STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215361	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, it was determined that the facility failed to ensure maintenance of a homelike environment. This was evident for 3 (#30, #13, and #22) out of 18 resident's rooms observed during the surveyor's initial tour during the facility's recertification survey. The findings include: During observation rounds the following was found: On 5/27/25 at 8:09AM in the room of Resident #30, the surveyor observed damage to the wall area adjacent to the resident bed just outside of the bathroom. The wall appeared with scratches and peeling and flaking of paint. On 5/27/25 at 8:19AM in the bathroom of Resident #13, the surveyor observed paint damage, brown streaking to the surrounding wall, and crumbling wall fragments to the base of the toilet where it meets the wall. On 05/27/25 at 8:28AM in the room of Resident #22, the surveyor observed the wall to the head of the resident bed area with scratches and peeling and flaking paint. During staff interview on 5/28/25 10:10 AM the surveyor discussed with Maintenance Supervisor #26, the paint that is peeling, flaking, and with scratches within the resident areas. Maintenance Supervisor #26 stated they would submit work orders to start repairs to the resident room areas. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interview and record review it was determined the facility failed to ensure a resident was monitored for side effects of psychotropic medications. This was evident for 1 (Resident #50) out of 5 residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: On 5/28/25 at 8:46AM the surveyor reviewed the medical record of Resident #50 which revealed active medical orders for the following medications: trazodone (antidepressant/sedative), buspirone (anxiolytic), and zyprexa (atypical antipsychotic) with no side effect monitoring order observed to be in place. On 5/28/25 at 9:16AM the surveyor reviewed the medical record of Resident #50 which included the May 2025 medication and treatment administration records which revealed there was no medication side effect monitoring present for the trazodone, buspirone, or zyprexa medications. On 5/28/25 at 9:36AM the surveyor conducted an interview and shared their concern regarding Resident #50 with Unit Manager, Registered Nurse #11 who reported to the surveyor that during the admission process for residents, side effect monitoring orders are placed on the treatment administration record and also placed anytime there is a medication change, and so I'm not sure how that one was missed. On 5/28/25 at 9:55AM the surveyor conducted an interview with the Director of Nursing (DON) and inquired as to their expectation for medication side effect monitoring. The DON reported to the surveyor that there were two orders expected to be in place for psychotropic medication monitoring, one for behavior monitoring, and one for medication side effects monitoring which is used for monitoring of the specific target symptoms the resident could have, and they would be listed in the medical order and additionally reflect on the treatment administration record of the resident. At this time, the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the concern and observed the concern within the medical record with the surveyor. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and DON.

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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 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 interview and record review it was determined the facility failed to ensure that an allegation of abuse was timely reported. This was evident for 1 (#MD00212201) out of 3 facility reported incidents reviewed during the facility's recertification survey. The findings include: On 5/29/25 at 8:47AM the surveyor requested and reviewed the facility's complete investigation file for facility reported incident #MD00212201. Review of the complete investigation file revealed the following information: 1.) a statement written by the Director of Social Services #7 dated 11/26/24 which documented allegations of abuse verbalized to them by Resident #269, 2.) an initial self report submitted by the facility on 11/26/24 which documented that facility staff became aware of the incident at 2:00PM with physical abuse as the type of allegation being reported, and 3.) an email confirmation of submission of the initial self report made to the Office of Health Care Quality on 11/26/24 at 4:10PM. Review of the complete investigation file and initial self report documentation revealed the self report to the Office of Health Care Quality was not made within the two hour timeframe. On 6/2/25 at 8:27AM the surveyor conducted an interview with the facility's Director of Nursing (DON) who confirmed that the facility's expectation is for staff to report an allegation of abuse within two hours to the Office of Health Care Quality. At this time the surveyor shared their concern with the DON, who acknowledged and confirmed understanding of the concern. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and DON.

