STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interview it was determined that the facility failed to develop and implement policies and procedures for medication regimen reviews, as evidenced by 1) failing to ensure that pharmacist identified irregularities reviewed by the attending physician, along with the action taken or not taken including rationale, was documented in the resident's medical record, and 2) failing to ensure medication irregularities were identified during monthly medication regimen reviews. This was evident for 4 (#6, #5,#16, #13) of 5 residents reviewed for unnecessary medication.The findings include: 1) On 3/11/26 at 2:45 PM, a review of Resident #6's February 2026 Medication Administration Record (MAR) revealed a 1/31/26 physician order for Metoprolol (lowers blood pressure) ER (extended release) by mouth one time a day for hypertension (HTN) (high blood pressure (BP)), hold for systolic (S) (top BP number) less than 110, or Pulse (P) less than 60 that documented Resident #6 received the Metoprolol every day in February. There was no documentation in the MAR to indicate that prior to the administration of metoprolol, Resident #6's BP and P was obtained, and metoprolol administered within the prescribed parameters. Review of Resident #6's March 2026 MAR revealed a 1/31/26 physician order for Metoprolol ER by mouth every day for HTN, hold for SBP less than 110 or P less than 60. The MAR documented Resident #6 received Metoprolol every day 3/1/26 to 3/12/26 with no documentation to indicate that prior to the administration of metoprolol, Resident #6's BP or P was obtained, and the metoprolol was administered within the prescribed parameters. On 3/18/26 at 9:02 AM, a review of Resident #6's electronic medical record (EMR) revealed monthly Pharmacist medication regimen reviews (MRR) on 2/2/26, 2/9/26 and 3/11/26 that documented see report for any noted irregularities and/or recommendations with no corresponding written reports of the pharmacist identified irregularities and recommendations found in the medical record and no documentation of the physician's potential response to the recommendations found in the medical record. A review of a binder located on the nurse's station and labeled, Note to Attending Physician/Prescriber, dated 1/26/26 - 3/2026, revealed pharmacist reports for resident MRR reviews conducted since 1/1/26. Review of the written reports for Resident #6's MRR reviews conducted on 2/2/26, 2/9/26 and 3/11/26 found documentation of irregularities identified by the pharmacist and the physician response to the pharmacist's recommendation which was not documented in the medical record. In addition, Resident #6's MRR reports revealed the pharmacist failed to identify the irregularity related to administration of medication without evidence of adequate monitoring. Cross Reference F 757 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 3/18/26 at 9:02 AM, a review of Resident #5's EMR revealed Pharmacist monthly MRR reviews on 3/10/25, 4/22/25, 5/20/25, 8/11/25, 9/9/25, 11/12/25 that documented see report for any noted irregularities and/or recommendations with no corresponding reports of the irregularities identified by the pharmacist, or the physician's potential response to the recommendations were found in the medical record. The Nursing Home Administrator (NHA) provided the surveyors with written reports dated 1/24/25 – 12/9/25 for all residents with pharmacist recommendations and indicated the pharmacist reports were in the Director of Nurses (DON) office and in a binder at the nurses station and had not bee uploaded into resident records. Review of the written pharmacist reports revealed a written reports for Resident #5 dated 3/10/25, 4/22/25, 5/20/25, 8/11/25, 9/9/25, 11/12/25 which documented pharmacist identified irregularities and recommendations, along with the physicians response which had not been documented in the medical record. On 3/19/26 at 12:15 PM, the above concerns were discussed with the NHA, who acknowledged the concern and offered no further comments at that time. 3) Resident #16's medical record was reviewed on 3/18/26 at 10:20 AM. Review of the monthly Pharmacist Consult Notes reflected that irregularities were identified for Resident #16 on 3/11/26, 2/9/26, 1/20/26, 11/12/25, 10/21/25, 7/22/25, 6/17/25, 5/20/25 and 4/22/25 and indicated see report. No reports of the irregularities identified by the pharmacist including physician response were found in the record. An unidentified unit staff member produced a binder from a shelf in the nurses' station containing the consultant pharmacist reviews for all residents titled Note to Attending Physician/Prescriber dated from 1/2026 – 3/2026. The reports for Resident #13 were in the binder with dated notation and signature of the provider. However, the resident's medical record did not reflect the irregularities identified by the pharmacist and the physician's response. The binder contained no record of reviews conducted prior to 1/2026. On 3/18/26 at 1:05 PM the Administrator provided a stack of Pharmacy review reports titled Notes to Attending Physician/Prescriber dated 1/24/25 – 12/9/25. She indicated they were for all of the residents with pharmacist recommendations and were in the DON's (Director of Nursing's) office. She was asked where to find the documentation of the irregularities/recommendations identified by the pharmacist and the physician's response, in the residents' medical records. She indicated the review forms would be placed in the resident's records and confirmed that the forms were in the DON's office and in the binder on the unit and were not yet uploaded in the resident records. Therefore, the irregularities/recommendations and the providers response were not currently documented in residents' records. 