STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215340	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Point Healthcare Center	2525 West Belvedere Avenue Baltimore, MD 21215

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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 observation and staff interviews, it was determined that the facility failed to ensure that all areas were in good repair. This was evident on all the units in the facility during the recertification/complaint survey.The findings include.On 12/4/25 and 12/10/25 at 8:40 AM and 9 :00 AM respectively, an environmental round was conducted on all the facility units. Observation of the residents' rooms revealed environmental issues to include but not limited to:room [ROOM NUMBER] A/B- The wall paint was scraped off behind each resident's bed measuring about 6x3 feet. The paint on the door edges leading to the bathroom were peeled off and the door in the bathroom connecting to the next room had paint scrapes on the lower edges measuring about 3x1 foot long.In room [ROOM NUMBER], the door handle/Knob was almost off the hinges, and the curtain rods on the window frame were broken and taken down. The bathroom sink was partially pulled off the wall leaving a see-through gaping hole. The wall adjacent to the lateral side of the bed had paint scraping coming off the wall and measuring about 6x2 feet long.In room [ROOM NUMBER] B, the wall paint was scrapped off behind the head of the bed measuring about 4x3 feet.Behind the head of the 2 beds in room [ROOM NUMBER] were observed paint scrapes on the walls measuring 3x4 feet and 10x2 feet respectively while room [ROOM NUMBER]A had the wall paint scratched up behind the head of bed and measuring about 5x3 feet. The same was observed in rooms [ROOM NUMBERS]. In an interview with the maintenance person on 12/4/25 at 11:35 AM, the surveyor asked how staff let maintenance know when a piece of equipment needed to be fixed or that residents area needed to be fixed. The maintenance person stated that staff put information in TELS - a system that provide information to the maintenance department. He checks the system daily, makes walk rounds to look for things that need repair, or staff can call him on the phone or the walkie-talkie.On 12/10/2025 at 9:20 AM the Nursing Home administrator (NHA) and the director of Nursing (DON) were asked in an interview if they were aware of the above findings. The NHA said they've had issues with hiring a maintenance director but have support from their regional director of operations, the maintenance director from a sister facility and their maintenance associate. She said they are fully aware that these rooms are damaged and would need more help to get the building fixed up. They were made aware that this was a concern, they agreed that it was.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interviews it was determined that the facility failed to send a copy of the notice of discharge to the representative of the Office of the Long-Term Care Ombudsman. This was evident during the recertification/complaint survey. The findings include:On 12/03/25 at 11:21 AM review of resident #3's medical records revealed that resident was sent out to the hospital for a medical condition on 10/28/25 and came back to the facility on [DATE].On 12/08/25 at 2:30 PM the ombudsman revealed in an interview that she has not been receiving discharge notification from the facility since April/May of 2025 till date.In an interview with the nursing Home Administrator (NHA) on 12/08/25 at 3:37 PM, the NHA acknowledged that the facility has not been notifying their Ombudsman of discharges. She was made aware that it was a concern.On 12/09/25 at 10:16 AM The Director of Nursing (DON) was also asked if the facility notifies their ombudsman when residents are discharged and she confirmed that they do not. On 12/09/25 at 11:54 AM The NHA brought a document Blue Point HC November transfers and discharges, stating that it's a letter sent to the ombudsman regarding discharges which they have not been doing. She said it covers discharges from July through November which they just sent to the ombudsman. She explained that the social worker was supposed to be responsible for sending it to the ombudsman but there was a gap in their social work team and that's how it fell through the cracks. She confirmed that March 2025 was the last time the ombudsman received a copy of the discharges. She was made aware that this was a concern.