STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215339	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchorage Rehabilitation and Wellness Center	105 Times Square Salisbury, MD 21801

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to maintain a sanitary and comfortable environment, as evidenced by persistent odors of urine throughout multiple resident care floors and common areas. This deficient practice was observed on three separate dates during the annual survey and had the potential to impact all residents, staff, and visitors in the facility.Findings include:On 12/04/2025 at 7:30 AM, upon entry into the facility, the surveyor detected a strong, pungent odor of urine in the main lobby on ground floor, which was consistently present throughout the hallways of floor G, floor 1, and floor 3. During interview on 12/04/2025 at 11:00 AM with Nursing Home Administrator and Director of Nursing were made aware of the concerns of a strong, pungent odor of urine in the main lobby, which was consistently present throughout the hallways of floor G, floor 1, and floor 3. During interview with facility visitor on 12/04/2025 at 5:17 PM, visitor stated that there is always a strong odor of urine and stool in the building main lobby and the 3rd floor when I visit and I visit almost every day. On 12/05/2025 at 9:20 AM, the surveyor detected a strong urine odor consistently present throughout the main lobby on ground floor, hallways of floor 1 and floor 3.During interview on 12/05/2025 at 12:30 PM staff #13 stated, The facility uses linen to provide incontinence care to residents and the carts that soiled linen and trash are placed into, are located on the floors and kept out in the resident hallways. On 12/08/2025 at 10:05 AM, the surveyor detected a strong urine odor consistently present throughout the hallways of floor 1, 2 and floor 3.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to: 1.) use appropriate infection control practices according to professional standards of practice, 2.) ensure hand sanitizer supply was available at all dispensers, 3.) implement infection control practices to ensure oxygen equipment was dated when put into use, 4.) ensure linens were handled in a safe and sanitary manner. This deficient practice was evident for: 1.) 5 resident rooms observed during breakfast tray collection and 4 residents (Resident #77, #4, #113, and #35) observed during medication administration and 2.) 3 out of 8 hand sanitizer dispensers located on the second floor during the facility's recertification survey, 3.) 1 (Resident #7) of 2 residents reviewed for oxygen equipment and 4) 1 observation of the laundry processing room during the annual survey. Based on observation and interview, it was determined that the facility failed to use appropriate infection control practices according to professional standards of practice. This deficient practice was evident for 5 resident rooms observed during breakfast tray collection and 4 residents (Resident #77, #4, #113, and #35) observed during medication administration, 3 out of 8 hand sanitizer dispensers located on the second floor during the facility's recertification survey, 1 (Resident #7) of 2 residents reviewed for oxygen equipment and 1 observation of the laundry processing room during the annual survey. The findings include: 1a. On 12/8/2025 at 8:51AM, the Surveyor observed Geriatric Nursing Assistant (GNA) #15 enter rooms 101, 102, 103, 105, and 106 without washing or sanitizing their hands before entering and exiting the resident's rooms. During an interview with GNA #15, the Surveyor informed the staff of their observation and asked if they were aware of proper hand hygiene protocol prior to entering and exiting residents' rooms. GNA #15's response was This is the first time I heard of that. On 12/8/2025 at 9:25AM, during an interview conducted with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) #16, the Surveyor expressed the concern that GNA #15 did not use proper hand hygiene by washing or sanitizing their hands prior to entering and exiting resident rooms during breakfast tray collection. ADON/IP #16 informed the Surveyor that the expectation for proper hand hygiene is to wash with soap and water or use hand sanitizer when entering and exiting a resident's room, especially after direct contact with the resident and their personal items. Staff are trained and observed on proper hand hygiene multiple times a year, they should be aware of the protocol. ADON/IP #16 stated they were going to do an immediate in-service on hand hygiene. 1b. On 12/8/2025 at 9:45AM, the Surveyor observed Certified Medication Aide #21 during medication administration for Resident #77. CMA #21 retrieved the resident's blood pressure using a manual blood pressure cuff. CMA #21 failed to disinfect the manual blood pressure cuff after use. CMA #21 failed to wash or sanitize their hands after completing medication administration for Resident #77. 1c. On 12/8/2025 at 10:35AM, the Surveyor observed CMA #21 during medication administration for Resident #4. CMA #21 failed to wash or sanitize their hands prior to medication administration and after administering the medication. During an interview with CMA #21 on 12/8/2025 at 10:40AM, the Surveyor expressed the concern that they failed to disinfect the blood pressure cuff after using it with Resident #77 and failed to wash or sanitize their hands after administering medication to Resident #77 and before and after administering medication to Resident #4. CMA #21 acknowledged the Surveyor's concern. