STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and record review it was determined that the facility failed to ensure an environment that promotes resident dignity. This was evident for 2 (Resident #56 and #61) of 2 residents observed for dignity during the recertification survey.The findings include: 1) On 01/05/2026 at 8:31 AM, the Surveyors observed Geriatric Nursing Assistant (GNA) #2 enter Resident #56's room without knocking or introducing herself. GNA #2 tried to quickly exit the room once she saw the Surveyors inside the room. During an interview conducted on 01/05/2026 at 8:31 AM, GNA#2 could not provide an explanation as to why she entered Resident #56's room without knocking or introducing herself. GNA #2 stated I saw the door closed and I came to see why. On 01/12/2026 at 12:50 PM, an interview with the Director of Nursing (DON) confirmed it is the facility's expectation for a GNA or any staff to knock on the door and wait for a response from the resident before entering the Resident's room. If the Resident is nonverbal, staff are to still knock and wait to see if there are any visitors inside the room to invite them in. Once the staff open the Resident's door, it is the expectation that they greet the Resident and introduce themselves and state why they are there. This was confirmed as the facility practice every time a staff member enters a Resident's room. 2) On 01/05/2026 at 3:15 PM, this surveyor conducted an interview with Resident #61. When asked whether he/she had ever felt mistreated by a staff member, Resident #61 reported mistreatment by Geriatric Nursing Assistant (GNA) #5. The resident explained that this staff member, instead of speaking directly, would use her fingers to communicate rather than verbally interacting. Resident #61 stated that he/she had shared this concern with a family member, who subsequently reported it to the facility, although the Resident was unsure to whom the report was made. On 01/07/2026 at 11:01 AM, a record review of the facility's investigation file for a facility-reported incident of alleged neglect involving Resident #61 by GNA #5 was conducted. The investigation file showed that Resident #61's Power of Attorney (POA) reported concerns to the facility, stating that GNA #5 had no communication with the resident, just pointing, and that the Resident became anxious at the mention of the GNA's name. In a statement dated 10/30/2025, GNA #5 reported that she used both verbal and non-verbal communication, including hand gestures, while providing care to Resident #61. The facility concluded the investigation with a determination that the allegation of neglect could not be verified. On 01/08/2026 at 9:13 AM, a record review of a psychiatric note dated 11/12/2025 for Resident #61 (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed that the chief reason for the visit was patient seen due to patient-to-staff conflict. The note documented that the Resident reported feeling anxious when a particular staff member provided care. The Resident stated that the staff member did not communicate verbally, but instead used hand gestures, which caused the Resident to feel anxious. On 01/08/2025 at 9:43 AM, a follow-up interview was conducted with Resident #61. When asked about his/her experience with GNA #5, the Resident reported that this staff member communicated using hand gestures rather than verbal communication. When asked how this made him/her feel, the Resident stated that it made him/her feel offended. When asked if he/she felt disrespected by GNA #5, the Resident confirmed that he/she did, due to the use of hand gestures for communication. On 01/09/2026 at 1:38 PM, this surveyor conducted an interview with the Administrator to discuss the investigation into the allegation of neglect by GNA #5. The Administrator confirmed that the facility was able to substantiate that GNA #5 used non-verbal communication with Resident #61, as documented in her statement in the investigation file. He further confirmed that following the investigation, GNA #5 was educated not to use hand gestures or pointing when communicating with residents. It was discussed with the Administrator that multiple sources of documentation indicated Resident #61 experienced anxiety and offense when receiving care from GNA #5, including reports from the Resident's Power of Attorney, surveyor interviews with the Resident, and a psychiatric note stating the Resident felt anxious when a staff member used hand gestures while providing care. This was communicated as a concern for resident dignity, as it was confirmed that GNA #5's non-verbal communication caused Resident #61 to feel anxious, offended, and disrespected. The Administrator acknowledged and agreed that this was an issue impacting resident dignity.