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, it was determined that the facility failed to label oxygen tubing and humidifier bottle with date of change to indicate maintenance of respiratory equipment for proper hygiene and safety. This was evident of 5 (Resident #11, #49, #65, #90, and #134) of 7 residents observed for respiratory care during this recertification/complaint survey.The findings include:During the screening phase of the survey process on 12/03/2025 at 8:42 AM, surveyor observed Resident #49 and Resident #90 receiving oxygen through an unlabeled Nasal Cannula (N/C) tubing hooked to an unlabeled humidifier.A second observation was made on 12/4/2025 at 10:15 AM that prompted surveyor to observe other residents receiving oxygen. The surveyor observed the following residents: Resident #11- N/C tubing not labeled and humidifier not labeled Resident #65 - N/C tubing not labeled, and humidifier not labeled Resident #90 - N/C tubing not labeled Resident #134- N/C tubing not labeled, no humidifier in placeOn 12/4/2025 at approximately 11:30, an interview was conducted with the ADON (Staff # 4) who stated that oxygen tubing are changed every 7 days and as needed, and humidifiers are changed when emptied and both should be labeled with the change out dates. The ADON accompanied surveyor to verify that the tubing and humidifiers were not labeled for Resident #49 and Resident #90 who were on the same unit.On 12/4/2025 at 12:15 PM, record review of resident #49 noted an order for oxygen (O2) at 2L via NC continuous every shift for Shortness of Breath (SOB). The care plan documented that resident is on oxygen therapy as ordered and to change oxygen tubing per facility policy. On 12/9/2025 at 10:12 PM, the Nursing Home Administrator (NHA) provided the surveyor with the Supplemental Oxygen using Nasal Cannula procedure and standard policy, which indicated that oxygen is considered a medication and will be treated similarly and that nasal cannula tubing should be labeled when opened. On 12/09/2025 at 10:21 AM an interview was conducted with the Director of Nursing (DON) who stated that oxygen tubing should be changed out and labeled. Oxygen tubing is changed every 7 days, and the facility had provided education to the nursing staff that tubing and humidifier bottle should be labeled. The surveyor informed the DON that the findings were a concern, and the DON agreed that the N/C tubing and humidifiers should have been labeled.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record review and staff interview, it was determined that the facility failed to ensure that advance directives were discussed with residents and/or responsible representatives and/or a copy of an advance directive was in the medical record. This was evident for 2 (Resident #75 and Resident # 6) out of 3 residents reviewed for advanced directives during the recertification/complaint survey. The findings include: 1) On 12/03/2025 at 9:42 AM, a review of Resident #75's admission record revealed the resident was documented as his/her own representative. However, the medical record lacked evidence of an Advance Directive. On 12/04/2025 at 10:14 AM during an interview, the Social Worker stated she only informs Residents of their right to an advance directive, which is noted in their care plan. She clarified that the admission director is responsible for handling advance directives. On 12/04/2025 at 11:14 AM, review of the 11/03/2025 Social History assessment, Section C (Advance Directives) question 1, showed that none of the four options (Living Will, Durable Power of Attorney for Health Care, Behavior Health Advance Directive, and MOLST) were checked. Furthermore, there was no documentation of a discussion with Resident #75 regarding their right to formulate an advance directive. On 12/04/2025 at approximately 11:20 AM, further review of Resident #75's medical record revealed no evidence of a care plan for an advance directive. On 12/04/2025 at 12:29 PM, during an interview with the Admission's Director she claimed she only handles PASARR (Preadmission Screening and Resident Review) and the MOLST (Maryland Orders for Life-Sustaining Treatment) forms, not advance directives. On 12/04/2025 at 12:36 PM, the Administrator confirmed that there was no record of an advance directive for Resident #75 or evidence of documentation that a discussion occurred with Resident #75 regarding their right to formulate one. The Administrator was informed of the concern at this time. 2) During the record review for advance directive for Resident #6 on 12/3/2025 at 12:00, the Social Worker (SW) assessment note dated 11/17/2025 stated in Section C question 6- Advance Directive was uploaded under document tab. On 12/03/2025 at 12:15 PM, during the review of Resident #6's medical record, the surveyor could not locate a copy of an advance directive. During an interview with SW on 12/04/2025 at 10:14 AM, she/he stated that residents are informed of their right to an advance directive, which is noted in their care plan and that the admission Director handled the advance directives. On 12/04/2025 at 12:29 PM, an interview was conducted with the Admission's Director, who stated that she/he only handles PASARR (Preadmission Screening and Resident Review) and the MOLST (Maryland Orders for Life-Sustaining Treatment) forms, not advance directives, however, advance directive is discussed within the admissions process. The surveyor requested a copy of the advance (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directive that was documented as being uploaded in the document section of Resident #6's medical record. On 12/04/2025 at 12:36 PM, the Nursing Home Administrator (NHA) confirmed that there was no record of an advance directive for Resident #6. The NHA acknowledged that this was a concern.