4) Review of Resident #13's medical record and the consultant pharmacist review forms on 3/18/26 at 2:31 PM revealed that irregularities/recommendations were identified by the pharmacist for Resident #13 on 4/22/25, 5/20/25, 7/22/25, 8/18/25, 9/9/25, 11/12/25, and 1/20/26. These reports were included in the documents located in the binder or DON's office and were not documented in the resident's medical record with the physician's response. These concerns were reviewed with the Administrator on 3/19/26 at 10:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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 the facility staff failed to reveal evidence that the resident or resident representative was informed of their right to formulate an advanced directive, and failed to ensure that a current copy of a resident's advance directive was in the resident's medical record. This was evident for 3 (#5, #12, #4) of 11 residents reviewed for advanced directives. The findings include: Advanced Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual are not able to make their own decisions. 1) On 3/10/26 at 11:50 AM, a review of Resident #5's paper medical record failed to reveal an advance directive for Resident #5. Review of the electronic medical record (EMR) on 3/13/26 at 11:07 AM revealedResident #5 resided in the SNF since March 2023, and no documentation was found in the EMR to indicate the resident had an advance directive, whether the resident/representative was informed of the right to formulate an advanced directive or wished to formulate an advanced directive. 2) On 3/10/25 at 12:00 PM, a review of Resident #12's paper medical record failed to reveal an advance directive for Resident #12. Review of the EMR on 3/13/26 at 10:00 AM, revealed Resident #12 resided in the SNF since December 2025, and no documentation was found to indicate the resident had an advance directive, or whether the resident/representative was informed of his/her right to formulate an advanced directive or wished to formulate an advanced directive. 3) On 3/10/25 at 12:49 PM, a review of Resident #4's paper medical record failed to reveal an advance directive for Resident #4. Review of the EMR on 3/13/26 at 11:07 AM revealed Resident #4 resided in the SNF since October 2025 and no documentation was found to indicate the resident had an advance directive, or whether the resident/representative was informed of his/her right to formulate an advanced directive or wished to formulate an advanced directive. On 3/13/26 at 1:19 PM, during an interview, when asked how, when a resident was admitted to the SNF, it was determined whether the resident had an advance directive and, if not, whether the resident wished to formulate an advance directive, Staff #9, Social Worker, Staff #9 stated that prior to January 2026, the SNF, which is part of a continuing care retirement community (CCRC), only admitted residents within the CCRC and s/he could get a copy of a resident's advanced directive from the CCRC' s wellness center (health clinic). When asked the process for addressing advanced directives with newly admitted residents who were not the CCRC, Staff #9 stated a marketing person addressed those resident admissions and indicated that s/he recently created a check list for admissions that included advanced directives. Following the interview, Staff #9 was made aware of the above concerns with advanced directives not being found in the resident's medical record with no documentation to indicate the resident and/or the resident's representative had been informed of the right to formulate an advanced directive. On 3/13/26 at 3:10 PM, Staff #9 provided the surveyor with a copy of an advanced directive for Resident #5, a copy of an advanced directive for Resident #4 and stated s/he still had to get one for Resident #12. As of the end of the survey, no additional documentation was provided to the surveyor. On 3/19/26 at 12:15 PM, the Nursing Home Administrator (NHA) was made aware of the above concerns. At that time, the NHA acknowledged the concerns and offered no further comments. No additional documentation was provided to the surveyor regarding as of the time of exit on 3/19/26 at approximately 12:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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 record review and interview it was determine the facility staff failed to notify the physician when a resident was identified to have a significant weight loss. This was evident for 1(#13) of 5 residents reviewed for Nutrition.The findings include:Resident #13's medical record was reviewed on 3/10/26 at 1:12 PM. The resident's weight record in the EMR (Electronic Medical Record) revealed that on 12/5/25 the resident weighed 320 lbs.(pounds). No weights were recorded for January or February 2026. Resident #13's next documented weight was 3/4/26 by Staff #4 the MDS nurse. The resident's weight at that time was 281.8 lbs. It was checked and recorded again the next day 3/5/26, as 281.8 lbs. by Staff #6 an LPN (Licensed Practical Nurse). The weights obtained on 3/4/26 and 3/5/26 reflected a 38.2 lb. or 11.94% significant weight loss over 3 months. A weight change note was written on 3/5/26 by the DON (Director of Nursing) for Weight Warning and reflected Resident #13's significant weight loss and included Dietitian will address, will have him/her on weekly weight. A Quarterly Nutrition Evaluation dated 3/5/26 by the Dietician addressed Resident #13's significant weight loss, his/her nutrition diagnoses and indicated that the resident had no nutritional deficiency per available labs. and that his/her Glycemic control was adequate.Resident #13's Nutrition Plan of Care developed on 12/5/24 was revised on 3/5/26. One of the Care Plan intervention initiated on 12/5/24 was: Weigh per orders and alert MD (Physician)/RD (Registered Dietician) of any significant weight changes. There was no indication that the physician or another medical provider was notified when Resident #13 was assessed to have a significant weight loss on 3/4 and 3/5/26. Further review of the medical record on 3/12/26 