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1d. On 12/9/2025 at 8:40AM, the Surveyor observed Unit Manager (UM) #18 during medication administration for Resident #113. Prior to administering the resident's medication, UM #18 retrieved the resident's vital signs with a portable vital sign machine. UM #18 used the blood pressure cuff and the pulse oximeter. UM #18 failed to disinfect the portable vital sign machine including the blood pressure cuff and the pulse oximeter after use. 1e. On 12/9/2025 at 8:50AM, the Surveyor observed UM #18 transition to Resident #35 for medication administration. Using the same portable vital sign machine, UM #18 retrieved the resident's vital signs using the blood pressure cuff and the pulse oximeter. UM #18 failed to disinfect the portable vital sign machine including the blood pressure cuff and the pulse oximeter after use. During an interview with UM #18 on 12/9/2025 at 9:00AM, the Surveyor expressed the concern that they failed to disinfect the portable vital sign machine including the blood pressure cuff and the pulse oximeter between residents. UM #18 acknowledged the Surveyor's concern. During an interview with ADON/IP #16 on 12/9/2025 at 1:50PM, the Surveyor expressed the concern that CMA #21 failed to disinfect the blood pressure cuff after use and perform hand hygiene before and after medication administration and UM #18 failed to disinfect the portable vital sign machine including the blood pressure cuff and the pulse oximeter after use. ADON/IP informed the Surveyor that they are currently educating staff on proper hand hygiene and disinfecting equipment after use. 2a. During the surveyor's initial tour of the facility on 12/4/25 at 7:42AM the surveyor attempted to utilize hand sanitizer from the dispenser located on the wall outside of room [ROOM NUMBER] at which time it was observed that no hand sanitizer would dispense from the dispenser. On 12/4/25 at 7:50AM the surveyor observed and shared the concern with Geriatric Nursing Assistant #9 who acknowledged the concern. During dual rounding observations on the facility's second floor with the facility's Administrator on 12/4/25 at 8:06AM the surveyor shared all concerns at which time the Administrator acknowledged and confirmed understanding of the concerns and stated: Thank you I appreciate it. 2b. On 12/4/25 at 8:19AM the surveyor attempted to use the hand sanitizer dispenser located on the wall outside of room [ROOM NUMBER] at which time it was observed that no hand sanitizer would dispense from the dispenser. On 12/4/25 at 1:41PM the surveyor again attempted to use the hand sanitizer dispenser located on the wall outside of room [ROOM NUMBER] at which time it was observed that no hand sanitizer would dispense from the dispenser. At this time the surveyor rounded on the facility's second floor and observed and found 3 out of 8 hand sanitizer dispensers which were unable to dispense hand sanitizer. On 12/5/25 at 11:42AM the surveyor conducted an interview and shared concerns with the facility's Environmental Services Account Manager (ESAM) #13 who reported to the surveyor that they were in charge of the hand sanitizer dispensers, and when the dispensers are empty the housekeeping staff is expected to place that in the TELS system (computer program the facility utilizes to report maintenance concerns). ESAM #13 reported to surveyors that it is housekeeping staff's responsibility to be keeping an eye on it. ESAM #13 reported that the hand sanitizer dispensers that were found by the surveyor to not be dispensing hand sanitizer were older model ones and there were not sanitizer (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refills for those dispensers. Additionally ESAM #13 reported the older model dispensers were to be replaced and also that there were dispensers that were working but battery replacement was neglected by staff and the facility was in the process of ordering more. ESAM #13 reported that no housekeeping staff had reported inoperable hand sanitizer dispensers to them. On 12/5/25 at 11:58AM surveyors conducted an interview and shared concerns with Regional Operations Facility Manager (ROFM) #7 who reported that housekeeping replaces the sanitizer refills and if there is a maintenance issue they contact maintenance staff. When the surveyor inquired as to if the maintenance department had any requests from housekeeping staff for maintenance concerns regarding hand sanitizer dispensers, ROFM #7 reported there were no TELS reports. On 12/5/25 at 12:08PM the surveyor shared concerns with the facility Administrator and Administrator In Training #3. 3. On 12/4/25 at 8:09 AM, Resident #7 was observed with an oxygen setup. The humidifier bottle and oxygen tubing attached to the resident's oxygen concentrator were noted to be in use but were not dated. The surveyor located Staff #14, who was identified as responsible for the care of Resident #7, and brought them to the room. Staff #14 confirmed the humidifier bottle and tubing were in use and acknowledged that there was no date on the tubing or humidifier bottle. The Nursing Home Administrator was informed of the findings and infection control concerns at 3:19 PM during a conference with the survey team. 4. On 12/9/2025 at 1:40PM, the Surveyor observed the soiled laundry processing room with the Director of Housekeeping (DOH) #13. The room was odorous. The Surveyor observed loose and unbagged resident personal garments and linens, and facility linens which were all scattered on the floor, on top of laundry hampers, and on top of an unused/inoperative white washing machine. Multiple pieces of linen were visibly soiled with brown, red, and yellow stains. DOH #13 confirmed the Surveyor's observations. The Surveyor expressed the concern that the residents' personal garments and linens and facility linens were not maintained in a safe and sanitary manner. On 12/10/2025 at 8:00AM, during an interview with the Administrator in Training (AIT) #3, the Surveyor was informed that the administrative staff had been made aware of the conditions in the soiled laundry processing room on 12/9/2025. The Surveyor expressed the concern that the residents' personal garments and linens and facility linens were not maintained in a safe and sanitary manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews with staff, it was determined that the facility failed to provide the residents with respect and dignity by failing to knock/ask permission to enter prior to entering the resident's room. This was evident for 5 resident rooms observed during breakfast tray collection on the first floor.The findings include:On 12/8/2025 at 8:51AM, during an observation of breakfast tray collection on the first floor, the Surveyor observed Geriatric Nursing Assistant (GNA) #15 enter rooms 101,102,103,105, and 106 without knocking or asking permission to enter prior to entering the residents' rooms.On 12/8/2025 at 8:55AM, during a conversation with GNA #15, the Surveyor expressed the concern that they did not knock before entering rooms 101, 102, 103, 105, and 106. GNA #15 had no response. On 12/8/2025 at 9:25AM, an interview with the Assistant Director of Nursing (ADON) #16 revealed that the expectation is for staff to knock on the resident's door and ask permission before entering a resident's room. Staff have been educated on that topic. The Surveyor informed ADON #16 about the observation of GNA #15 entering rooms, to collect breakfast trays, on the first floor without knocking or asking permission to enter the residents' rooms prior to entering