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of medical records and interview with facility staff, it was determined that the facility failed to notify the Physician that ordered labs were not obtained. This was evident for 1 (Resident #75) of 41 residents reviewed during the recertification/complaint survey.The findings include: On 12/04/2025 at 8:24 AM, in review of Resident #75's medical record revealed a physician order dated 12/01/2025 for labs to be obtained of a CBC (Complete blood count) and a CMP (Comprehensive Metabolic Panel) in am for the date of 12/02/2025. On 12/04/2025 at 8:26 AM, in review of Resident #75's progress note, dated 12/2/2025 at 07:14 AM, revealed: Unable to obtain blood specimen after two trials. Lab work rescheduled for AM on 12/3/25. On 12/04/2025 at 8:28 AM, in review of the medical record for Resident #75 showed that lab orders for CBC and CMP, dated 12/03/2025, were cancelled. Documentation noted the labs were unable to be obtained, facility aware. However, there was no documented evidence that a Physician was notified of the inability to obtain the ordered labs on either 12/02/2025 or 12/03/2025. On 12/4/2025 at 09:12 in further review of Resident #75's medical record revealed a late entry progress note, dated 12/03/2025, the note stated: resident labs were unable to obtain obtained, Nurse Practitioner (NP) made aware, orders given to repeat labs. This entry, however, was made following surveyor intervention. On 12/04/2025 8:37 AM, in an interview with Staff #5 (Unit Manager) explained that labs are drawn routinely or when a patient's condition changes. If a lab cannot be obtained, the nurse is required to notify the physician and document this in the medical record. However, Staff #5 stated she failed to document any notification to the physician in this instance. On 12/04/2025 at 9:31 AM, in an interview with the Director of Nursing (DON) stated that if resident labs could not be obtained, the nurse was expected to notify the Physician and document this in the medical record. The DON was informed of the concern regarding the notification process for labs at this time.

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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 medical record review and staff interviews it was determined the facility failed to implement recommended wound care treatments based on wound consults. This was evident for 1 (Resident #8) of 1 resident reviewed for pressure ulcer/injury during the recertification/complaint survey. The findings include:On 12/05/2025 at approximately 1:05 PM, review of Resident #8's November Treatment administration record (TAR) revealed physician orders dated 9/23/2025. Treatments included daily, as needed changes for sacral, right/left hip, and right ischium wounds. The sacral wound required cleansing with Dakin's solution, patting dry, applying Medihoney and calcium alginate, and covering with ABD pads then bordered gauze. Right/Left Hip wounds needed cleansing with Dakin's solution, patting dry, applying calcium alginate, and covering with ABD pads then bordered gauze. The right ischium wound required cleansing with Dakin's solution 0.125%, applying Medihoney and calcium alginate, and covering with ABD pads then bordered gauze.On 12/05/2025 at approximately 1:15 PM, review of Resident #8's November Treatment Administration record (TAR) revealed a Physician order dated 9/25/2025 for the Left Lateral ankle wound with Dakins Solution and apply Calcium Alginate with Medihoney cover with bordered gauze dressing every day and as needed.On 12/05/2025 at approximately 1:20 PM, continued review of Resident #8's medical record revealed wound assessment reports for the following dates of 09/24/2025, 10/01/2025, 10/09/2025, 10/15/2025, 10/22/2025, 10/29/2025, 11/05/2025, and 11/12/2025. These reports, signed by a wound Nurse Practitioner, consistently documented a Stage 4 pressure injury on the right hip and recommended the following treatment: daily cleansing, application of Dakins moistened fluffed gauze and Santyl, secured with bordered gauze and an ABD pad. However, the treatment administration records for September, October, and November indicated that Resident #8 continued to receive the original order from 09/23/2025, which included: Right/Left Hip wounds needed cleansing with Dakin's solution, patting dry, applying calcium alginate, and covering with ABD pads then bordered gauze.During an interview on 12/05/2025 at 1:48 PM, the Director of Nursing (DON) described the facility's wound care process. A Nurse Practitioner assesses residents with wounds and makes recommendations for treatment