at 2:08 PM revealed a monthly provider note written by Staff #10, a CRNP (Certified Registered Nurse Practitioner) on 3/11/26 at 3:42 PM. The note included Appetite satisfactory, weight stable. There was no documentation to indicate that the CRNP was aware that Resident #13 was assessed to have a significant weight loss on 3/4/26. An interview was conducted on 3/17/26 at 11:21 AM with Staff #4 the MDS (Minimum Data Set) nurse, who was filling in while the Director of Nursing was away. She was made aware of the above findings. When asked if it would be documented in the resident's record that the physician was notified of the resident's weight changes she indicated that it should be. The Administrator was made aware of these findings on 3/19/26 at 10:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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 observation, medical record review and staff interview it was determined that the facility failed to develop and implement comprehensive resident person-centered care plans with measurable goals and interventions. This was evident for 1 (#18) of 3 resident's reviewed for respiratory care, and 2 (#6, #5) of 5 residents reviewed for unnecessary medications.The findings include: The MDS (Minimal Data Set) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1.) On 3/9/26 at 11:53 AM the surveyor observed Resident #18 lying in bed wearing a nasal cannula (NC). A nasal cannula is a tube used to administer oxygen through the nose. The cannula was connected to an oxygen concentrator (a machine that concentrates and delivers oxygen from room air). Review of Resident #18's medical record on 3/13/26 at 11:21 AM revealed a physician order for Oxygen at 2L/min (2 Liters per minute) via NC as needed for SOB (shortness of breath). The order was included on Resident #18's TAR (Treatment Administration Record) with spaces for staff to document and sign off when they administer the oxygen. For the month of March 2026 Resident #18's oxygen was signed off as administered on 3/6/26, and 3/10/26. It was not signed off as administered on 3/9/26 as observed by the surveyor. The February 2026 TAR revealed that supplemental oxygen was administered to Resident #18 on 2/13/26. Review of Resident #18's Plans of Care revealed the facility staff failed to develop a Plan to address Resident #18's respiratory/pulmonary problems or the need for or use of supplemental oxygen. During an interview on 3/13/26 at 12:28 PM Staff #8 the CRNP (Certified Registered Nurse Practitioner) indicated that Resident #18 was prescribed oxygen for Diastolic Heart Failure and history of Pulmonary Embolism. Staff #4 the MDS (Minimum Data Set) nurse was made aware of these findings on 3/17/26 at 11:28 AM. She provided no explanation as to why the Plan of Care did not identify Resident #18's need for and the provision of supplemental oxygen. The facility Administrator was made aware of these concerns on 3/19/26 at 10:00 AM. Cross reference F 695. 2.) On 3/12/26 at 10:00 AM, a review of Resident #6's electronic medical record (EMR) was conducted. The medical record documented Resident #6 was admitted to the facility in late January 2026 for rehabilitation following a revision of a left hip hemiarthroplasty (a surgical procedure to treat hip fractures). A hospital Discharge summary dated [DATE] documented Resident #6 required a left knee immobilizer and hip abduction brace and would be required to wear the brace for 3 months and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could only be removed for showers with care to hold the leg in a neutral position. Review of Resident #6's physician orders revealed a 2/1/26 order, Resident to be in bed with pillows for pressure relief 24/7. Bed cannot be rolled up past 60 degrees. Resident cannot be up in wheelchair unless cleared by ortho, a 2/2/26 order, Left Hip abductor brace and left knee extension brace to be worn at all times, May be removed briefly for showers with someone holding the left leg to support the left leg during shower; a 2/9/26 order, Abductor pillow to be worn at all times. Check for skin integrity; a 2/27/26 order, Abduction wedge to be used at all times while patient is in bed. Resident #6's admission MDS assessment with an assessment reference date (ARD) of 2/5/26 documented that the resident had severe cognitive impairment, that s/he had functional limitations in range of motion (ROM) of one of his/her lower extremities, and the resident was dependent on staff for all activities of daily living. The MDS further documented Resident #6's had diagnosis that included dislocation of internal left hip prothesis, presence of left artificial hip joint, and the resident also had a diagnose of a seizure disorder. Review of Resident #6's care plans failed to reveal evidence that a comprehensive care plan, with measurable goals, and resident centered interventions had been developed to address Resident #6's limited range of motion, immobility and positioning needs following his/her surgical revision of left hip hemiarthroplasty, and use of a left hip abduction brace and left knee extension brace which the resident was required to wear 24 hours a day, as well as the abduction pillow required to maintain proper leg alignment. Further review of Resident #6's care plans failed to reveal a comprehensive care plan had been developed to address Resident #6's ADL (Activity of Daily Living) and functional care needs. Resident #6's had care plan, Current ADL (Activities of Daily Living) - Functional Status initiated 1/30/26 with the goal, Resident #6 will maintain or improve current functional ADL abilities, had one intervention, Ambulation: 2 person assist. The care plan's only intervention was inaccurate, as Resident #6 was non-ambulatory. In addition, the resident had a care plan, Resident #6 at risk for functional abilities, decline, initiated on 1/30/26, with the goal, the resident will return to desired level of function with the