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, it was determined that the facility failed to maintain a clean, sanitary bathing environment. This deficient practice was evident for 1 of 1 shared shower rooms reviewed during the annual survey. Based on observation and interview it was determined the facility failed to ensure a homelike environment. This was evident for 1.) 1 out of 1 Resident reviewed for respiratory (Resident #3) and 2 out of 2 second floor Residents reviewed for environment (Resident #43 and #32) 2.) 1 out of 1 ceiling adjacent to the second floor nursing station and 3.) 1 out of 1 shared shower rooms during the facility's recertification survey. The findings include: 1.) On 12/4/25 at 7:48AM the surveyor observed Resident #3's room with an area of wall damage which extended several feet across the length of the room's window, above the window with areas of water marks, brown staining, areas of chipped paint and wall material, rust colored areas and a bubbled appearance. On 12/4/25 at 7:50AM the surveyor requested and performed a dual observation and shared the concern with Licensed Practical Nurse #17 who observed and acknowledged the surveyor's concern and stated: I'll put the wall damage issue in TELS, (computer program used to communicate maintenance concerns to maintenance staff) that's a maintenance issue. On 12/4/25 at 8:03AM the surveyor requested and performed a dual observation of the concern with the facility's Administrator who observed the concern and acknowledged and confirmed understanding of the surveyor's concern. On 12/4/25 at 8:11AM the surveyor observed a spackled unfinished section of ceiling above Resident #43's bed and black marks were observed present on their room wall with areas of chipped paint. Further observation of Resident #43's room revealed the following concerns within their bathroom: 1.) one mirror with dark worn areas was present, 2.) one tilted, loosely affixed light fixture in which only half the fixture was able to light up, 3.) one peeling area of paint below the air vent , and 4.) an air vent with debris present within it and rust colored spots. On 12/4/25 at 1:18PM the surveyor observed the following concerns within Resident #32's bathroom: 1.) several damaged ceiling tiles with a stained and brown appearance, 2.) air vent with an extensive rust colored appearance, 3.) rust colored spots present on the metal ceiling grid which held the ceilings tiles, 4.) one lifted ceiling tile, 5.) a light fixture affixed to the wall above the bathroom mirror with no cover and 2 uncovered light bulbs, 6.) one mirror with dark grey worn areas present, 7.) one bathroom hand soap dispenser observed to have a pool of sitting liquid and debris within the plastic catch piece and splattered debris on the surface of the dispenser, 8.) one area of chipped wall paint next to the hand soap dispenser, 9.) one toilet with no toilet tank cover, 10.) one toilet which was observed with wet toilet paper present on the toilet seat and trailing into the toilet bowl, and 11.) red matter was observed to be present on the bathroom light switch. On 12/5/25 at 11:42AM the surveyor shared concerns and conducted an interview with the facility's Environmental Services Account Manager #13 who acknowledged and confirmed understanding of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor's concerns. On 12/5/25 at 11:58AM the surveyor shared concerns and conducted an interview with the facility's Director of Maintenance #5 who acknowledged understanding of the surveyor's concerns. On 12/5/25 at 12:08PM the surveyor shared concerns with the facility's Administrator and Administrator in Training #3. 2.) On 12/9/25 at 7:00PM surveyors observed the second floor ceiling located between the elevator and nursing station with a several foot long crack where the ceiling connected with a lower area of the ceiling. On 12/10/25 at 9:23AM surveyors shared the concern with the facility's Administrator in Training #3 who acknowledged and confirmed understanding of the concern and stated: Okay, I'll go have maintenance fix it. 3.) On 12/4/25 at 8:12 AM, Resident #61 was interviewed as part of the survey process and the resident expressed concerns about the cleanliness of the shared shower room used for residents on the first-floor unit. At 8:39 AM, the surveyor observed the shared shower room on the first floor. A used disposable razor was observed on a shower bed that had brown stains on the mattress. It was parked in a corner next to a broken toilet which was wrapped in what appeared to be a plastic garbage bag. A used face mask was on the floor under some other equipment blocking the entryway to the room where the toilet was. The baseboard tile on the wall separating the two rooms was broken. There were pieces of gray debris on the floor of the shower where residents were showered. At 9:06 AM, the administrator was alerted to the concerns expressed by the resident and the observations made by the surveyor. The administrator stated he would have the situation addressed. On 12/9/25 at 8:39 AM, the surveyor made a follow-up observation of the first-floor shower area and found that the used face mask was still on the floor. Some equipment had been moved and now two used disposable razors were on the shower bed along with various used patient care items. The shower bed mattress still had visible brown stains on the surface where a resident would lay on it. A used Band-Aid was on the floor near the entrance door and another used Band-Aid was observed next to a shower chair in the resident shower area. There was a pile of debris, which resembled the gray debris observed on 12/4/25, pushed into a corner of the shower area. At 8:49 AM, the administrator and administrator in training were brought to the shower room on the first floor by the surveyor to see firsthand the conditions. At this time the administrator alerted the housekeeping staff to improve the cleanliness of the shower area. All concerns were reviewed by surveyors with facility staff on 12/10/25 at approximately 10:00AM during the facility's exit conference.