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. cite:Based on observation and interview, it was determined that the facility failed to ensure adequate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and safe environment. This was evident during the Infection Control review conducted as part of the annual survey. This deficiency has the potential to affect all residents.The findings include:On 01/12/2026 at 10:55 AM, this surveyor observed a large hole in the ceiling in the Laundry room, in the clean clothes drying area. The hole exposed pipes, dust, and drywall. Photographs of the observation were taken at this time.On 01/12/2026 at 11:29 AM, this surveyor observed a large hole in the ceiling in the clean linen folding room. There was a ceiling fan near the edge of the hole, and the hole exposed pipes, dust, and drywall. Photographs of the observation were taken at this time.On 01/14/2026 at 09:45 AM, this surveyor conducted an interview with the Maintenance Director regarding building maintenance and plumbing concerns. The Maintenance Director reported that he has observed ongoing leaks in the building since his employment began in 2014. He confirmed that there are currently no issues with mold despite the leaks. He explained that leaks are being repaired as they occur; however, a full plumbing replacement is needed, which has been delayed due to budget constraints and other priorities. He reported that these concerns have been communicated to the Administrator and discussed during morning meetings when leaks occur, although these discussions are not documented. When asked about the holes in the ceiling, he confirmed that the holes were created to access plumbing for repairs. He stated that the holes remain open due to limited maintenance staffing, which prevents timely repair of the ceiling with drywall.On 01/14/2026 at 09:57 AM, a dual observation was conducted with the Maintenance Director of holes in the ceiling in the Laundry/dryer room. The Maintenance Director confirmed that these holes were created last week to repair a leak. During the observation of the clean linen room, where clean clothes are folded, the Maintenance Director confirmed that the holes in the ceiling were created in December to address a separate leak.On 01/14/2026 at 1:00 PM, this surveyor conducted an interview with the Administrator regarding environmental concerns related to the ongoing leaks in the facility and the resulting holes in the ceilings. The Administrator acknowledged the concern and reported that he would begin utilizing a service to bring in a maintenance staff member on a rotating basis from other facilities to assist with maintenance issues, including repairing exposed ceilings.On 01/14/2026 at approximately 2:00 PM, the Administrator showed this surveyor photographs of maintenance staff repairing the holes in the ceiling of the Laundry/dryer room.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, interview and record review, it was determined that the facility failed to ensure that 1) an allegation of neglect was reported to the Office of Health Care Quality no later than 2 hours after the allegation was made. This was evident for 1 (Resident #61) out of 6 residents reviewed for neglect allegations and 2) to report the malfunction of the HVAC heating system to the State Agency the Office of Health Care Quality (OHCQ) in a timely manner. This was found to be evident for 1 out 8 Facility Reported Incidents (FRI) reviewed during the recertification survey.The findings include: 1) On 01/05/2026 at 3:15 PM, this surveyor conducted an interview with Resident #61. When asked whether the Resident had ever felt mistreated by a staff member, Resident #61 reported mistreatment by Geriatric Nursing Assistant (GNA) #5. Resident #61 stated that this concern was communicated to a family member, who then reported the concern to the facility, although the Resident was unsure to whom the report was made. On 01/07/2026 at 11:01 AM, this surveyor conducted a record review of the facility's investigation file related to a facility-reported incident involving Resident #61. The review showed that an interview with Resident #61 was conducted on 10/27/2025 by the Registered Nurse (RN) Unit Manager, with the Social Worker Assistant #27 present as a witness. According to the interview documentation, Resident #61 was asked whether there were any concerns regarding a staff member. Resident #61 reported a concern involving GNA #5. When asked to describe the concern, Resident #61 stated that after requesting a brief change, GNA #5 covered the Resident with a blanket and did not change the brief. When asked when the incident occurred, Resident #61 reported that it happened approximately three weeks prior, but was unable to recall the specific date. On 01/07/2026 at approximately 11:30 AM, a continued record review of the facility's investigation file showed that the facility reported an allegation of abuse involving Resident #61 to the Office of Health Care Quality on 10/29/2025 at 1:39 PM. The report was submitted by the Administrator. On 01/07/2026 at 2:02 PM, this surveyor conducted an interview with RN Unit Manager. It was discussed the interview she had had with Resident #61. During the interview, she recalled that Resident #61 had reported an aide did not change him, that the GNA covered him up and left without changing him. When asked about what happened