interventions, assess [Resident #6] current functional level, and Physical therapy, Occupational Therapy and Speech Therapy to eval and treat per physician order. The care plan was not comprehensive and failed to included interventions specific to the resident. Continued review of Resident #6's care plans failed to reveal a comprehensive care plan had been developed to address Resident #6's ADL and functional care needs. Review of Resident #6's February 2026 Medication administration record (MAR) revealed a 1/31/26 physician's order for Topiramate (Topamax) (ant-seizure medication) by mouth in the morning for seizures that was documented as given every morning in February and the resident's February 2026 treatment administration record (TAR) had a 2/2/26 order for seizure precaution (safety measures to prevent injury to the resident during a seizure). Continued review of the resident's care plans failed to reveal a comprehensive, resident centered care plan, with measurable goals and interventions had been developed to address Resident #6's seizure disorder. On 3/17/26 at 12:24 PM, when asked who responsible for developing resident care plans, Staff #6, Licensed Practical Nurse (LPN) indicated resident care plans would be initiated by the nurse, then modified, or made resident centered by MDS and MDS was responsible for reviewing care plans and making any changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/17/26 at 3:03 PM, Staff #4, Registered Nurse, MDS Coordinator stated s/he was responsible for initiating and updating resident care plans. The above concerns were then discussed with Staff #4, who confirmed the findings and offered no further comments at that time. 3) On 3/18/26 at 9:02 AM, a review of Resident #5's medical record was conducted and revealed the resident resided in the skilled nursing facility for long term care since the end of March 2023. Review of Resident #5's Significant Change MDS with an ARD of 1/15/26 documented Resident #5 was moderately cognitively impaired and had an active diagnosis of Non-Alzheimer's dementia and anxiety disorder. Review of Resident #5's progress notes revealed, on 3/9/26, in a Health Services note, the Certified Registered Nurse Practitioner - Psychiatric Mental Health (CRNP-PMH) wrote the reason for the visit was for follow-up evaluation of mood and management of psychotropic [medication]. The CRNP-PMH documented Resident #5's had psychiatric history of dementia, aggressive behavior and agitation, with target symptoms of intermittent insomnia, intermittent depressive symptoms and intermittent dementia related agitation/anxiety. In a practitioner encounter note for routine follow-up, on 3/11/26, the CRNP wrote that Resident #5's medical history included unspecified dementia, moderate mood disorder, mild cognitive impairment, and generalized anxiety disorder. The CRNP's assessment and plan documented Resident #5 had moderate dementia with mood disturbance, stable baseline with decline anticipated due to natural disease progression, and agitation due to dementia; continue Depakote. Review of Resident #5's February 2026 MAR revealed a 7/9/24 order for Depakote (divalproex) (anticonvulsant, mood stabilizer) by mouth 2 times a day for mood disorder that was documented as given 2 times a day, every day in February. Resident #5's March 2026 MAR documented the resident received Depakote by mouth 2 times a day, every day from 3/1/26 to 3/17/26 for a mood disorder. 3a.) Review of Resident #5's care plans revealed a care plan, Resident #5 uses antipsychotic medications: Depakote, with the goal, will be free from side effects due to the use of antipsychotic medication through the review date, and the interventions, 1. administer medication as ordered, 2. AIMS Test every six months and as needed, 3. Behavior Health Services Consult as ordered, 4. Consult with MD to consider dose reduction at least every three months, 5. Educate the resident/family/caregivers on the risk, benefits, potential side effects, reason for medication, and alternatives to antipsychotic medications, 6. Monitor Vital Signs as ordered. Report abnormalities to HCP, 7) Monitor/record/report to MD side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, and 8) Monitor/Document behaviors and side effects on Behavior Monitoring Form The care plan erroneously identified Depakote as an antipsychotic, which was inaccurate and prescribed as mood-stabilizer for Resident #5. In addition, the care plan had no resident centered interventions that addressed Resident #5's mood disorder or the behaviors for which the Depakote had been prescribed. Continued review of the resident's care plans failed to reveal a person-centered care plan had been developed that addressed Resident #5's mood disorder and the behaviors for which Depakote had been prescribed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 had a care plan, Behavior management, delusional behavior (episodic), wandering behavior, behavior toward staff (cursing, yelling) with the goal, undesirable behavior(s) will be monitored managed, and the interventions, 1. Attempt an alternate time to provide care refused,2. Ensure wanderguard is in place and functioning properly,3. Evaluate elopement risk, 4. Monitor for cognitive factors that may contribute to new behavior, 5. Monitor for emotional factors that may contribute to new behaviors.6. Monitor for signs/symptoms of infection, 7. Provide emotional support regarding new onset delusions. Provide emotional support regarding onset disruptive behavior, and 8. Provide verbal feedback to resident regarding behavior. The behavior care plan was not comprehensive, the goal was not resident centered and measurable. There was no indication of the underlying reasons for the resident's behavior and the interventions failed to include nonpharmacological approaches directed at understanding, preventing, and relieving the behavioral and psychological symptoms of the resident's distress. Continued