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, it was determined that the facility failed to ensure that residents were free from verbal abuse when a staff member verbally threatened a resident. This was evident for 1 (MD#2664395) of 1 facility reported incident reviewed during the annual survey.The findings include:On 12/4/25 at 10:27 AM, Resident #97 was interviewed regarding an incident that occurred on 11/8/25 and was reported to the State Agency. Resident #97 stated that Staff #6, a kitchen employee, threatened to alter his food following a dispute between the staff member and the resident. Resident #97 recalled the events and confirmed the details contained in the facility's report.On 12/4/25 at 12:34 PM, a review of the facility's documentation of the reported incident showed that Staff #6, the employee who verbally threatened the resident, was immediately removed from the premises when the facility became aware of the incident on 11/8/25 at 12:20 PM. As part of the facility's investigation, Resident #97 was interviewed and stated that Staff #6 said I could be a ruthless motherfucker and I can put something into your food. Resident #53, who was present at the time of the incident, reported hearing the threat and corroborated the allegation. A review of time clock records confirmed Staff #6 was present on the day of the event. The investigation into the incident led to the allegation of abuse being substantiated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to: 1.) Maintain and provide documentation of required Ombudsman notifications related to resident transfers and discharges and provide the resident and/or resident representative with written notification of transfer to the hospital and written notification of the facility's bed hold policy. This is evident for 4 (Residents #2, #11, #110, and #112) of 7 residents reviewed for transfers and discharge. The findings include: Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. 1. On 12/8/25 at 10:19 AM, a request was made for documentation showing the facility's notification to the Ombudsman regarding the October 2025 hospitalizations of Residents #2 and #11. At 3:08 PM the same day, the documentation was again requested from Staff #3. On 12/9/25 at 7:56 AM, during an interview, Staff #3 stated the facility was unable to produce the required Ombudsman notification list for October 2025. 2. On 12/9/2025 at 10:30AM, during a review of Resident #112's electronic medical record, the Surveyor discovered the resident was discharged home on 9/16/2025. There was also no documentation that the local Ombudsman was informed of the resident's discharge on [DATE]. 3. On 12/9/2025 at 11:25AM, a review of Resident #110's electronic medical record revealed that the resident was transferred to the hospital on 9/19/2025 due to abnormal lab values. Further review of Resident #110's medical record failed to reveal documentation to verify Resident #110's resident representative had been provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 9/19/2025. There was also no documentation that the local Ombudsman was informed of the resident's hospital transfer on 9/19/2025. During an interview conducted with the Administrator in Training (AIT) #3 on 12/9/2025 at 11:30AM, the Surveyor expressed the concern that the facility failed to provide documentation to verify the Resident #110's resident representative had been provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital, and failed to ensure the local Ombudsman was notified of Resident #110's transfer to the hospital and Resident #112's discharge home in September 2025. The Surveyor requested those documents from the Administrator in Training (AIT) #3. On 12/9/2025 at 12:45PM, an interview conducted with Social Worker #11 revealed that it is their responsibility to email the Ombudsman the transfers and discharged from the facility monthly. SW #11 acknowledged that they dropped the ball and have not sent emails to the Ombudsman consistently every month. At the time of exit, on 12/10/2025 at 10:25AM, AIT #3 was unable to provide the Surveyor with documentation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, it was determined that the facility failed to provide the resident and/or resident representative with a written summary of their baseline care plan. This was evident for 2 residents (Resident #110 and #112) out of 41 residents reviewed during the annual survey.The findings include: 1. On 12/9/2025 at 10:31AM, the Surveyor discovered that Resident #112 was admitted to the facility on [DATE] from the hospital for hyperglycemic management and physical and occupational therapy. A review of the resident's electronic medical record revealed a care conference sign in sheet dated 9/5/2025 where resident representatives, Social Worker (SW) #11, and the Director of Rehabilitation (DOR) #20 were in attendance. Additional review failed to reveal documentation that the resident and/or resident representatives received a copy of the written summary of their baseline care plan.2. On 12/9/2025 at 11:21AM, during a review of Resident #110's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE]. Further review revealed a Care Conference note dated 9/17/2025 which discussed the resident's plan of care. Additional review failed to reveal documentation that the resident and/or resident representative received a copy of the written summary of their baseline care plan.On 12/9/2025 at 12:44PM, during an interview conducted with SW #11, the Surveyor was informed that the baseline care plan should be completed within 48 hours of admission by members of the interdisciplinary team. During the initial care plan meeting, held within 7 days of admission, the baseline care plan and medications are reviewed with the resident and/or resident representative. Documentation of the care plan meeting and review of the resident's care plan and medications should be in the resident's medical record. A written summary of the baseline care plan should be provided and that receipt should be documented in the resident's medical record. The Surveyor expressed the concern that there was no documentation to verify that Resident #112, Resident #110, and/or their resident representative received a copy of the written summary of their baseline care plan. The Surveyor requested documentation.On 12/9/2025 at 1:00PM, SW #11 confirmed there was no documentation to verify Resident #112, Resident #110, and/or their resident representative received a copy of the written summary of their baseline care plan.