changes, which the wound nurse is then responsible for implementing and updating treatment orders. The DON confirmed that the recommended change in wound treatment for Resident #8's right hip wound was never implemented between 09/24/2025 and 11/12/2025.On 12/05/2025 at 1:55 PM, further review of Resident #8 medical records revealed a physician order dated 11/13/2025 to schedule the next appointment with MedStar Wound Healing.On 12/05/2025 at approximately 2:05 PM, further review of Resident #8's November Treatment Administration Record (TAR) showed an active physician's order from 11/14/2025 to 11/18/2025. This order was to be completed daily, and as needed wound cleansing with Dakin's solution, application of Aquacel Silver (including gentle packing for all wounds), and covering with gauze and foam border dressings or ABD pads secured with tape. The TAR also contained September wound treatment orders, indicating the resident was receiving two different wound treatments during that five-day period. On 12/08/2025 at 8:56 AM, the DON provided the surveyor with Medstar Wound Clinic documents from 11/13/2025 and 11/25/2025. These recommended daily wound care for all wounds: cleansing with Dakin's, applying Aquacel Silver, gently packing into sacral wounds, and covering with gauze/foam/ABD pads. The DON stated that if a Resident has two different wound providers, the facility should follow the outside clinic's recommendations. The facility's Director of Nursing (DON) confirmed a failure to implement the recommended wound care for Resident #8. The resident received the proper treatment for only five days in November, which resulted in the continuation of treatments that had been ongoing since September. The DON was notified of this concern.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation and interview with facility staff, it was determined that the facility failed to ensure that a resident was provided with splints based on the recommendations of the rehabilitation staff. This was evident for 1 (Resident #10) of 3 Residents reviewed for position and mobility during the recertification/complaint survey.The findings include:According to the Cleveland Clinic contractures affect one's skin, muscle, joints, tendons or other soft tissue. It happens when scarring or fibrosis makes the tissues tighten and stiffen. Without intervention, contractures can permanently reduce range of motion.According to the Cleveland Clinic, a splint, is a medical device that stabilizes a part of your body and holds it in place. On 12/08/2025 at 8:34 AM, during an observation and interview, Resident #10 reported being unable to use or straighten their contracted left hand.On 12/08/2025 at 10:02 AM, the Rehab Director confirmed Resident #10 received therapy from 08/25/2025 to 09/23/2025 for a left-hand contracture, with a recommendation for a resting hand splint and left elbow extension splint. He stated Therapy is responsible for training the Geriatric Nursing Assistants on application and reviewing with Unit Managers. The Therapy Manager verified Resident #10 had no splints available and they would need to be ordered. On 12/08/2025 at approximately 10:30 AM in review of and Occupational Therapy note provided to surveyor by the Rehab Director with a certification period from 08/25/2025 through 09/23/2025 revealed a goal of Resident #10 would wear a resting hand splint on the left hand and left wrist, and a left elbow extension splint for up to 2 hours with minimal signs or symptoms of redness, swelling, discomfort, or pain. On 12/08/2025 at 10:58 AM, an interview with the Director of Nursing (DON) explained the process for a Resident for splints would come from a recommendation from therapy that is communicated in the morning clinical meeting. Therapy would train the Geriatric Nursing assistants (GNA) on how to apply the splints and when to apply. This would be documented in the task (a reference for GNA's to refer to for resident care) for the GNA to apply. On 12/08/2025 at 11:00 AM, in review of Resident #10's medical record specifically the task section, no instructions for splint application by the GNAs for Resident #10 were found. On 12/08/2025 at 11:24 AM, the Director of Rehab returned and stated the Splint for Resident #10 was ordered and received on 12/05/2025. Therapy re-evaluated Resident #10 and provided the Surveyor with an evaluation dated 12/08/2025 that indicated a focus on proper application, wearing schedule (left hand splint up to 4 hours, left elbow splint up to 2 hours), and caregiver education. The Rehab Director verified this was completed after surveyor intervention.On 12/10/2025 at approximately 9:00 AM, the Director of Nursing (DON) provided the surveyor with a Task list report for Resident #10, that indicated Resident #10 was to wear a resting left-hand splint and left elbow extension splint with instructions. The DON verified this was only done after surveyor intervention. The DON was notified of the concern at this time.