review of Resident #5's care plans, failed to reveal a person-centered care plan that addressed Resident #5's cognitive decline and dementia care needs with measurable goals and resident centered interventions that addressed the resident's symptoms and rate of progression. The Nursing Home Administrator (NHA) was made aware of the above concerns on 3/19/26 at approximately 12:15 PM. The NHA acknowledged the concern and offered no further comments at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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, record review and interview it was determined the facility staff failed to ensure that each resident received necessary respiratory care and services consistent with professional standards of practice by failing to administer oxygen at the prescribed rate, failing to assess and document the resident's immediate and ongoing need for, provision of and response to supplemental oxygen. This was evident for 1 (#18) of 3 residents reviewed for Respiratory Care.The findings include:On 3/9/26 at 11:53 AM the surveyor observed Resident #18 lying in bed wearing a nasal cannula (NC) - a tube used to administer oxygen through the nose. The cannula was connected to an oxygen concentrator - a machine that concentrates and delivers oxygen from room air. The concentrator was set to deliver oxygen at 3 L/min (Liters per minute). Review of Resident #18's medical record on 3/13/26 at 11:21 AM revealed a physician's order for Oxygen at 2L/min via NC as needed for SOB (shortness of breath); not 3L/min as observed by the surveyor. The order for 2L/min was included on Resident #18's TAR (Treatment Administration Record) including spaces for staff to sign off when the oxygen was administered.Review of Resident #18's Plans of Care revealed the facility staff failed to develop a plan to address Resident #18's Respiratory/Pulmonary problems or Oxygen use.During an interview on 3/13/26 at 12:28 PM Staff #8 the CRNP (Certified Registered Nurse Practitioner) indicated that Resident #18 was prescribed oxygen for Diastolic Heart Failure and history of Pulmonary Embolism. The resident was observed again on 3/13/26 at 2:16 PM and 3/17/26 at 9:06 AM, lying in bed with Oxygen via NC from the concentrator which was set at 3L/min.Review of the residents TAR (Treatment Administration Record) record on 3/17/26 at 9:13 AM revealed that staff signed off administration of oxygen to Resident #18 on 3/6/26, and 3/10/26. It was not signed off as administered on 3/9/26, 3/13/26 or 3/17/26 as observed by the surveyor.No progress notes related to the administration of Resident #18 oxygen were found in his/her medical record, including but not limited to an assessment of the resident, his/her oxygen saturations, presence of respiratory symptoms and effectiveness of the oxygen intervention.Staff #7 an LPN (Licensed Practical Nurse) was assigned to provide care for Resident #18 and was interviewed on 3/17/26 at 10:45 AM. She confirmed that administration of Resident #18's oxygen was signed off for 3/6/26 and 3/10/26. She confirmed that the resident was currently receiving oxygen and indicated that she had not signed it off yet for that date.She was asked to identify what parameters were used to determine if and when the resident required the oxygen. She stated, our protocols indicated that any resident with an oxygen saturation less than 90% needs to have oxygen. When asked to provide resident #18's oxygen saturation readings for that day she indicated that she had not checked it. When asked to explain what protocol she used to determine that Resident #18 required supplemental oxygen on that date she stated: I will check him/her with the oxygen on if more than 90% I will take it off, recheck then reapply if needed and notify the Nurse Practitioner and doctor, then document it in the progress note. There was no evidence that she had done that, that morning.Staff #7 observed the resident with the surveyor at that time and confirmed that the oxygen concentrator was set at, and delivering 3L/min instead of 2L/min as ordered by the physician. Staff #4 the MDS (Minimum Data Set) nurse who was filling in for the Director of Nursing, was made aware of these findings on 3/17/26 at 11:28 AM. The facility Administrator was made aware of these concerns on 3/19/26 at 10:00 AM.Cross reference F 656

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on a review of the medical record and interview with staff it was determined that the facility failed to ensure that the physician addressed a significant weight gain/weight loss. This was evident for 1 (#3) of 5 residents reviewed for weight gain/weight loss.The findings include:On 3/12/26 at 9:30 AM, a review of Resident #3's medical record revealed, in a weight tracking system report, Resident #3's weight was documented as 181 pounds on 2/24/26 and 195 pounds on 3/1/26, which was a 7.7 % weight gain in 8 days. Further, the record review revealed that the dietician did not document in the medical record that the resident had a 7.7% gain in 8 days, and no other follow-up was noted by the dietician in the medical record.Continued review of the medical record failed to reveal that the physician did not evaluate and addressed the resident's significant weight gain when it was identified. Progress notes were reviewed in the medical record on 3/9/2026, with no mention of a 7.7% weight gain for Resident #3.On 3/12/26 at 10:40 AM during an interview, the Administrator Director confirmed that no documentation was present to indicate that the physician had addressed Resident #3's weight gain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to follow physician orders to follow blood pressure and pulse parameters for administering a blood pressure medication. This was evident for 1 (#6) of 5 residents reviewed for unnecessary medications. The findings include: On 3/11/26 at 2:45 PM, a review of Resident #6's February 2026 Medication Administration Record (MAR) revealed