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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. Based on interview and record review it was determined the facility failed to ensure allegations of abuse were thoroughly investigated. This was evident for 1 (#MD00212201) out of 3 facility reported incidents reviewed during the facility's recertification survey. The findings include: On 5/29/25 at 8:47AM the surveyor requested and reviewed the facility's complete investigation file for facility reported incident #MD00212201. Review of the complete investigation file revealed a statement written by the Director of Social Services #7 dated 11/26/24 which documented allegations of abuse verbalized to them by Resident #269, which included both allegations of physical and verbal abuse. Review of the interviews conducted revealed that staff members were questioned regarding the allegation of physical abuse, however, there were no documented questions to staff regarding the allegations made of verbal abuse. Review of the complete investigative file revealed there was no documentation of an interview conducted or statement obtained from the alleged perpetrator, and no written statement obtained from the resident. On 6/2/25 at 10:55AM the surveyor conducted an interview with the facility's Director of Nursing (DON) and shared concerns that there was no written statement obtained from Resident #269, and no documentation of an interview or statement obtained from the alleged perpetrator, Geriatric Nursing Assistant (GNA) #23. At this time, the surveyor requested to the DON for the facility to provide all documentation regarding these concerns. On 6/2/25 at 12:08PM the DON informed the surveyor that there was no statement obtained from the resident, no statement obtained from the alleged perpetrator, and no interview of them conducted. The DON confirmed there was no documentation that could be provided to the surveyor to show the facility had made any attempt at either obtaining a statement or conducting an interview with GNA #23. At this time, the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the concern. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and DON.

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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. Based on review of medical records and interviews it was determined that the facility failed to review and revise a quarterly comprehensive care plan by all interdisciplinary team members. This was evident for 1 (Resident #21) out of 1 residents reviewed for care planning during the facility's recertification survey. The findings include: Review of Resident #21's medical record by the surveyor on 5/28/25 at 9:55AM revealed a progress note stating that a quarterly care plan meeting and review was completed for Resident #21 on 3/4/25 by the interdisciplinary team, but did not include the attending physician and a nurse aide with responsibility for the resident. During an interview on 5/28/25 at 2:07PM, Director of Social Services #7 confirmed and stated that the attending doctor and a nurse aide with responsibility for the resident did not review or revise Resident #21's 3/4/25 quarterly care plan. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review it was determined the facility failed to take measures to ensure a resident was free from accident hazards. This was evident for 1 (Resident #20) out of 2 residents reviewed for accidents during the facility's recertification survey. The findings include: On 5/27/25 at 10:38AM the surveyor observed Resident #20 from the hallway to be laying on their back in their bed which was in a flat position and also in the highest position, with a hoyer sling situated under them and their foley catheter bag laying on top of their right thigh. No staff was observed by the surveyor to be present within the resident's room or within the hallway. On 5/27/25 at 10:40AM the surveyor conducted an interview of Resident #20 who reported to the surveyor that their nursing assistant had left to get something and they had been laying there for five minutes. Resident #20 stated to the surveyor: It makes me feel helpless. On 5/27/25 at 10:42AM the surveyor requested a dual observation with the resident's assigned nurse. On 5/27/25 at 10:43AM the surveyor observed Activities Staff #24 enter the resident's room and inform them of the day's activities which were to occur, and then left the room while the resident remained in the same position. On 5/27/25 at 10:47AM the surveyor observed Geriatric Nursing Assistant (GNA) #25 in the hallway and shared the concerns with them. At this time the surveyor conducted an interview with GNA #25 