STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215351	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Mays Chapel	12230 Round Wood Road Timonium, MD 21093

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that oxygen tubing was changed and dated as per the physician orders and according to the oxygen therapy facility policy and procedures. This was evident in 4 (#56, #46, #38, #5) of 5 residents observed receiving oxygen during the annual survey.The findings include: 1. On 04/06/2026 at 12:54 PM, Resident #56 was observed receiving O2 at 2L/min. However, the O2 tubing was not labeled. The humidifier bottle was labeled with the date of 04/01/2026. On 04/07/2026 at 09:30 AM, the surveyor, during observation rounds on the clinical unit, observed that resident # 56 was receiving O2 therapy at 2 liters per minute via nasal cannula, and the oxygen tubing connected to the humidifier bottle was not labeled with a date indicating when the tubing was last changed. On 04/08/2026 at 08:30 AM, the surveyor reviewed the electronic medical record of Resident #56. The physician orders related to oxygen therapy revealed that the O2 nasal cannula tubing and humidifier were to be changed every week and that the resident was to receive O2 therapy via nasal cannula at the rate of 2 liters per minute for Resident #56. On 04/08/2026 at 08:46 AM, the surveyor, while performing observation rounds, the resident # 56 was receiving O2@2l/min via nasal cannula. The oxygen tubing for Resident #56 was not labeled with a date. On 04/08/2026 at approximately 10:30 AM, the surveyor requested the DON to provide a copy of the oxygen therapy policy and procedure. The DON stated that the staff is expected to change and date O2 tubing and humidifier bottles at least weekly. On 04/09/2026 at 08:45 AM, the surveyor reviewed the facility's oxygen therapy policy and determined that the dating and changing of the oxygen nasal cannula are part of the infection prevention process related to oxygen therapy for residents, per the facility's oxygen therapy policy and procedure. The facility was found to be non-compliant. 2. During observation rounds on 04/06/2026 at 8:06 am, Resident #46's oxygen nasal cannula and tubing were found tied and hanging from the cord of the resident's over the bed light fixture, not on the resident, and the other end of the oxygen tubing was connected to a concentrator that was running at 2 liters. The oxygen nasal cannula and tubing were also found not to be labeled with a date indicating (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when they were last changed. During interview and observation rounds on 04/06/2026 at 8:10 AM Staff # 3 verified that Resident #46's oxygen nasal cannula and tubing was tied and hanging from the cord of residents over the bed light fixture, not on resident, tubing was connected to a concentrator that was on running at 2 liters and there was no date indicating when the nasal cannula and tubing was last changed. Staff #3 immediately removed the oxygen nasal cannula and tubing for the cord and placed it on Resident #46. Staff #3 stated, The resident should have the oxygen on. Review of resident #46's medical record on 04/06/2026 at 9:54 AM revealed a physician's order dated 02/26/2026 stating the following: Oxygen: every shift O2 at 2 L/MIN CONTINUIOUS VIA N/C FOR >92 % every shift for MONITORING. Further review revealed a physician's order dated 02/10/2025 stating the following: OXYGEN EQUIPMENT: 11-7 Shift weekly WEEKLY 02/NEB Equipment CHANGE 02 TUBING NASAL CANNULA/MASK WEEKLY IF IN USE – LABEL TUBING WITH DATE CHANGED. During an interview on 04/06/2026 at 10:05 AM with the Director of Nursing (#2), was informed of the surveyor's observations as stated above. During an interview and review of resident #46's oxygen orders on 04/08/2026 at 1:18 PM, the Director of Nursing (#2) stated, Resident #46's oxygen PRN order dated 02/10/2025 should have been discontinued and was an oversight. I will call the doctor and get the order discontinued. The resident should be on oxygen 2 L/min by nasal cannula continuous. 3. On 4/06/2026 at 12:36 PM, the surveyor observed that Resident #38's oxygen tubing was not labeled with the date and time of administration. The oxygen tubing was also noted to be on the floor next to the resident's bed. On 4/06/2026 at 1:39 PM, the nurse (LPN #22) for Resident #38 was interviewed and asked why the resident did not have their oxygen on and why the oxygen tubing was not labeled with the date and time it was administered to the resident. LPN #22 responded that 'Resident #38 gets Nebulizer Treatment every 6 hours for his/her asthma and that he/she takes the mask off themself when if finished. He/she must have dropped it to the floor. The surveyor then asked LPN #22 if it was a standard practice not to date and time the tubing. LPN #22 responded, I will change it out and get a new one with the date and time on it. On 4/08/2026 at 1:42 PM, the surveyor asked the DON for a copy of the Oxygen Therapy Policy. After reviewing the Oxygen Therapy policy, the surveyor noted that it states within the policy that 'Tubing and bottles are labeled with date' and 'Clean and store equipment in a clean plastic bag with the date. 4. On 4/06/2026 at 1:27 PM, the surveyor observed that the Oxygen tubing for Resident #5 was on the floor and was not dated, and the Oxygen