a 1/31/26 physician order for Metoprolol Succinate (lowers blood pressure) ER (extended release) tablet by mouth one time a day for hypertension (HTN) (high blood pressure (BP)) and hold for systolic (S) (top number of BP) reading) less than 110, or Pulse (P) (heart rate) less than 60 that documented Resident #6 received the Metoprolol every day in February. There was no documentation in the MAR to indicate that prior to the administration of the metoprolol, Resident #6's BP and P were monitored and the metoprolol administered within the parameters of the physician's order. Review of Resident #6's March 2026 MAR revealed a 1/31/26 physician order for Metoprolol by mouth every day for HTN and hold for SBP less than 110 or P less than 60 that documented Resident #6 received Metoprolol every day from 3/1/26 to 3/12/26. There was no documentation in the MAR to indicate that prior to the administration of the metoprolol, Resident #6's BP and P was monitored and the metoprolol administered within the parameters of the physician's order. The above concerns were discussed with Staff #4, Registered Nurse (RN), Minimum Data Set (MDS) Coordinator on 3/17/26 at 3:29 PM. Staff #4 acknowledged the concerns and offered no further comments at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility staff failed to keep complete and accurate medical records. This was evident for 5 (#4, #12, #11,#18, #16) of 10 residents reviewed for Advanced Directives and 1 (#13) of 5 residents reviewed for nutrition. The findings include Maryland Orders for Life Sustaining Treatment (MOLST) includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options based on a patient's wishes. It is valid in all healthcare facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Included in the No CPR section are three options: A-1 Intubate; A-2 Do Not Intubate but comprehensive efforts may include limited ventilatory support by CPAP or BiPAP; or Option B No CPR, Palliative and Supportive Care. Section 2 to 9 have options for situations other than cardiopulmonary arrest. Per the MOLST instructions: Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form. Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record. 1) On [DATE] at 10:19 AM, a review of Resident #11's paper medical record revealed a voided MOLST and an unvoided MOLST: - Resident #11 had a MOLST, signed and dated [DATE], with VOID handwritten across the MOLST. - The resident had an unvoided (active) MOLST, that elected Option A-1, Intubate, and options in Section 2-9, that was signed and dated [DATE]. On [DATE] at 9:00 AM, a review of scanned documents in Resident #11's EMR revealed the resident had more than one unvoided (active) MOLST in the medical record: - Resident #11 had an unvoided MOLST, that elected Attempt CPR, and options selected in sections 2-9, that was signed and dated [DATE]. - Resident #11 had an unvoided (active) MOLST that elected Option A-1, Intubate, and options in Section 2-0 that was signed and dated [DATE] and matched the unvoided MOLST in the resident's paper medical record. The practitioner failed to void Resident #11's previous MOLST when a new MOLST was created as evidenced by more than one unvoided MOLSTs in the resident's medical record. 2) On [DATE] at 12:00 PM, a review of Resident #12"s paper medical record revealed an unvoided (active) MOLST and an unsigned MOLST. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #12 had an unvoided MOLST that elected No CPR, Option A-2, Do not intubate (DNI), with options selected in Section 2-9, that was signed and dated [DATE]. - There was an unsigned, undated MOLST labeled with Resident #12's name, date of birth , and gender, that elected, No CPR, Option B, Palliative and Supportive Care, and options in Section 2-9. A MOLST that has not been signed by the practitioner is not a valid order. There is potential to cause confusion when the invalid MOLST is kept with active orders in the resident's medical record. On [DATE] at 10:00 AM, a review of scanned documents in Resident #12's EMR revealed the resident had 2 unvoided (active) MOLSTs in the medical record: - Resident #12 had an unvoided MOLST that elected, Attempt CPR, and was signed and dated [DATE]. - Resident #12 had an unvoided MOLST that elected No CPR, Option A-2, Do not intubate (DNI), that was signed and dated [DATE] and matched the unvoided MOLST dated [DATE] in the resident's paper medical record. The practitioner failed to void Resident #12's previous MOLST when a new MOLST was created as evidenced by more than one unvoided MOLSTs in the resident's medical record. 3) On [DATE] at 12:49 PM, a review of Resident #4's paper medical record revealed copies of 2 unvoided MOLSTs and one voided MOLST in the resident's paper record, - There were 3 copies of an unvoided MOLST for Resident #4 that elected No CPR, Option A-2, Do not intubate (DNI), with no options selected in section 2-9, that was signed and dated [DATE] at 1:58 PM. - Resident #4 had a voided MOLST that had VOID handwritten across the MOLST. The voided MOLST elected No CPR, Option A-2, Do not intubate (DNI), was signed and dated [DATE] at 1:58 PM and matched the [DATE] unvoided MOLST in the paper record. - There were 2 copies of an unvoided (active) MOLST for Resident #4, that elected No CPR, Option A-2, DNI and options in Section 2 -9 that was signed and dated [DATE]. On [DATE] at 11:07 AM, review of scanned documents in Resident #4's EMR revealed more than one unvoided MOLST in Resident #4's medical record: - Resident #4 had an unvoided MOLST that elected No CPR, Option A-2, Do not intubate (DNI), with no options selected in section 2-9, that was signed and dated [DATE] at 1:58 PM. The unvoided MOLST matched the unvoided MOLSTs dated [DATE] in the resident's paper record. - Resident #4 had an unvoided MOLST that elected No CPR, Option A-2, DNI and options in section 2 -9 that was signed and dated [DATE] and matched the unvoided MOLST dated [DATE] in the resident's paper record. The facility failed to ensure that when an updated MOLST was completed, all older forms were voided in accordance with the form's instructions. The concerns with resident's having more than one unvoided MOLST in the medical record were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed with the Nursing Home Administrator on [DATE] at 3:40 PM. The NHA acknowledged the concerns at that time and stated they were looking at their process. 