who stated to the surveyor that No, s/he's not been here three seconds, I went to get the hoyer lift. At this time, in response to the sharing of the surveyor's concerns, GNA #25 was observed removing the resident's catheter bag from their lap and hung it below the level of the bladder and then lowered the resident's bed before leaving the room. On 5/27/25 at 10:48AM the surveyor shared concerns with Licensed Practical Nurse #6 and Unit Manager, Registered Nurse #11, who both acknowledged and confirmed understanding of the concerns. On 5/27/25 at 10:50AM the surveyor observed GNA #25 bringing the hoyer lift into the room to assist the resident. On 5/27/25 at 11:44AM the surveyor conducted an interview with the facility's Director of Nursing (DON) who stated that the facility's expectation is for GNA's to come into the room prepared with the hoyer lift to complete the transfer with the resident. The DON acknowledged the surveyor's concerns and informed the surveyor that in response to the surveyor's concerns, staff were provided safety education regarding bed height and a quality assurance plan was started for the issue. At this time the DON confirmed understanding of the surveyor's concerns. Review of Resident #20's care plan by the surveyor on 5/28/25 at 12:17PM revealed the following documentation: Dependent on staff for meeting emotional, intellectual, physical and social needs r/t physical limitations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and DON.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to ensure proper reconciliation of expired controlled drug medications during medication administration and drug record keeping for the resident. This was evident for 1 (Resident #33) out of 6 residents reviewed for medication storage during the facility's recertification survey. The findings include: During observation rounds and resident record review on [DATE] at 1:57PM with Licensed Practical Nurse (LPN) #6, the surveyor reviewed the narcotic count log book and the narcotic medications on-hand within the lock box where they are stored. The surveyor observed Resident #33's Oxycodone TAB 5mg medication card and noted an expiration date located on the back of the card, which revealed the medication was expired as of [DATE]. The surveyor then reviewed the controlled drug receipt/record/disposition form within the narcotic count log book which revealed that Oxycodone 5mg Tab was given to the resident on [DATE] by Registered Nurse (RN) #27. During staff interview on [DATE] at 2:00PM the surveyor asked the LPN #6 if the record review reflected a narcotic medication card expired on [DATE] and an entry on the controlled drug receipt/record/disposition form reflected a medication entry made for [DATE]. LPN #6 confirmed that the expired medication was given to the resident. During staff interview on [DATE] at 2:57PM with Director of Nursing (DON) #2, they were informed of expired narcotic medication and administration to Resident #33. The surveyor asked the DON about the expectation of the narcotic count log with 2-person handoff at each change of shift, and the DON stated the expectation is to verify counts and expiration dates of the medication at the time of the 2-person count. Additionally, the DON stated the expiration date should have been checked during medication administration on [DATE]. Review of the medical record on [DATE] at 12:21 PM for Resident #33 revealed a physician's order for Oxycodone HCl Tablet 5MG Give 0.5 tablet by mouth every 6 hours as needed for pain administer for pain score >3 and per request by resident for Pain score >3, Start date [DATE] 1200. Further review of Resident #33's medical record revealed a medication administration record entry for Monday, [DATE]; Pain Level 5; given by RN #27, at 01:58. On [DATE] at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, and interview it was determined that the facility failed to follow prescriber's orders and manufacturer's specifications regarding medication preparation during medication administration for the resident. This was evident for 1 (Resident #13) out of 4 residents observed for medication administration during the facility's recertification survey. The findings include: During observation rounds for medication administration on 5/28/25 at 8:56AM the surveyor observed Registered Nurse #5 prepare Resident #13's medications using a white eating utensil spoon not labeled with measurements to scoop 2 scoops out of a bulk Benefiber bottle, to mix in a measured cup prior to adding liquid. During surveyor review of Resident #13's medical record on 5/28/25 at 9:00AM the record revealed the following physician's medication order: Benefiber