after this interview had taken place, she reports that she spoke with the Assistant Director of Nursing (ADON) about the interview. On 01/07/2026 at 2:21 PM, this surveyor conducted an interview with the Administrator to discuss the investigation into the allegation of abuse involving Resident #61. During the interview, the Administrator reported that he first became aware of Resident #61's concerns regarding GNA #5 after receiving a letter from the Resident's family member on 10/29/2025. Based on the information contained in the letter, the Administrator reported that an allegation of abuse was subsequently reported to the Office of Health Care Quality. During the interview, the Administrator was asked whether he was aware of an interview conducted on 10/27/2025 between Resident #61 and the RN Unit Manager; the Administrator reported that he was not aware that this interview had occurred. On 01/07/2025 at 2:52 PM, this surveyor conducted an interview with the ADON. During the interview, the RN Unit Manager's interview of Resident #61 on 10/27/2025 was discussed. The ADON reported that she did not recall this interview and stated that the first time she was made aware of Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#61's concerns involving GNA #5 was upon receipt of a letter from the Resident's family member on 10/29/2025. On 01/07/2026 at 3:00 PM, during an interview with the Administrator and the ADON, this surveyor communicated concerns regarding the facility's failure to timely report an allegation of neglect. Record review showed that Resident #61 communicated an allegation of neglect to the RN Unit Manager on 10/27/2025; however, the Administrator and ADON were not made aware of the allegation on that date, and the allegation was not reported to the Office of Health Care Quality within the required two-hour timeframe. It was explained that, had the Administrator and ADON been informed of Resident #61's concern regarding GNA #5 following the RN Unit Manager's interview on 10/27/2025, the initial report of alleged neglect could have been made on that date rather than on 10/29/2025 after receipt of the family member's letter. 2) On 01/05/2026 at 7:30 AM the Survey team conducted an unannounced entry of the facility to conduct a recertification and complaint survey. The night Registered Nurse (RN) #17 advised the team to have a seat because he needed to contact the Administrator and Maintenance Director to assign the Survey team a room because the usual room (1st floor B-wing Solarium) did not have heat. At 8:19 AM Licensed Practical Nurse (LPN) #4 met the Survey team and moved the team from the lobby of the facility to a room on the second floor C-wing. On 01/05/2025 at 8:30 AM the Assistant Director of Nursing (ADON) met with the team and explained that the room that is usually assigned to the Surveyors did not have heat and that the Maintenance Director was working on the heat. During a review of a Facility Reported Incident (FRI) # 2709075 it was discovered that the facility reported on 01/05/2026 at 6:40 PM that the HVAC was not functional in the B-wing Solariums on the 1st and 2nd floor. On 01/05/2026 at the end of the day the Survey team was moved to the 1st floor B-wing Solarium. On 01/06/2026 at 6:00 AM, this Surveyor observed 2 of the 3 portable heaters on and spaced out across the room. The room was very cold and required this Surveyor to wear his/her coat throughout the day. From 01/06/2026 through 01/14/2026 the room was very cold on many of the days. The breaker would trip on most of the days cutting off the power to the portable heaters. The NHA attempted to turn on a wall heating unit however that unit was ineffective in heating the portion of the room it was located. During an interview conducted on 01/13/2026 at 10:09 AM, the Nursing Home Administrator (NHA) reported that he contacted the fire marshal and the Life Safety Code Coordinator to get direction on what type of portable heaters could be used to heat the 1st floor B-wing Solarium on 01/05/2026 following the entry of the Survey team. He then later that day reported the malfunctioning of the HVAC heating system on 01/05/2026 at 6:40 PM to OHCQ. The NHA explained that the HVAC heating system malfunctioned and that Corporate required 3 estimates to have the heating system repaired. The NHA stated that he had 2 estimates and was working on obtaining a third estimate. This Surveyor requested the documentation for the repair of the heating unit. During a review of the facility documentation provided by the NHA on 01/13/2026 at 11:00 AM, it was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discovered that the facility received an estimate on 11/14/2025 for the repair of the heating system for the 1st and 2nd floor B-wing Solariums. During the continued review it was discovered that there was no other evidence of the 2nd estimate that the NHA had reported previously to the Surveyor. During an interview conducted on 01/13/2026 at approximately 1:15 PM, the NHA explained that the HVAC heating system malfunctioned in early November 2025. He stated that he had obtained 1 estimate of the 3 required for Corporate to repair the heating system in November 2025. He also stated that he had not obtained the 2nd estimate because he still needed to provide the contractor with additional information. When asked what the name of the 2nd contractor was the NHA could not recall. When asked why the facility did not report the malfunction of the heating unit until the Survey team entered the facility instead of when the heating system malfunctioned in early November of 2025, the NHA stated he did not have an explanation. The NHA acknowledged the delay in obtaining the 3 required estimates to repair the heating system and the delay in reporting the issue to the State Agency, the Office of Health Care Quality (OHCQ).