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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 record review and interviews with staff, it was determined that the facility failed to ensure comprehensive person-centered care plans were developed and implemented for residents. This was evident for 2 (Resident #111 and Resident #112) out 41 residents reviewed during the annual survey.The findings include: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.Palliative care is specialized medical care for people living with a serious illness and is focused on providing relief from symptoms and stress of the illness. The goal is to improve the quality of life for both the patient and the family. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. It is a state specific medical document, with signed physician orders.Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor informs the medical staff that CPR should not be attempted.1. On [DATE] at 1:32PM, the Surveyor discovered a physician's note dated [DATE] which stated, Palliative care status: continue palliative, comfort care. Appears comfortable. Further review revealed a nursing note dated [DATE] which stated Resident continues to be on palliative care and has an order for no weights.On [DATE] at 1:40PM, a review of Resident #111's MOLST dated [DATE] revealed that the resident was DNR option B and included no intubation, no blood, no hospital, no medical tests, no tube feed, and no dialysis. On [DATE] at 1:45PM, during additional review of Resident #111 electronic medical record, the Surveyor discovered a care plan initiated on [DATE] with a focus, [Resident] has a DNR B code status strong support system, a goal, Resident's code status will be honored through review date, and interventions Code status will be established at time of admission/re-admission. To be reviewed quarterly and [as needed]. A review of Resident #111's care plan failed to reveal a patient centered care plan for palliative care.On [DATE] at 10:26AM, during an interview with Unit Manager #10, the Surveyor expressed the concern that Resident #111 did not have a palliative care plan which includes symptom management, quality of life, specific measurable goals and interventions for physical, emotional, spiritual support for the serious illness of the resident and the family, and for comfort measures, education, and coordination of care with the resident, family, and interdisciplinary team. The Surveyor confirmed that Resident #111 did not have a care plan for palliative care and was informed that residents who are receiving palliative care services should have a care plan developed and implanted for the services provided to the resident.2. On [DATE] at 10:31AM, the Surveyor discovered that Resident #112 was admitted to the facility on [DATE] from the hospital for hyperglycemic management and physical and occupational therapy with a plan to return to the community/home.On [DATE] at 10:40AM, a review of Resident #112's care plan, created on [DATE], failed to reveal a person-centered care plan implemented for discharge planning to assess and meet the resident's potential needs.During an interview conducted with Social Worker (SW) #11 on [DATE] at 12:44PM, the Surveyor was informed that discharge planning is discussed during the initial care plan meeting held within 7 days of admission as well as during quarterly care plan meetings. Discharge planning should be included in the residents' care plan. The Surveyor expressed the concern that Resident #112's care plan failed to include discharge planning to ensure a safe transition home and back to the community.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with residents and staff, it was determined that the facility failed to 1.) Have a system in place to ensure the resident and/or resident representative had the opportunity to participate in their care planning process with members of the interdisciplinary team at care plan meetings. 2.) Hold and complete quarterly care plan meetings for residents an 3.) Perform appropriate revisions to resident's care plans. This was evident for 4 (Resident #112, #110, #6 and #89) out of 41 residents reviewed during the annual survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments. It outlines what needs to be done to plan, assess, and manage care needs. This helps to evaluate the effectiveness of the resident's care. The residents, their family or legal representative, and the nursing home interdisciplinary team must participate in the residents' care plan meetings. The interdisciplinary team (IDT) includes representatives from nursing (including Geriatric Nursing Assistants, GNAs), social work, activities, dietetics, therapy, and any other professionals as appropriate to ensure a comprehensive and coordinated care plan. 1.) On [DATE] at 10:31AM, the Surveyor discovered that Resident #112 was admitted to the facility on [DATE] from the hospital for hyperglycemic management and physical and occupational therapy. A review of the resident's electronic medical record revealed a care plan created on [DATE] and a care conference sign in sheet dated [DATE] where resident representatives, Social Worker (SW) #11, and the Director of Rehabilitation (DOR) #20 were in attendance. The care conference sign-in sheet failed to include the resident and failed to identify that other members of the IDT participated in the care plan meeting. On [DATE] at 11:21AM, during a review of Resident #110's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE]. Further review revealed a Care Conference note dated [DATE] which discussed the resident's plan of care and a care conference sign in sheet dated [DATE] where resident representative, Social Worker (SW) #11, and the Director of Rehabilitation (DOR) #20 were in attendance. The care conference sign-in sheet failed