4) Maryland MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. The instructions for completing the MOLST includes: Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form. Voiding the Form: To void this medical order form, the physician, NP (Nurse Practitioner), or PA (Physician's Assistant) shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record. 4A) Resident #18's medical record was reviewed on [DATE] at 11:58 AM. A MOLST signed and dated [DATE] by Staff #8 a CRNP (Certified Registered Nurse Practitioner) indicating NO CPR Option B. Palliative & Supportive Care. The form was in the front of the paper record behind the face sheet. Another MOLST form signed and dated by Staff #8 on [DATE] included the notation Social worker discussed with pt (patient) on [DATE]. This form also identified No CPR Option B, and was located behind the Advance Directive tab in Resident #18's paper record with a photocopy of the form. Resident #18's EMR (Electronic Medical Record) contained a scanned copy of the MOLST form dated [DATE] as well as a MOLST signed and dated by Staff #8 on [DATE] indicating Attempt CPR. None of the MOLST forms were voided as per the MOLST instructions. 4B) Resident #16's medical record was reviewed on [DATE] at 10:20 AM. The paper chart contained a MOLST form signed and dated by Staff #8 on [DATE] indicating No CPR option A-2 DNI (Do Not Intubate). The dates [DATE], [DATE] and [DATE] with 0 changes and initials were written across the bottom of the first page. Another MOLST form signed and dated by Staff #8 on [DATE] was in the Social Services section of the paper record. The word VOID was written diagonally across the form without a signature or date. This MOLST was also scanned into the EMR however it did not include the VOID. An interview was conducted with Staff #8 the CRNP on [DATE] at 12:18 PM. She was asked to explain the process for completing MOLST forms. She indicated that she walks the resident or their responsible party through the whole form. She stated, If I'm the one doing a new MOLST, I void the old one and put it in the Social Work section of the paper chart. When asked to explain why there were unvoided copies of previous MOLST forms in the records she stated: That's the tragedy of the MOLST form, some things are in the paper chart, some have to be scanned into the EMR. An interview was conducted with Staff #9 the Social Worker on [DATE] at 1:02 PM. She indicated that old MOLST forms were put into the Social Service section of the resident's record. When asked what happened to the MOLST's that were scanned into the EMR she stated, I thought you can't delete it. When asked who voids the previous MOLST forms she stated, I do, sometimes it's (Staff #8), (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually it's one of us but sometimes it's Staff #5 (the physician). She indicated that she was not familiar with the instructions for MOLST forms. The Administrator was made aware of these concerns on [DATE] at 10:00 AM. 5) Resident #13's medical record was reviewed on [DATE] at 1:12 PM. The resident's weight record in the EMR (Electronic Medical Record) revealed that on [DATE] the resident weighed 320 lbs.(pounds). No weights were recorded for January or February 2026. There was no notation as to why his/her weight was not obtained. Resident #13's next documented weight was 281.8 pounds on [DATE] by Staff #4 the MDS (Minimum Data Set) nurse and on [DATE] by Staff #6 an LPN (Licensed Practical Nurse). On [DATE] at 11:26 AM the surveyor requested copies including but not limited to Resident #13's weight log for the past year. The Administrator provided a list with the print date [DATE] 12:22 PM which reflected entries for September and [DATE] and [DATE]. She returned a short time later with another list with the print date [DATE] 13:16 (1:16 PM) which included weight entries for April, May, June, August, September, October, November and [DATE] as well as [DATE]. She indicated that this was a revised list and that all the weights were not entered when she provided the first list to the surveyor. During an interview on [DATE] at 4:13 PM Staff #4 provided 6 paper Monthly Vital Sign Sheets which listed resident's names. Review of the logs revealed: 1 page hand labeled Monthly Weights [DATE] shift 7-3. No weight was listed in the space for Resident #13 or notation of why it wasn't obtained. 2 pages were labeled Monthly Weight February 2026, and a second page labeled Weights [DATE], 7-3 which included a weight of 213.4 beside Resident #13's name. The page labeled Monthly Weights, [DATE] included 281.8 which was heavily scribbled out, and 320.4 written beside it. There was no other notation related to this weight recording. Staff #4 was unable to identify who obtained the weights, why his/her February weight was not documented in the resident's record. She was unable to identify who changed Resident #13's March weight or when and why it was done. When asked why there were weights recorded on the paper forms that were not recorded in each resident's medical record, she indicated that she will usually enter the resident weights into the EMR quarterly, prior to completing the resident's MDS assessment. She was unable to identify the facilities policy or procedure for ensuring accurate and timely documentation of the residents' weights into the medical records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview it was determined the facility staff failed to ensure respiratory care equipment was 1) properly date