concentrator was still running. On 4/06/2026 at 1:39 PM, the nurse (LPN #22) for Resident #5 was interviewed and asked why the resident did not have their oxygen on and why the oxygen tubing was not labeled with the date and time it was administered to the resident. LPN #22 responded that 'Resident #5 receives Oxygen PRN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and they take the nasal cannula off when they don't want it on. They must have dropped it to the floor.' The surveyor then asked LPN #22 if it was a standard practice not to date and time the tubing. LPN #22 responded, I will change it out and get a new one with the date and time on it. On 4/08/2026 at 1:42 PM, the surveyor asked the DON for a copy of the Oxygen Therapy Policy. After reviewing the Oxygen Therapy policy, the surveyor noted that it states within the policy that 'Tubing and bottles are labeled with date' and 'Clean and store equipment in a clean plastic bag with the date.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to ensure that required beneficiary protection notifications were provided to a resident. Specifically, the facility did not issue the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, and the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), Form CMS-10055, as applicable. This deficient practice was identified for 1 of 3 residents reviewed for Beneficiary Protection Notifications (Resident #38).Findings include:On 04/06/2026, the facility received Beneficiary Protection Notification Review forms for three residents, including Resident #38.On 04/08/2026 at 2:15 PM, the Director of Nursing (DON) returned the forms. Review indicated that Resident #38 did not receive the required NOMNC or SNF ABN.During an interview on 04/08/2026 at 3:34 PM, the DON confirmed that the notices were not provided and was unable to explain the omission.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews with facility staff it was determined the facility failed to ensure that residents' environment was clean and well maintained. This was found to be evident for 1 (Resident # 101) of 40 residents observed on the third floor during the facility's annual Medicare/Medicaid survey.Findings include,During an initial tour conducted on the third floor on 04/06/2026 at approximately 8:40 AM, an observation was made of Resident # 101's room. There were many dark marks noted on the floor in front of the resident's nightstand. The markings appeared to be marred onto the floor. The Administrator was made aware of the concerns at approximately 10:15 AM on the same date. He stated that maintenance would address the concerns.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review and staff interview, the facility failed to ensure that a gradual dose reduction (GDR) was attempted for an antianxiety medication and failed to provide adequate clinical documentation supporting the continued use of the medication. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #8).Findings include: Medical record review on April 7, 2026, revealed that Resident #8 has been receiving Ativan (lorazepam) three times daily since February 29, 2024, for dementia with agitation. A pharmacy consultant recommendation dated February 9, 2026, suggested a gradual dose reduction (GDR); however, the physician declined the recommendation, stating the resident was at high risk for decompensation. The medical record did not contain sufficient clinical documentation to support this determination, and there was no evidence that a GDR had ever been attempted.Further review indicated that the resident has also been receiving Cymbalta (duloxetine) 30 mg at bedtime since January 2024 for depression, which may also address anxiety symptoms. The dosage decreased to 20 mg on March 17, 2026. Behavioral monitoring sheets from November and December 2025 and January through March 2026 revealed no documented behaviors to substantiate the continued need for scheduled Ativan. Additionally, physician progress notes lacked documentation indicating that a GDR was attempted or provided a clear clinical rationale for the ongoing use of the medication.During an interview, the Director of Nursing (DON) stated that the behavioral monitoring sheets might be inaccurate and reported that the resident yells out. When asked whether the yelling could represent an unmet need, such as pain, particularly given the resident's cognitive impairment and inability to effectively communicate, the DON acknowledged that this was possible.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and interviews with facility staff it was determined the facility failed to provide written information to the resident and/or the resident responsible party (RP) regarding a hospital transfer and provide them with a copy of the facility's bed hold policy. This was found to be evident for 1 (Resident # 90) of 3 residents reviewed for hospitalizations during the facility's annual Medicare/Medicaid survey.Findings include,A medical record review was conducted on 04/07/2026 1:15 PM and upon review, it revealed that Resident # 90 went to the hospital on 1/30/26 for expiratory rhonchi (low pitched rattling lung sounds heard primarily when breathing out, caused by air passing through narrow airways).The survey team requested documentation of written notification of the transfer documentation and the bed hold policy that