to include the resident and failed to identify that other members of the IDT participated in the care plan meeting. On [DATE] at 12:44PM, during an interview conducted with SW #11, the Surveyor was informed that a representative from Social Work, nursing (usually the Unit Manager), activities, dietary, and the Director of Rehabilitation, if a skilled resident, and any other discipline requested by resident and/or resident representative should participate in care plan meetings. However, the Activity Director has been out on leave and therefore not at meetings, a representative from nursing comes occasionally if they don't have to work on the floor, and the Dietician does not come to meetings. There is a care conference sign-in sheet that each member of the IDT and the resident and/or resident representative should sign to indicate they attended the care plan meeting. If they did not sign, they did not attend the care plan meeting. The Surveyor expressed the concern that according to the care conference sign-in sheet, Resident #112 and Resident #110 did not participate in their care conference meeting and the resident representatives, SW #11, and DOR #20 were the only members of the IDT to attend the meetings. SW #11 confirmed the Surveyor's findings and that the presence of the complete IDT would allow the resident and resident representatives to participate in the care planning process and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have their questions and concerns addressed by the team. 2.) During an interview on [DATE] at 10:10 AM Resident #6 representee stated, the facility has not been completing quarterly care plan meetings. Review of resident #6 medical record on [DATE] at 11:15 AM revealed that care plan meetings were not held quarterly from [DATE] to [DATE] and were held only on the following dates: [DATE], [DATE], [DATE]. During an interview on [DATE] at 11:35 AM staff # 11 agreed and stated that there was no evidence in the Resident #6 medical record or any facility documentation that quarterly care plan meetings were being completed for resident #6. 3.) Review of resident #6 medical record on [DATE] at 12:45 PM revealed a care plan with interventions of a revision date of [DATE] stating to report abnormal findings to hospice company and coordinate care with hospice company. Further review revealed that resident #6 was discharged from hospice care on [DATE]. Review of resident #89 medical record on [DATE] at 2:30 PM revealed a care plan with a focus area revision date [DATE] stating resident has a FULL code status. Further review revealed a Maryland Medical Orders for Life-Sustaining Treatment form dated [DATE] indicating Resident #89 had orders for No CPR option A-2. During an interview on [DATE] at approximately 2:45 PM the Director of Nursing confirmed that Resident #6'scurrent care plan was incorrect and Resident #6 is not receiving hospice care and confirmed that Resident #89's current care plan was incorrect and Resident #89's code status was No CPR option A-2.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview it was determined that the facility failed to maintain a resident environment that is free of accident hazards. This was evident for 2 out of 4 housekeeping carts observed during the annual survey. The findings include : During observation rounds on 12/04/2025 at 8:30 AM housekeeping cart on facility ground level was found to be unattended and unlocked containing containers of cleaning chemicals. During observation rounds on 12/08/2025 at 8:45 AM housekeeping cart on facility second floor was found to be unattended and unlocked containing containers of cleaning chemicals. During interview on 12/08/2025 at 1:00 PM staff #13 stated and confirmed, both housekeeping carts are unlocked due to the locks being broken. Staff #13 further stated, all housekeeping carts should be locked at all times to prevent the residents from getting into them, new locks will be ordered and carts will be kept locked up in a room until new locks arrive.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review it was determined the facility failed to follow medical orders for respiratory care consistent with professional standards of care. This was evident for 1 (#3) out of 2 Residents reviewed for respiratory during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility, the surveyor observed Resident #3 on 12/4/25 at 7:43AM receiving oxygen delivered to their tracheostomy in which the plastic tubing for the system was observed to have an unclean appearance with an orange and brown crusted appearing substance and debris present which was also observed to be present on Resident #3's hospital gown they were wearing. Further observation of the respiratory equipment at this time revealed Resident #3's humidification bottle attached to the oxygen delivery system was empty and dry in appearance, and not providing any humidification to the resident while oxygen was being delivered via a concentrator observed to be set at 8 liters per minute. On 12/4/25 at 7:43AM the surveyor conducted an interview with Resident #3 who reported to the surveyor: My tubing is dirty and they don't have the things to take care of me and my trach. Resident #3 further explained that because of their respiratory care concerns they had asked facility staff to transfer them to a different facility. Resident #3 stated to the surveyor: I didn't come here to lay in a bed, I live in an apartment, I can't walk because they (facility) don't have portable oxygen. At this time a wheelchair was observed within the resident's room, however, no portable oxygen equipment was observed to be present. Resident #3 reported that they had informed the Director of Social Work of their concerns and had additionally asked for their trach to be cleaned. Resident #3 reported to the surveyor that their