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. cite:Based on record review and interview, it was determined that the facility failed to prevent further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress. This was found to be evident for 1 (Resident #61) out of 6 residents reviewed for allegation of neglect. The findings include:On 01/07/2026 at 11:01 AM, a record review of the facility's investigation file for a facility-reported incident of alleged neglect involving Resident #61 by Geriatric Nursing Assistant (GNA) #5 was conducted. The review showed that the initial report of the allegation was submitted to the Office of Health Care Quality on 10/29/2025 by the Administrator. The final investigation report was submitted to the Office of Health Care Quality on 11/04/2025, also by the Administrator. The report indicated that GNA #5 was suspended on 10/29/2025 and returned to work on 11/01/2025.A continued record review of the investigation file on 01/07/2026 at approximately 11:35 AM showed that the file included a statement from the Registered Nurse (RN) Unit Manager, dated 11/04/2025, as well as a separate statement from RN #30, also dated 11/04/2025.On 01/07/2026 at 2:21 PM, an interview was conducted with the Administrator regarding the course of the investigation. The Administrator confirmed that the investigation was completed on 11/04/2025. He also confirmed that GNA #5 was suspended from 10/29/2025 to 11/01/2025. When asked why GNA #5 was allowed to return to work prior to the completion of the investigation, he stated that by 11/01/2025, he had determined that the allegation of neglect could not be verified, and therefore the employee was permitted to resume work.On 01/07/2026 at 3:06 PM, an interview was conducted with both the Administrator and the Assistant Director of Nursing (ADON), who were involved with the investigation. It was discussed that the investigation was completed and submitted to the Office of Health Care Quality on 11/04/2025; however, GNA #5, who was accused of neglect, was allowed to return to work on 11/01/2025. Review of the facility's investigation file showed statements collected on 11/04/2025, including one from the RN Unit Manager and another from RN #30, which were part of the ongoing investigation. It was explained that because these statements were collected on 11/04/2025, the investigation was still in progress on 11/01/2025, and therefore GNA #5 returned to work before the investigation was completed. This was communicated as a concern because the purpose of suspending the accused staff member during an active investigation is to prevent the potential for any further abuse, neglect, exploitation, or mistreatment during the course of the investigation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and facility staff interview, it was determined that the facility failed to ensure 1) the resident/resident representative received the bed hold notification form in writing. This was evident for 1 (resident #79) of 2 residents reviewed for transfers during the recertification survey and 2) the local ombudsman was notified of facility discharges. This was evident for 2 (Residents #76 & #80) of 2 residents reviewed for discharges during the recertification survey. The facility implemented effective and thorough corrective measures after discovering the delay in ombudsman reporting prior to the start of this survey. Therefore, this deficiency was found to be past noncompliant with a compliance date of [DATE]. The findings Include: 1) On [DATE] at 1:00 PM, a review of the Facility Reported Incident (FRI) #2598892 investigation revealed Resident #79 fell while self transferring out of the wheelchair to the toilet in the bathroom. 