was provided to the RP. The DON was unable to provide this documentation to the survey team.During a subsequent interview with the DON on 4/7/26 at 1:55 PM she was asked to explain why this resident RP was not notified of the hospital transfer and a hospital bed-hold policy was not provided and she stated that no bed hold policy was sent because it was missed. In addition, written documentation for RP notification should have been sent as well but was also not done. She went on to say that re-education will be provided for staff.All concerns were discussed with Administration at the exit conference conducted on 4/9/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews, and record review, it was determined that the facility failed to develop and implement a complete, comprehensive care plan. This was evident for 1 (Resident #38) out of 6 residents reviewed during this annual survey.A comprehensive person-centered care plan for each resident must include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.The findings include:On 4/06/2026 at 12:36 PM, the surveyor observed that Resident #38's oxygen tubing was not labeled with the date and time of administration. The oxygen tubing was also noted to be on the floor next to the resident's bed.On 4/06/2026 at 1:39 PM, the nurse (LPN #22) for Resident #38 was interviewed and asked why the resident did not have their oxygen on and why the oxygen tubing was not labeled with the date and time it was administered to the resident. LPN #22 responded that 'Resident #38 gets Nebulizer Treatment every 6 hours for her asthma and that she takes the mask off herself when if finished. She must have dropped it to the floor. The surveyor then asked LPN #22 if it was a standard practice not to date and time the tubing. LPN #22 responded, I will change it out and get a new one with the date and time on it.On 4/08/2026 at 1:42 PM, the surveyor asked the Director of Nursing (DON) for a copy of the Oxygen Therapy Policy and for a copy of the resident's care plan. On 4/08/2026 at 3:39 PM, after reviewing the care plan, the surveyor had an interview with the DON. The surveyor asked the DON to review the care plan for any respiratory care focus. The resident has a diagnosis of asthma/COPD and acute bronchitis. The DON looked over the care plan and then confirmed that she did not see any focus areas in the care plan for respiratory care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, it was determined that the facility failed to ensure that the comprehensive care plan was reviewed and revised after each assessment. It was evident for 1 (Resident #38) out of 6 residents reviewed during this annual survey. The findings include:On 4/08/2026 at 1:42 PM, the surveyor asked the Director of Nursing (DON) for a copy of Resident #38's care plan.On 4/08/2026 at 3:39 PM, after reviewing the care plan, the surveyor noted that the care plan was missing a respiratory focus area. The resident has a diagnosis of asthma/COPD and acute bronchitis. Resident #38 was admitted to the facility on [DATE] and had had 2 care plan meetings since admission on [DATE] and 4/09/2026. The surveyor asked the DON to come for an interview. The surveyor asked the DON to review the care plan for any respiratory care focus. The DON looked over the care plan and then confirmed that she did not see any focus areas in the care plan for respiratory care. The DON continued to state that she was unsure how this was missed in the care plan and that she would revise the care plan as soon as possible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to follow the physician orders. This was evident 1 (Resident #46) out of 1 residents observed receiving oxygen during the annual survey. The findings include: During observation rounds on 04/06/2026 at 8:06 am Resident #46's oxygen nasal cannula and tubing was found tied and hanging from the cord of the residents over the bed light fixture, not on resident, and the other end of the oxygen tubing was connected to a concentrator that was on running at 2 liters.During interview and observation rounds on 04/06/2026 at 8:10 AM Staff #3 verified that resident #46 oxygen nasal cannula and tubing was tied and hanging from the cord of residents over the bed light fixture, not on resident, and tubing was connected to a concentrator that was on running at 2 liters. Staff #3 immediately removed the oxygen nasal cannula and tubing for the cord and placed it on resident #46. Staff #3 stated, resident should have the oxygen on.Review of resident #46 medical record on 04/06/2026 at 9:54 AM revealed a physician's order dated 02/26/2026 stating the following: Oxygen: every shift O2 at 2 L/MIN CONTINUIOUS VIA N/C FOR >92 % every shift for MONITORING. Further review revealed a physician's order dated 02/10/2025 stating the following: OXYGEN PRN FOR O2 BELOW 90% AS NEEDED FOR HYPOXIA every 15 minutes as needed for HYPOXIA TITRATE OXYGEN AS NEEDED TO MAINTAIN 02 SATURATION - 90%.During an interview on 04/06/2026 at 10:05 AM with the Director of Nursing staff #2 was informed of the surveyor observations as stated above. During an interview and review of resident #46 oxygen orders on 04/08/2026 at 1:18 PM with the Director of Nursing staff #2 stated, Resident #46 oxygen PRN order dated 02/10/2025 should have been discontinued and was an oversite. I will call the doctor and get the order discontinued. Resident should be on oxygen 2 L/min by nasal cannula.