labeled, and 2) cleaned and stored as per the manufacturer's instructions. This was evident for 2 (#18 and #13) of 3 residents reviewed for Respiratory Care.The findings include: 1) On 3/9/26 at 11:53 AM the surveyor observed Resident #18 lying in bed wearing a nasal cannula (NC) (a tube used to administer oxygen through the nose). The cannula was connected to an oxygen concentrator (a machine used to concentrate and deliver oxygen from room air). A piece of white tape was attached to the nasal cannula tubing with the date 3/1/26 in black marker. Another observation on 3/17/26 at 9:06 AM revealed Resident #18's nasal cannula tubing had no date label. On 3/17/26 at 10:45 AM Staff #7 an LPN (Licensed Practical Nurse) observed the resident in his/her room with the oxygen running via NC and confirmed the nasal cannula was not labeled. She indicated that she did not know why the tubing wasn't labeled. Review of Resident #18's medical record on 3/13/26 at 11:21 AM revealed a physician's order for Oxygen at 2L/min via NC as needed for SOB (shortness of breath). The order was included on Resident #18's TAR (Treatment Administration Record) including spaces for staff to document the oxygen administration. No information was found in the resident's record regarding how and when staff were to clean and/or replace the equipment used to administer the resident's oxygen. The facility policy/procedure for Oxygen Administration, provided by the Administrator revealed: The purpose of this procedure is to provide guidelines for safe oxygen administration. However, the policy/procedure did not include instructions related to cleaning or replacement of oxygen administration equipment to minimize risk of infection. The policy revision date was October 2010. The Centers for Disease Control and Prevention (CDC) recommends: Nasal cannulas should be cleaned weekly with soap/water and replaced every 2-4 weeks, while filters are cleaned weekly. 2) CPAP stands for Continuous Positive Airway Pressure, a common, non-invasive therapy for breathing disorders, particularly obstructive sleep apnea (OSA). It uses a machine to deliver a continuous, gentle stream of pressurized air through a mask, keeping the airway open during sleep to prevent apnea episodes, snoring, and to improve oxygen levels. Resident #13 and his/her room were observed on 3/10/26 at 10:30 AM. The resident was lying in bed. A CPAP machine was on the nightstand beside the head of the bed. The humidification/water chamber was in the machine. The CPAP tubing was draped over the table with the face mask hanging down over the right side of the table approximately 18 inches above the floor, uncovered. The resident was asked but unable to identify how the facility cleans and maintains his/her CPAP machine, s/he was unable to identify where the manufacturers' instructions were located. Another observation was made on 3/12/26 at 9:17 AM. The water chamber was in the CPAP machine, and the mask was hanging over the top of the machine uncovered.Review of Resident #13's medical record on 3/12/26 at 12:52 PM revealed several physician orders and TAR (Treatment Administration Record) for:CPAP on at bedtime;Remove water chamber and allow to air dry;Change distilled water in water chamber every day shift;CPAP filter - change every 2 weeks on night shift every Friday;Inspect the filter weekly on night shift Friday;Clean CPAP and tubing with soap and water every week on Wednesday.There were no specific directions on how to clean and dry the machine or the tubing, how or when to clean the water chamber, and face mask, how often to replace the face mask, water chamber and tubing, or storage of the face mask when not in use. Resident #13's Plan of Care for Sleep Apnea included the use of the CPAP Machine. The resident's goal was (Resident #13) will have no complications with CPAP or sleep apnea. Interventions included: apply CPAP at night as ordered and Clean CPAP per manufacturer's instructions. An interview was conducted with Staff #7, the LPN (Licensed Practical Nurse) providing care for Resident #13 on 3/17/26 at 10:33 AM. When asked where to find the manufacturer's instructions for the care of Resident #13's CPAP equipment she initially indicated that they were in the EMR (electronic medical record). When asked to show the surveyor the cleaning/replacement instructions for the machine and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment she showed the surveyor the TAR. When asked specifically where to find the instructions regarding the care/cleaning of the water chamber and face mask as well as storage/replacement of components other than the filter she indicated that she was not sure. She accompanied the surveyor to Resident #13's room at that time and observed that his/her CPAP face mask was lying on the floor under the head of the resident's bed. She confirmed the water chamber was still in the machine and began tipping the machine around and over in an attempt to determine if it contained water, potentially spilling water into the electronic components of the machine. When asked where to find the manufacturer's instruction manual for the CPAP machine she indicated that it may be in the back of the resident's paper medical record but was not sure. Further review of Resident #13's paper medical record on 3/17/26 at 10:58 AM failed to reveal manufacturer's instructions for the CPAP machine. Review of the facility policy for CPAP/BiPAP Support revealed General Guidelines for Cleaning 1. These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device. On 3/17/26 at 11:00 AM Staff #4, the MDS (Minimum Data Set) nurse was made aware that there was no evidence the facility staff had a process to ensure that Resident #13's CPAP equipment was cleaned, maintained and stored in a sanitary manner and as per the manufacturer, as indicated in Resident #13's Plan of Care and the facility policy. The Administrator was made aware of these concerns on 3/19/26 at 10:00 AM.