911 was activated and the Resident was transferred to the hospital on [DATE]. A long-term care bed hold reserves a nursing home bed for a resident temporarily absent for hospitalization or therapeutic leave, ensuring their return; state Medicaid rules vary, but often cover a set period (e.g., 7 days for Medicaid, private pay for extra days), requiring facilities to have written policies and provide residents notice of their rights to readmission and costs. On [DATE] at 9:33 AM, review of Resident #79's medical records showed a transfer summary was generated for the hospital transfer on [DATE]. The Resident's family, medical provider on call, and ombudsman were notified of the incident. There was no written copy of the facility's bed hold notification form in Resident # 79's medical records. A review of the facility's bed hold policy and procedure was conducted on [DATE] at 12:30 PM. It revealed that a copy of the bed hold policy is given to every Resident / resident representative at the time of admission to the facility. A copy of the bed hold form should be given to every resident /resident representative at the time of a resident's transfer outside the facility. On [DATE]/2026 at 12:45 PM, an interview with the Regulation Specialist confirmed there were no written copies of the bed hold notification form in Resident #79's medical record for the hospital transfer on [DATE]. 2) During a review of medical records on [DATE] at 9:36 AM for Resident #76 it was discovered that he/she was sent to the hospital on [DATE] and did not return to the facility. During a review of medical records on [DATE] at 6:31 PM for Resident #80 it was discovered that he/she expired while in the facility on [DATE]. During an interview with the Business Office Manager (BOM) on [DATE] at 11:26 AM she confirmed that the ombudsman had not been notified in a timely manner. The BOM advised she had started in August and was not aware that it was her responsibility to handle ombudsman notifications. She reported she had discussed the reporting concerns with the ombudsman after learning it was her duty and was now up to date. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of a copy of an e-mail provided by the BOM on [DATE] at 11:33 AM it was discovered that the e-mail was sent to the ombudsman on [DATE] and was titled Discharges. The e-mail had attachments for discharged Residents for [DATE], [DATE], [DATE] and [DATE]. During further review of the October attachment included with the e-mail it was revealed that Resident #76 was identified as discharged to the hospital with return expected and Resident #80 was identified as expired. During a review of another copy of an e-mail provided by the BOM on [DATE] at 11:35 AM it was revealed that the Ombudsman was notified of the [DATE] discharges, hospitalizations and admissions via e-mail on [DATE] @ 9:59 AM. During an interview with the BOM on [DATE] at 11:36 AM she advised she had discussed the reporting concerns with the Ombudsman after learning it was her duty. She reported that she had submitted the discharges from [DATE] to [DATE] by e-mail to the Ombudsman which caught her up. She also reported she had also sent the discharges for December to the ombudsman in January. Based on the above actions taken by the facility and verified by surveyors on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of [DATE]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews and record reviews, it was determined that the facility failed to ensure 1) medication carts were locked and resident health information was protected. This was found to be evident for 2 out of 3 medication carts observed and 7 out of 29 opportunities to protect resident health information, 2) a physician order was implemented. This was found to be evident for 1 (Resident #2) out of 1 Resident reviewed for physician orders, 3) behavior monitoring was conducted. This was found to be evident for 3 (Resident #56, #12 & #66) out of 3 Residents reviewed for behavior monitoring, and 4) medication was properly administered. This was found to be evident for 1 (Resident #22) out of 1 Resident reviewed for medication administration. It was determined that the facility failed to provide care that meets professional standards of practice during the recertification survey. The findings include: 1) On 01/08/2026 at 5:57 AM, during first-floor unit rounds on B-Wing, the surveyor observed a medication cart left unlocked and unattended. At the same time, an unlocked laptop with resident-specific information visible on the screen was observed unattended at the doorway of Room B140. On 01/08/2026 at 6:01 AM, during a medication administration observation with Registered Nurse (RN) #17, the surveyor observed the medication cart left open and the computer screen unlocked. This occurred in Room A104 at 6:01 AM, Room A108 at 6:04 AM, Room A117-B at 6:11 AM, Room A112 at 6:17 AM, Room D108-B at 6:24 AM, and Room D110-B at 6:26 AM01/08/2026 at 6:20 AM: The surveyor observed at the 1st floor lobby RN#17 left the medication cart open, and the computer screen unlocked and unattended, with residents' information visible. On 01/08/2026 at 6:32 AM, during an interview, RN #17 stated that the medication cart and computer screen are expected to remain locked at all times during medication administration. RN #17 confirmed leaving the medication cart open and the computer screen unlocked and unattended in the lobby while retrieving applesauce. On 01/12/2026 at 8:25 AM, during further observation on the second floor, the surveyor observed the B-Wing medication cart C open and unattended. On 01/12/2026 at 8:30 AM, during an interview, Licensed Practical Nurse (LPN) #20 stated, I was going to get medication from the medication room. The nurse further confirmed that the facility's expectation is for medication carts to always remain locked when not in use. The above concern was reviewed with LPN #20, who acknowledged the expectations. 