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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. Based on observation, resident interview, record review, and staff interviews, it was determined that the facility failed to provide appropriate pain management. This was evident for 1 (Resident #75) out of 2 residents reviewed for pain during the recertification/complaint survey.The findings include: A pain scale is a numerical scale, usually 0-10, used to determine the severity of a person's pain. Parameters (Instructions in order on when a medication can be given) for a pain scale are used to determine which pain medication would be given according to a person's severity of pain. On 12/02/2025 at 9:30 AM, Resident #75 was observed in the hallway, sitting in a wheelchair and moaning in pain. On 12/02/2025 at 12:20 PM, Resident #75 was observed moaning and reported experiencing inadequate back pain relief despite receiving medication. On 12/03/2025 at 2:49 PM, in review of Resident #75's medical record revealed a Physician order dated 11/24/2025 for oxycodone HCl Oral Solution 5 MG/5ML (Oxycodone HCl) give 5 ml by mouth every 8 hours as needed for severe pain 7-10. On 12/03/2025 at approximately 2:53 PM, in review of Resident #75's medical record revealed a Physician order dated 10/31/2025 for Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for Mild Pain 1-3. On 12/04/2025 at 8:05 AM, in review of Resident #75's November medication administration record (MAR) showed Oxycodone was administered 11 times for pain scores below 7, and Tylenol was given once for a pain score of 5 on 11/5/2025. On 12/04/2025 at 8:37 AM, Staff #5 (Unit Manager RN) outlined the pain protocol as a nurse would assess for pain, attempt a non-pharmacological interventions first; if those are ineffective, establish the pain scale, administer appropriate medication based on the scale, and then reassess for effectiveness. Staff #5 confirmed that Resident #75's pain medication was not administered according to the established appropriate pain parameters. On 12/04/2025 at 9:31AM, in an interview with the Director of Nursing (DON) clarified that nurses are expected to adhere to the pain management parameters detailed in the physician's order. The DON was informed of the concern at this time.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of medical record and interview with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #5) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include: On 12/4/2025 at 8:44 AM, The surveyor received copies of the Medication Regimen Review (MRR) for the past 6 months from the Director of Nursing for Resident #5. During the review of the MRR documents on 12/4/2025 at 08:45 AM, the MRR dated 10/8/2025 had the following recommendation: Please consider monitoring a TSH level on the next convenient lab day to monitor this change in therapy. The copy was not signed or dated. A review of Resident #5's medical record on 12/04/2025 at 08:48 AM, noted that there was no order documented for a TSH level from 10/8/2025 to current date of 12/4/2025. During an interview with the Director of Nursing (DON) that took place on 12/04/2025 at 9:04 AM, the DON stated that the process for processing pharmacy recommendations is that the recommendation is sent to the DON and the In - house Nurse Practitioner (NP) via email on the same day that the recommendation were made. The NP reviews it as soon as possible and then lets the unit manager or the nurse know of the recommendation; and that is why the copy provided to the surveyor is not dated or signed. Surveyor requested documentation that the recommendation from 10/8/2025 for Resident #5 was completed.On 12/04/2025 at 11:46 AM, the Nursing Home Administrator (NHA) stated that there was no documentation that the recommendation was completed and that the facility missed the order. The surveyor informed the NHA that this was a concern, and the NHA acknowledged the concern and stated that the facility will follow up on the recommendation.

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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 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, staff interviews and record reviews, it was determined that the facility failed to ensure that it was free of medication error rates of five percent or greater. This was evident during observation of med pass on 2 of the 2 units in the facility during a recertification/complaint survey.The findings includeOn 12/08/25 at 8:20 AM an observation of med pass was conducted on the basement floor with Staff #15, a Registered Nurse (RN). Resident #90's two eye drops Cosopt ophthalmic solution and artificial eye drop were not given, Staff #15 stated that she could not find them and will call pharmacy to bring it stat. On 12/8/25 at 9:52 AM during another med pass observation for Resident #36 with staff #16 a certified medicine aide (CMA), the resident was ordered Visine ophthalmic and Systane ophthalmic eye drops for dry eyes, the CMA could not find the eye drops, she said the facility allows them to use the artificial tear drops as substitutes.Review of the physician's order for Resident #36 did not reveal an order to substitute any of the eye drops with the artificial tear drops. Staff #18 a registered nurse (RN) was standing by, she stated that both eye drops will be reordered and confirmed that both medications cannot be substituted with the artificial tear drops.On 12/8/25 at 12:15 PM the surveyor asked Staff #15 again about the eye drops for Resident #90, she stated that pharmacy would deliver it that day. That the eye drops were supposed to be reordered when it was noted to be running low. She confirmed that Resident #90 did not get their morning doses of eye medication.In an Interview on 12/8/25 at 9:30 AM, the director of nursing (DON) was asked the process for reordering medications. She stated that it was the responsibility of the assigned nurses to reorder medications when they observe them running low or call pharmacy to send it Stat.The DON and the administrator were made aware that both residents missed their morning eye drops and that staff were substituting medications without orders and that their med error rate was 13.33%. The DON stated that she will follow up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215340	A. Building B. Wing	12/10/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview and record reviews, it was determined that the facility failed to 1) appropriately store drugs for Resident #121 and, 2) label drugs and biologicals in accordance with currently accepted professional standards. This was evident for 2 of 2 nursing units observed during the recertification/complaint survey.The findings include1) On 12/02/25 at 1:08 PM Observation of a medicine cup in Resident #121's room with 4 pills were made including an inhaler labelled Symbicort 160 mcg/4.5 mcg, 2 puffs twice a day and an icy hot max pain relief lidocaine cream 2.7 oz bottle. The resident stated it was his Gabapentin and Tylenol and that the inhaler was from the hospital.On 12/02/25 at 1:16 PM Staff #3 a Certified medicine Aide (CMA) was asked about the medication at the bedside. She said the medications should not be left at the bedside and verified the surveyors' findings. In an Interview with the Director of Nursing (DON)/Administrator on 12/03/25 at 9:03 AM. They stated that there is a protocol for medications at the bedside and that Resident #121 can keep his icy hot pain medication, but no other medication. They were made aware that this was a concern at this time. 2) On 12/8/25 at 8:55AM review of the med cart on the basement floor with Staff #15 a Registered Nurse (RN) revealed a medication for Resident #54- Vit D3 25 mcg (1000 U) take one tab daily, it was not dated with an open date. Also Observed on the med cart on the A/B wing with Staff #3 a certified medicine Aide (CMA) was a medication for heartburn relief in a white medicine container labelled Famotidine 20mg tablet an inhouse stock, it was not dated with an open date.On the A/B wing med. room, was observed in the refrigeration on 12/8/25 at 10:18 AM a liquid medication in a dark brown bottle for Resident #60. It was labelled-Gabapentin 250mg/5ml, it was 1/3 full and was not dated with an open date.On 12/8/25 at 10:21 AM this medication was shown to Staff #17 a Licensed Practical Nurse (LPN) who confirmed that it was not dated. He was asked about the process for labelling multi-dose medications, and he said medications should be dated with an open date to indicate when they were opened.Review of resident #54's physician's order on 12/8/25 at 10:23 AM revealed an order written as Cholecalciferol Tablet 1000 UNIT Give 1 tablet by mouth, one time a day for supplement. Further review of Resident #60's physician's order revealed an order written as Gabapentin Oral Solution 250 MG/5ML (Gabapentin) Give 6 ml by mouth three times a day for Neuropathy. This confirmed that both residents were actively taking these medications.On 12/8/25 at 10:30AM the Director of Nursing (DON) and the Nursing Home administrator (NHA) were made aware of the findings, they stated they will follow up.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on medical record review and interviews, it was determined that the facility failed to provide Dental services. This was evident for 3 (Resident #4, #12, and #8) of 4 residents reviewed for dental services during the recertification/complaint survey. The findings include: 1) During the investigative interview on 12/03/2025 at 9:17 AM with Resident #4, the resident stated my teeth are falling out, and I need dentures. Surveyors observed missing teeth on the top and bottom areas of the resident's mouth. A record review on 12/04/2025 at 8:25 AM noted that Resident #4 had a consult ordered on 10/3/2025 for: Audiology, Dental, Optometry, Ophthalmology and/or Podiatry as needed. 