trach was not being cleaned, they had asked facility staff for it to be cleaned, vomit was present on the tubing, and their water for humidification had been empty for days. On 12/4/25 at 7:50AM the surveyor requested and conducted a dual observation of concerns with Resident #3's assigned nurse, Licensed Practical Nurse (LPN) #17 who responded to the surveyor with the following information regarding the concerns: Today is a pick-up day, I don't usually work on this floor, I'm gonna have to go down and find some trach supplies. LPN #17 confirmed with the surveyor that their shift was from 7am- 7pm. On 12/4/25 at 8:03AM the surveyor requested and conducted a dual observation of the concerns with the facility's Administrator who observed the concerns and acknowledged and confirmed understanding of the concerns. Resident #3 was observed relaying their care concerns to the Administrator, at which time the Administrator stated to both Resident #3 and the surveyor: The concerns will be addressed.On 12/9/25 at 6:22PM the surveyor conducted an interview of the facility's Director of Social Work (DSW) #11 who reported that Resident #3 had expressed being concerned regarding their care and a grievance was completed for the care concerns and they had given the grievance to the Director of Nursing (DON). DSW #11 indicated that the facility in which the Resident had requested a transfer to had a Respiratory Therapist.On 12/9/25 at 6:42PM the surveyor conducted an interview of the DON who reported that the facility has a specific respiratory order set for tracheostomies. After surveyor intervention, the DON reported to surveyors that they had looked into the respiratory nursing care issues and believed the Unit Manager had corrected it. The DON reported to surveyors that Resident #3's humidification bottle was changed out and confirmed that orders for respiratory care were present but not followed by nursing staff and further reported that the concerns were addressed with Unit Manager (UM) #18 and staff education was provided in response to the concerns.On 12/9/25 at 7:00PM a dual surveyor observation of Resident #3's respiratory equipment was requested and conducted with the DON. One spare trach was observed to be present at the bedside observed to be a size 7. Review of the medical record by the surveyor on 12/9/25 at 7:15PM with the facility's Mobile Director of Nursing (MDN) #4 revealed the following active medical orders for Resident #3: 1.) Trach-type 8.0 Portex deflated cuff on 35% 8L every day and night shift dated as beginning on 10/23/25, 2.) Trach care q shift and prn every shift for Trach care dated as beginning on 10/24/25, 3.) 02 at 8L via tracheostomy continuous every shift dated as beginning on 10/24/25, 4.) Have same (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	size trach and one size smaller at bedside at all times dated as beginning on 10/21/25, 5.) Change oxygen tubing and humidifier Q7 (every 7) days and prn (as needed) dated as beginning on 10/21/25 and 6.) No powders, aerosols, or small particles around tracheostomy tube dated as beginning on 10/24/25. At this time, the surveyor inquired to MDN #4 as to why a size 7 was the only spare trach available at the resident's bedside when the resident's trach was a size 8. MDN #4 was observed reviewing Resident #3's medical order and reported to both the surveyor and facility DON that the medical order stated to have the same size trach and a size smaller at the bedside. Further review of the medical record revealed the Resident was their own responsible party/decision maker. On 12/9/25 at 7:20PM surveyors requested and conducted another dual observation of the concern with the DON. Surveyors observed the DON review the respiratory equipment within the resident's room and no spare size 8 trach was present. After surveyor intervention, the DON was observed walking to the facility's supply room located behind the nursing station and retrieved a spare size 8 trach at which time they handed it to UM #18 and stated: Next time you go in (Resident #3's) room, put the spare trach in there. When the surveyor inquired to UM #18 as to when the spare emergency trach would be placed at Resident 3's bedside, they reported: I'll do it. At this time, the surveyor continued to conduct observation of the spare trach equipment until it was observed to be placed at the bedside by Unit Manager #18. On 12/10/25 at 8:22AM concerns were again shared with the facility's DON. On 12/10/25 at 8:30AM surveyors conducted another dual observation of Resident #3 in their room at which time their oxygen concentrator was observed set at 5 liters per minute. Resident #3 stated to surveyors that they believed they came to the facility with medical orders for 10 liters which was then changed to 8 liters and subsequently they were weaned and were to now be receiving 6 liters. UM #18 was requested by surveyors to perform an observation of Resident #3's oxygen concentrator settings at which time they observed and confirmed the concentrator was set delivering at 5 liters. UM #18 reported they believed the Resident was to be receiving 8 liters. Unit Manager #18 reviewed the resident's active medical order for oxygen and confirmed with surveyors that they were to be receiving 8 liters. After surveyor intervention, UM #18 was observed turning Resident #3's oxygen concentrator from 5 liters up to 8 liters per minute. During the sharing of concerns with UM #18, Resident #3's respiratory tubing and attached bag was observed laying directly on the floor's surface. At this time, surveyors additionally shared this concern and Unit Manager #18 acknowledged and confirmed understanding of the concerns. On 12/10/25 at 9:00AM the surveyor conducted an interview with Resident #3 who reported during the interview that they had only refused care in the past when facility staff were not using the right sized respiratory equipment.All concerns were reviewed during the facility's exit conference on 12/10/25 at approximately 10:00AM.