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations, administrative record review, and interviews, the facility failed to ensure the staffing ratios and assigned the registered nurse for the unit was posted on the white board utilized to display the staffing assignments on the clinical unit. This was evident to be true for 1 out of 2 clinical units observed during an annual survey.The findings include:On 04/06/2026 at 08:15 AM during an observation tour of second and third floor clinical units the surveyor observed that the white boards used to display clinical staffing assignments had not been filled out for the day shift. On 04/06/2026 at 08:28 AM during a second observation tour of the third floor clinical unit the surveyor observed that the white board used to display the clinical staffing assignment did not include the ratios of staffing/resident assignments for the GNA and LPN staff members nor did the census board reflect which RN was in charge of the unit. After the surveyor took a picture of the census board the surveyor interviewed the assigned charge nurse, a LPN # 20. During the interview with LPN #20 she stated that the census and staffing assignment are to be updated during the change of shift between 0700 AM and 07:30 AM. The surveyor also observed that there was no RN identified on the census board.On 04/06/2026 at approximately 10:15 AM during an interview with the administrator and the DON the surveyors shared their initial observations of the clinical units. The administrator and DON were informed that the census boards were not completed prior to 08:15 AM.On 04/07/2026 at 09:30 AM the surveyor performed an observation tour of the third-floor nursing unit and found that there were no nursing staffing ratios posted on the white board used for posting the staff assignments.On 04/08/2026 at 11:30 AM the surveyor performed an observation tour of the third-floor clinical unit and found that there were no nursing staffing ratios posted on the white board used for posting the staff assignments. The census board did display which RN was in charge of the clinical unit.The facility was non-compliant with posting the staffing ratios related to the number of residents assigned to each licensed practical nurse (LPN) and geriatric nursing assistant (GNA) working on the clinical unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the accuracy and timeliness of controlled substance documentation, resulting in unresolved discrepancies in narcotic counts. This was evident in 2 of 2 medication count reconciliations observed and reviewed for accuracy during the recertification survey.Findings include: On 4/8/26 at 8:00 AM, during an observation of the narcotic count on Unit 2, Staff #24 was observed signing the narcotic count sheet for Tramadol. The count sheet documented 12 tablets; however, an actual pill count revealed 11 tablets, indicating an unresolved discrepancy.Continued observation revealed that Lorazepam 0.5 mg had a documented count of 59 tablets as of 6:00 AM, while 67 tablets were physically present. This finding demonstrated inaccurate documentation and a failure to reconcile controlled substances.During an interview on 4/8/26, Staff #24 stated that he was signing off medications for 4/7/26 on 4/8/26 because the nurse who administered the medication had failed to document the administration. Staff #24 further stated that he miscounted the Lorazepam when it was administered and signed it off at 6:00 AM, acknowledging the inaccuracy of the documentation.When asked whether the narcotic count on 4/7/26 was conducted with the off-going nurse, Staff #24 confirmed that it was completed. However, when questioned why the discrepancy in the Tramadol count was not identified at that time, he stated, we both missed it.The Director of Nursing (DON), who was present on the unit and informed of the findings, instructed Staff #24 to let's do another narcotic count, confirming the facility's awareness of the discrepancy at the time of the survey.On 4/8/26 at 1:00 PM, during an interview, the DON stated that Staff #24 had been in-serviced on the facility policy regarding accurate and timely documentation of controlled substances and ensuring that discrepancies in narcotic counts are promptly identified and resolved.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, the facility failed to ensure medications were securely stored and controlled to prevent unauthorized access, and failed to ensure timely storage of medications upon delivery in accordance with accepted professional standards of practice. This deficient practice was identified in 1 (Resident #20) of 1 resident observed for medication storage during the annual recertification survey.Findings include:On 4/7/26 at 8:00 AM, during observation rounds, the surveyor observed a brown bag containing medications with a list of medications stapled to the outside. The bag was unattended on a bedside table next to the nurse's desk and was accessible to unauthorized individuals.On 4/7/26 at 8:15 AM, a Licensed Practical Nurse (LPN), Staff # 24, was interviewed regarding the medications. The LPN stated that the pharmacy had delivered the medications during the 11:00 PM-7:00 AM shift and that he did not have time to store them where they belong, indicating a failure to ensure timely and secure storage of medications upon delivery.Additionally, on 4/7/26 at 8:20 AM, Resident # 20 was observed with a plastic bottle located under the resident's bed. Further observation revealed the bottle contained Nystatin powder, demonstrating that resident medications were not maintained in a secure manner to prevent unauthorized access.The Director of Nursing (DON) was informed of these findings on 4/7/26 at 9:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215351	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Mays Chapel	12230 Round Wood Road Timonium, MD 21093