2) During the investigative interview on 12/3/2025 at 8:54 AM, Resident #12 stated, I have been at this facility for a couple years, and I have not seen a dental hygienist or dentist. I am losing my teeth and would like dentures. A record review on 12/04/2025 at 8:35 AM noted that Resident #12 had a consult ordered on 11/29/2023 for: Audiology, Dental, Optometry, Ophthalmology and/or Podiatry as needed. On 12/04/2025 at 8:57 AM, an interview was conducted with ADON who stated that when a resident complained of dental pain or discomfort the information is given to the Social Worker (SW) to place them on a list. The new admissions are also seen on the upcoming appointment list for Health Drive, who come to the facility quarterly, annually and as needed. An interview was conducted on 12/04/2025 at 10:45 AM with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) regarding dental services at the facility. The NHA stated that residents are seen by Health Drive, a service provider that came to the facility to provide dental service to the residents. The NHA also stated that the list of residents to be seen are sent to Health Drive by the Social Worker and Health Drive will send a list of the residents back to the facility of the residents they will treat when they come to the facility. Surveyor requested a copy of the list of residents seen for the past 6 months. On 12/04/205 at 2:32 PM, The NHA provided a list of residents who were seen for dental care from 01/01/2025 to 12/04/2025 and Resident #4 and Resident #12 were not listed. On 12/5/2025 at 8:17 AM, the NHA provided the surveyor with a list of a Facility Census Audit for dental, eye, and audiology services provided for each resident in the facility from last visits to upcoming visits; Resident #4 and Resident #12 were not on the list. The NHA was made aware this was a concern, and the NHA acknowledged the concern and stated that the residents will be enrolled in the Health Drive program so that they can be put on the list to be consulted for dental services. 3) On 12/04/2025 at 3:14 PM, Resident #8's medical record revealed a Physician order dated 10/29/2025 for a Dental consultation for a broken tooth. On 12/04/2025 at 3:16 PM, in review of Health drive (Dental services used by the facility) list provided by the Administrator Resident #8 was not on the list as being seen or scheduled to be seen. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/2025 at 9:15 AM, during an interview with the Director of Nursing (DON) described the Dental consult process: Social Worker (SW) faxes a list to Health drive, which visits monthly for routine and as-needed consults. Nurses notify SW of new physician orders for Health drive. She verified Resident #8 was not on the health drive list and had not been seen, though the DON would have expected Resident #8 to have been seen if a dental consult physician order was placed for a broken tooth. On 12/05/2025 at 9:22 AM, during an interview with the Administrator explained that Residents must be enrolled to be seen by Health Drive. Resident #8 has not received services and requires an enrollment form (request for services form). The Administrator was notified of this concern at this time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determine that the facility staff failed to 1) follow the facility infection prevention policy to operate on a systematic and organized date-driven method track and trend for in-house infections effective and timely, and 2) maintain/use laundry dryers according to the manufacture's instructions for use. The second one was found to be evident of 3 out of 3 dryers observed during the recertification/complaint survey.The findings include-1) On 12/04/2025 at 08:50 AM, observation and interview of Residents' 2nd floor revealed that Infection isolation signs were up in some of the resident's doors. However, the staff was not sure the reasons why.On 12/04/2025 at 9:49 AM during an interview, The Infection preventionist Staff #19 stated she using infectious diagnosis daily information to format her worksheet. However, she did not follow the facility policy to run a systematic and organized data-driven method to track/ trend the rough data. She could not provide any back-up reports from Regional office in McGeer Criteria either.During Record Review, on 12/04/2025 at 10:59 AM, the Infection Prevention binder was examined and revealed that it only had about one year's worth of worksheets and Resident print-outs in chronological order but no data analysis or trending data records.In an Interview, on 12/08/2025 at 02:12 PM, The Director of Nursing reported that she was aware that the Infection Preventionist did not have a method to track/trend the in house infections.2) Laundry observation, on 12/04/2025 at 11:59 AM, revealed that 3 dryers were in poor condition, and full of debris caught in the drum's wall i.e. melted diapers, gloves, food and unknown items. The Administrator was present at the time and agreed it was not acceptable.In an Interview, On 12/04/2025 at 12:05PM, the Laundry manager Staff #20 stated that it was her mistake to check if her staff screen the dirty laundry and take out all objects. Further interview was conducted with the maintenance staff #21 who stated they did not keep a washer/dryer manufacture's instruction book on hand.On 12/04/2025 at 13:05PM, Record review of the laundry service record revealed that only the dryer exhausted air duct had a recent service. No other record including the dryer manufacture's instructions was revealed.On 12/08/2025 at 10:22 AM an observation was conducted, after surveyor's intervention, all 3 dryers' inside drum metal walls were cleaned, temperature was tested within functional range by the service company this AM. On 12/08/2025 at 2:12 PM, a further interview was conducted with the Administrator and the above findings were reviewed. She agreed that her staff did not follow the policy and procedure and both were concerns of deficient practices.