following day.