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with facility staff it was determined the facility failed to ensure that dishes were cleaned and stored properly, dishwashing machine temperatures were consistently entered on the dishwasher log, and, foods were dated upon opening and stored in a sanitary environment. This was found to be evident during the initial tour of the kitchen during the facility's annual Medicare/Medicaid survey.Findings include:An initial tour of the kitchen was conducted on 4/6/26 at approximately 7:50AM with the Kitchen Supervisor (KS #17), and the following concerns were identified:On the counter in the area where the dishwashing machine is located, there were 2 stacks of dirty food trays, 2 dirty pitchers and a dirty bowl present. At this time Staff #17 was asked to provide the surveyor with dishwashing machine temperature logs and he accompanied the surveyor to the location of the logs. Upon review, it revealed missing temperature entries of the dishwasher; the last temperature entry was on 4/2/26. Staff #17 stated that the dishwashing machine is to be checked each day and the temperatures are to be recorded.A continued tour of the walk-in refrigerator with the KS (#17), identified the following concerns:-an opened bottle of ranch dressing half full of no date when opened-a full bottle of Jelly that was opened with no date when opened-a large bag of broccoli florets that was opened and half full of no date when opened-slices of turkey luncheon meat that was sitting unwrapped in clear plastic wrap with no date.-a head of lettuce with no date.-large plastic bin that was filled with packs of chicken with water sitting at the bottom of the pan with no date.A continued tour of the dry storage area with the KS (#17) identified a large bag of sugar that was open and half full with no date when opened.The KS (#17) accompanied the surveyor to the area where refuse is taken for discard and upon entering the hallway, there were three separate bread holders that contained packs of bread that were stored. The first bread holder had 7 shelves filled with loaves of bread and/or rolls. The second bread holder had 6 shelves with an assortment of bread and rolls, and the 3rd bread holder had bread noted on a couple of the shelves. At the time of the observation, a staff member was observed pushing a mop and bucket past the bread, then another staff member came through the hallway pushing a large bin containing residents' laundry, past the bread containers. When the surveyor asked the KS about the bread containers being stored in the hallway, he stated that this is where the bread is usually stored. He was made aware that this was a concern.An interview was conducted with the Dietary Manager (DM #4), on 4/6/26 at approximately 10:45 AM in the presence of the survey team, and he was made aware of the identified concerns. He stated that the chicken was placed in the refrigerator on March 31, 2026, and that he has seven days to cook the chicken. At this time the survey team requested a copy of the facility's food storage policy. The DM returned to the survey team, moments later with a copy of the guidance that stated that food must be cooked after 3 days of being thawed, specifically for poultry. He stated that education will be done with the staff. He also stated that the bread will be moved from the laundry hallway and all identified concerns will be addressed.During a follow-up visit to the kitchen on 4/6/26, the chicken was removed and the bread containers were removed from the laundry hallway, and all other identified concerns were being addressed. The NHA and the DON were made aware of all the identified concerns at the exit conference on 4/9/26,

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview, it was determined the facility staff failed to maintain medical records in the most accurate form. This was evident for 1 (#46) out of 6 residents' medical records reviewed during the annual survey. The findings include: Review of Resident #46's medical record on 04/06/2026 at 9:54 AM revealed a physician's order dated 02/26/2026 stating the following: Oxygen: every shift O2 at 2 L/MIN CONTINUIOUS VIA N/C FOR >92 % every shift for MONITORING. Further review revealed a physician's order dated 02/10/2025 stating the following: OXYGEN PRN FOR O2 BELOW 90% AS NEEDED FOR HYPOXIA every 15 minutes as needed for HYPOXIA TITRATE OXYGEN AS NEEDED TO MAINTAIN 02 SATURATION - 90%.During an interview and review of Resident #46's oxygen orders on 04/08/2026 at 1:18 PM with the Director of Nursing (#2) stated, Resident #46's oxygen PRN order dated 02/10/2025 should have been discontinued and was an oversite. I will call the doctor and get the order discontinued. Resident should be on oxygen 2 L/min by nasal cannula continuous.