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review it was determined the facility failed to ensure adequate staffing level to meet the needs of residents on the facility's second floor. This was evident for 1 (floor #2) out of 3 floors of the facility during the surveyor's initial tour. The findings include:During an interview of Licensed Practical Nurse (LPN) #17 on 12/4/25 at 7:50AM conducted by the surveyor, LPN #17 confirmed the second floor Unit Manager #18 was not here yet. On 12/4/25 at 8:26AM the surveyor observed the posted staffing on the board located near the nurse's station on the facility's second floor at which time it was noted that the staffing consisted of LPN #17, two Geriatric Nursing Assistants (GNA), and Unit Manager #18 for the 12/4/25 7am-7pm shift. On 12/4/25 at 7:39AM two urinals containing yellow liquid were observed by the surveyor on Resident #28's over bed table sitting next to their drinking water. On 12/4/25 at 7:55AM the surveyor shared the concern and conducted an interview with GNA #9. GNA #9 stated to the surveyor: Okay, I'll take care of it, I'm going to take care of it right after trays are passed. On 12/4/25 at 8:01AM the surveyor observed the housekeeping room located on the facility's second floor was left open with cleaning chemicals present within the closet and at this time shared the observation and concern with the facility's Administrator. On 12/4/25 at 8:04AM the surveyor heard and observed Resident #55 from the Resident hallway stating the following information: Get me out of bed, I'm going nuts. At this time the surveyor observed the Administrator put the call light on for the Resident. Resident #55 was observed and heard stating the following to the Administrator: I've been in this bed too long. On 12/4/25 at 8:09AM the surveyor observed that the personal protective equipment container was empty in Resident #72's room and their urinal was observed to be 3/4 of the way full of yellow liquid hanging on the side of their bed. GNA #9 and GNA #22 were both observed engaged in passing out breakfast trays to serve unit Residents their breakfast meal. On 12/4/25 at 8:16AM Resident #32 was observed sitting diagonally on their bed and stated to the surveyor that they needed their wheelchair because it was out of reach. At this time, the surveyor observed Resident #32's wheelchair was located out of reach near to the room's door. After surveyor intervention, both GNA #9 and #22 assisted the resident with their wheelchair. On 12/4/25 at 8:23AM the surveyor observed Resident #105 who was visible from the hallway standing in their doorway in their incontinence brief asking for assistance from staff to get dressed for the day. On 12/4/25 at 9:12AM the surveyor shared concerns with the facility's Director of Nursing, Administrator, and Administrator In Training #3 who acknowledged understanding of the surveyor's concerns. On 12/4/25 at 1:38PM Resident #50 reported to the surveyor that there was not a lot of staff on each floor. On 12/4/25 at approximately 1:45PM an anonymous family member reported to the surveyor that regarding facility staff responding to Resident needs: Sometimes they come, sometimes they don't, they have a lot going on and they are short staffed in my opinion. On 12/9/25 at 3:20PM the surveyor shared concerns with the facility Administrator and Administrator In Training #3 who acknowledged and confirmed understanding of the concerns and the surveyor was thanked by the Administrator for sharing the concerns. Refer to F695.

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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 record review and interview it was determined facility staff failed to ensure documentation of attempts made to offer advanced directives. This was evident for 1 (#43) out of 5 Residents reviewed for advanced directives during the facility's recertification survey. The findings include: Review of the medical record of Resident #43 by the surveyor on 12/4/25 at 4:56PM revealed there was no documentation able to be found regarding documentation of advance directives offered. Review of the facility's general admission packet revealed that advance directive information offered to Residents of the facility was contained within the packet. On 12/5/25 at 10:41AM the surveyor conducted an interview of the facility's Administrator at which time they reported that Staff #11 was the facility's Social Worker for the past six months. At this time the surveyor requested an interview of the facility Social Worker. On 12/5/25 at 10:45AM the surveyor conducted an interview of the facility's Director of Social Work (DSW) #11 who reported that they offer advance directives to residents upon admission and that the offering of advanced directives is documented in the resident's baseline care plan and their regular care plan. At this time the surveyor shared the concern.On 12/9/25 at 4:20PM the surveyor conducted another interview of DSW #11 who confirmed with the surveyor that they did not have anything documented that advance directives were offered to Resident #43. On 12/9/25 at 4:25PM the surveyor conducted an interview of Hospital Liaison #19 who confirmed that Residents receive the admission packet upon admission to the facility and advance directives information is given at that time, however, the offering of advance directives was not documented by admissions staff. On 12/9/25 at 4:43PM the surveyor conducted an interview of and shared concerns with the facility's Administrator who reported during the interview that their expectation was for the offering of advance directives to be documented by the facility Social Worker.