2). On 01/14/26 at 9:16AM during a record review related to complaint , it was revealed that on 09/10/2025, Resident #2's physician ordered a Complete Blood Count (CBC) laboratory test for the diagnosis of pneumonia. The order was documented in the resident's medical record to monitor the resident's condition and to guide treatment. On 01/14/2026 at 9:20 AM, during a medical record review, it was revealed that the physician's order was not followed as written. On 01/14/26 at 12:20 PM, during an interview, the Assistant Director of Nursing (ADON) stated that physicians enter laboratory orders, and the receiving nurse transcribes the orders. The ADON further stated that the 11:00 PM–7:00 AM shift is responsible for ensuring the laboratory tests are completed, unless the order is designated as STAT. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/26 at 1:50 PM, during an interview, the ADON reported that Resident #2's laboratory test was not completed as ordered by the physician and stated that the reason was unknown. The surveyor informed the ADON and the Clinical Services Director of the above concerns, and both acknowledged receipt. 3) On 01/07/2026 at 8:28 AM, a review of Resident #56's medical record revealed diagnosis for depression, anxiety, and insomnia. Resident #56 had an order on their Treatment Administration Record (TAR) for: Behavior Monitoring Every Shift. On 01/08/2026 at 9:15 AM, a review of Resident #56 's TAR revealed Resident #56 was documented to have the highest number of behaviors at 20 observed on 12/20/25, there were no progress notes in the medical record for the type of observed behaviors on 12/20/25. A SBAR is a comprehensive nursing assessment done when there is a change in a Resident's condition. SBAR stands for Situation, Background, Assessment, and Request. The assessment prompts nurses to collect comprehensive information about a resident's change in condition in advance of calling a doctor to report the change. Behavior monitoring tools for psychotropic medications are structured systems used by healthcare teams and caregivers to track the efficacy and safety of medications prescribed for mental health and behavioral symptoms. These tools ensure that medications are used appropriately, at the lowest effective dose, and with minimal side effects. It is a holistic communication tool used by interdisciplinary teams in long-term care to report a resident's status, including behavioral distress and non-pharmacological attempts to the prescribing physician. On 01/09/2026 at 9:17 AM, an interview with Licensed Practical Nurse (LPN) #4 confirmed that when behaviors are documented on the TAR it is the facility's process to then document in a progress note the type of behaviors observed and applied interventions. If the behavior persists after interventions are implemented or is a newly observed behavior, then a SBAR is completed and notification sent to the medical provider. On 01/12/2026 at 8:57 AM, a review of Resident# 56's TAR revealed Behavior frequencies were documented on 12/06/25 for 3pm - 11pm, 12/10/25 3pm -11pm shift, 12/20/25 for the 7am-3pm shift, 12/20/25 for the 3pm -11pm shift, 12/21/25 3pm -11pm shift, 12/31/25 3pm -11pm shift, 01/09/26 3pm-11pm shift. The TAR does not indicate what behaviors were observed, only the number of times a behavior was observed. There were no progress notes in Resident #56's medical record for behaviors observed and documented on the TAR for the previous dates and shifts. On 01/13/2026 at 9:06 AM, Interview with the Director of Nursing (DON) confirmed that if there is an escalation of behavior there should be a progress note written. The progress note is what the psych consultants will review when they come to see the Resident. The DON stated that staff will call her at all hours to consult with her if a resident is expressing behaviors and she will tell them if they need a progress note. The DON is aware that the TAR only documents the number of episodes and not the actual behaviors. DON could not answer as to why on Resident #56 there were no progress notes on date / shifts where there were documented behaviors recorded on the TAR. On 01/07/26 at 9:58 AM, Resident #12 had active physician orders for Duloxetine 40 mg, one capsule orally once daily for depression; Escitalopram Oxalate 20 mg, one tablet orally once daily for depression; and Olanzapine 5 mg, one tablet orally once daily for anxiety. (continued on next page)

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	215350	A. Building B. Wing	01/14/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/26 at 7:15 AM, during review unnecessary medication review of Resident #12's medical records and Medication Administration Record (MAR) for the period of December 2025 through January 8, 2026, it was revealed that the resident received the prescribed antipsychotic and antidepressant medications. Review of the MAR confirmed the medications were administered as ordered; however, there was no documented evidence of behavior monitoring, nor was there documentation of monitoring for effectiveness related to the antipsychotic therapy. Further review of Resident #12's medical records on 01/08/26 at 7:30 AM revealed no evidence of documentation regarding behavioral monitoring or assessment for side effects associated with the prescribed medications, indicating a lack of ongoing evaluation of the necessity and safety of the medication regimen. On 01/08/26 8:22 AM interview with Assistant Director of Nursing (ADON) regarding effective monitoring for antipsychotic medications, ADON stated that staff monitor effectiveness using behavior monitoring flow sheets and document any observed behaviors in the progress notes. On 01/08/26 8:28 AM the surveyor and ADON reviewed Resident #12's MAR and nursing progress notes. ADON confirmed that the resident has been receiving psychotropic medications; however, no behavior monitoring flow sheets or related documentation were found in the nursing progress notes. During an interview with the Director of Nursing (DON) on 01/08/26 at 9:55 AM, she stated that the expectation is for nurses to administer medications, document the effectiveness of the medications, monitor resident behaviors, complete assessments on the behavior assessment sheet, and notify the physician of any unusual changes. On 01/08/26 at 10:15 AM the surveyor informed the DON and Clinical Services Director of the above concerns, and both acknowledged receipt. On 01/12/26 at 3:00 PM, review of Resident #12's medical record revealed that physician orders were initiated for behavioral monitoring and effectiveness monitoring every shift. On 01/13/2026 at 6:30 AM, during an investigation regarding a verbal altercation involving Resident #66, a review of the resident's medical record revealed diagnoses of vascular dementia with psychotic disturbance, mood disturbance, and anxiety. Further review of the medical record on 01/13/2026 at 6:50 AM revealed there was no documentation assessing Resident #66's behaviors related to the diagnosis of Dementia with behavioral disturbance, and no behavior monitoring tool was in place to assess the resident's behaviors. On 01/13/2026 at 7:50 AM, during an interview, the Director of Nursing (DON) confirmed that Resident #66 has a diagnosis of dementia with behavioral disturbances, which include yelling and screaming at other residents, and that the resident prefers to protect his/her personal space. However, review of the medical record revealed there was no documented behavioral assessment, no behavior monitoring tool in place, and no care plan interventions addressing the resident's identified behaviors. On 01/13/2026 at 1:02 PM, the surveyor informed both DON and Clinical Service Director of the above concerns and both acknowledged receipt. On 01/14/2026 at 8:30 AM, the Regulatory Specialist and Clinical Service Director reported to the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor that a behavior monitoring tool and care plan had been initiated for the resident. A copy of the care plan and behavior monitoring sheet was submitted to the surveyor. 4) During an observation with Wound Nurse #23 on 1/08/26 at 10:34 AM it was discovered that Resident #22 had a patch on his/her midback that was dated 1/07/26. During an interview with Wound Nurse #23 on 1/08/26 at 10:38 AM she reported that the patch was a Lidocaine patch on the back of Resident #22. During a review of the medication orders for Resident #22 on 1/08/26 at 10:40 AM it was discovered that the resident did not have a doctor's order for him/her have a Lidocaine patch and had no documentation of a Lidocaine patch being applied in his/her medical record. During an interview with Unit Manager #28 on 1/08/26 at 11:34 AM he confirmed that Resident #22 had a Lidocaine patch on and there was no doctor's order for the resident to have the patch so it was removed by the Resident's nurse.During an interview with the Director of Nursing on 1/08/26 at 11:46 AM she confirmed that Resident #22 did not have a doctor's order so he/she should not have had a Lidocaine patch on his/her back. She added the Lidocaine patch required a doctor's order prior to placing it onto the resident and the order would need to be signed off after administration. During a review of the facilities Nursing Policies and Procedures: Medical Management Program on 1/14/26 at 10:42 AM it stated that Documentation of medications administered is completed according to State and Federal Requirements. The initials and verifying signature are generally required. The Policy continued with The authorized staff member validates the following information is documented in the Medication Administration Record (MAR): Correct physician's order and diagnosis for each medication. Medication and label are correct. The policy added, If applying a transdermal patch or giving an injection, the location of administration site must be documented, and sites must be rotated.