powder (Wheat Dextrin) Give 1 packet by mouth one time a day for diarrhea Dissolve contents in 8 ounces of liquid; Benefiber powder ADMINISTER 2 TEASPOONSFUL BY MOUTH ONE TIME A DAY FOR DIARRHEA DISSOLVE CONTENTS IN 8 OUNCES OF LIQUID. On 5/28/25 at 10:01AM the surveyor conducted an interview of Director of Nursing (DON) #2 who discussed the expectations for medication preparation and measuring devices. The surveyor asked DON #2 what measuring device should be used when measuring from a bulk bottled medication. DON #2 stated the expectation is for the staff to measure all medications with appropriate measurement labeled devices when applicable. During record review on 5/28/25 at 12:00PM the surveyor reviewed policy and procedures received which indicated the following: Medication Administration, Policy 5.3 GENERAL GUIDELINES FOR MEDICATION ADMINISTRATION, Procedure, 5. Preparing Medications for Administration: B) Liquid Medications, c. Pour correct amount directly into a graduated medication cup . On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview it was determined that the facility failed to maintain proper storage with regards to reconciling expired medications and storing all drugs and biologicals in locked compartments. This was evident for 3 of 3 medication storage areas observed during the facility's recertification survey. The findings include: During observation rounds and staff interviews the following was found: On 5/28/25 at 1:57PM at the Baltimore hall #2 treatment cart to review the narcotic count log book with Licensed Practical Nurse (LPN) #6, the surveyor observed the Oxycodone tab 5mg medication pack for Resident #33 which had an expiration date of 4/30/25. The surveyor asked LPN #6 if the item was expired, and LPN #6 confirmed the expired date. On 6/2/25 at 10:40AM with Unit Manager #11 in the Baltimore hall medication supply room, two SURESITE IV slide safety intravenous catheter, size 2G ¾ syringes with expiration date of 8/31/24. The surveyor asked Unit Manager #11 if item was expired; and Unit Manager #11 confirmed the expired date. After surveyor intervention Unit Manager #11 discarded the expired item. On 6/2/25 at 10:42AM with Unit Manager #11 in the Baltimore hall medication supply room, one [NAME] STERILE IV START KIT was observed with an expiration date of 6/18/23. The surveyor asked staff #11 if the item was expired; at which time Unit Manager #11 confirmed the expired date. After surveyor intervention Unit Manager #11 discarded the expired item. On 6/2/25 at 11:10AM with Unit Manager #21 in the Harbor Hall medication supply room, one package of ArgiMent AT with Bimuno Prebiotic For Acute and Chronic Wounds - A Medical Food revealed an expiration date of 9/15/24. The surveyor asked Unit Manager #21 if the item was expired; Unit Manager #21 confirmed the expired date. After surveyor intervention, Unit Manager #21 discarded the expired item. On 6/2/25 at 11:15AM with Unit Manager #21 in the Harbor Hall medication supply room the narcotic lock box within the medication refrigerator was observed to be open and unlocked. The surveyor asked Unit Manager #21 if the narcotic box within the refrigerator was to remain locked; Unit Manager #21 confirmed the expectation for the narcotic box within the medication refrigerator to be always locked. During observation rounds and staff interview on 6/2/25 at 12:20PM with the Director of Nursing (DON) #2, within the Harbor Hall medication supply room, the surveyor informed the DON of the above findings as well as observed the medication storage refrigerator padlock was unlocked and the narcotic box within the refrigerator was unlocked. The DON stated the policy and procedure and expectation is for both to be always locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review it was determined the facility failed to: 1.) ensure the menu was followed, and 2.) meet resident choices based on his/her preferences. This was evident for: 1.) 7 out of 7 residents who had ordered bread sticks on their menu for the lunch meal occurring on 5/29/25 and 2.) 1 (Resident #5) out of 2 residents reviewed for food during the facility's recertification survey. The findings include: 1.) On 5/29/25 at 12:21PM the surveyor conducted a meal tray observation which revealed a menu ticket on a meal tray in which bread sticks were selected as an option, however they were not served on the meal tray. At this time, the surveyor requested a dual observation of the concern with Certified Dietary Manager (CDM) #28, who observed the meal tray, and acknowledged and confirmed understanding of the concern. On 5/29/25 at 12:27PM the surveyor observed CDM #28 approach the hot food cart and open it, and confirmed the bread sticks were not brought up from the kitchen to the unit. At this time, the surveyor conducted an interview with CDM #28 who stated the following to the surveyor: I am going to go get them from the kitchen and pass them out, I'm going to give that to them, there were seven resident orders for bread sticks. On 5/29/25 at 12:34PM the surveyor observed and confirmed with CDM #28 that the last resident meal tray for lunch service had been passed out and breadsticks listed on the menu had not been served. On 5/29/25 at 12:50PM the surveyor reviewed the concern with CDM #28. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing. 2.) During observation rounds, record review, and interview on 5/27/25 at 9:17AM the surveyor observed that Resident #5's dietary tray items did not reflect their dietary ticket on the tray. Per the dietary ticket, the items circled were: Beverage of choice, Milk of Choice, 8oz, Bacon, Danish, and Instructions: give 2 cereal at breakfast. The surveyor observed the breakfast meal tray to have the following: a hot beverage cup, and a tea bag and a half-eaten bagel on the plate. During interview on 5/29/25 at 3:25PM with Dietary Supervisor #8 the surveyor discussed the dietary ticket discrepancy with the food that was served to the resident on the breakfast tray. Dietary Supervisor #8 stated to the surveyor that the expectation is to follow the dietary ticket. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to ensure safe and separate storage of food brought in by family or visitors for residents. This was evident for 1 out of 2 Central Supply Room refrigerators observed during the recertification survey. The findings include: During observation rounds the following was found: On 6/2/25 at 11:00AM with Unit Manager (UM) #11 within the Central Supply room located on Baltimore Hall #2, the surveyor observed 3 of 6 containers of smoked salmon cream cheese spread, with an expiration date of 5/18/25. On 6/2/25 at 11:02AM with UM #11 within the central supply room located on Baltimore hall #2, the surveyor observed 2 of 2 white soup containers of liquid with visitor label dated [DATE]. On 6/2/25 at 11:04AM with UM #11 within the central supply room located on Baltimore hall #2, the surveyor observed 2 of 2 containers of cottage cheese with fruit, with the expiration date: 4/7/25. On 6/2/25 at 11:06AM with UM #11 within the central supply room located on Baltimore hall #2, the surveyor observed 1 of 1 container of Breakstone's cottage doubles with pineapple, with an expiration date of 3/18/25. During staff interview on 6/2/25 at 11:08AM with UM #11 the surveyor inquired as to if the items were resident items brought in by family and now expired, at which time UM #11 confirmed that they were resident items and that they were now expired. After surveyor intervention, UM #11 discarded the expired items. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 3) On 5/27/25 at 10:38AM the surveyor observed Resident #20 from the hallway to be laying on their back in their bed which was in a flat position and also in the highest position, with a hoyer sling situated under them and their foley catheter bag laying on top of their right thigh. No staff was observed by the surveyor to be present within the resident's room or within the hallway. On 5/27/25 at 10:40AM the surveyor conducted an interview of Resident #20 who reported to the surveyor that their nursing assistant had left to get something and they had been laying there for five minutes. Resident #20 stated to the surveyor: It makes me feel helpless. On 5/27/25 at 10:47AM the surveyor observed Geriatric Nursing Assistant (GNA) #25 in the hallway and shared concerns with them. At this time the surveyor conducted an interview with GNA #25 who stated to the surveyor that No, s/he's not been here three seconds, I went to get the hoyer lift. At this time, in response to the sharing of the surveyor's concerns, GNA #25 was observed donning medical gloves and removing the resident's catheter bag from their lap and hung it below the level of the bladder, lowered the resident's bed height and while still wearing the medical gloves, exited the resident's room with the medical gloves on in the hallway, removed them, and threw them on top of the trash and dirty linen container and walked away leaving the medical gloves on top of the container. At this time the surveyor shared the concern with GNA #25 and inquired as to if they perform hand hygiene after removal of used medical gloves. After surveyor intervention, GNA #25 was observed to utilize hand sanitizer located in the hallway. On 5/27/25 at 10:48AM the surveyor shared concerns with Licensed Practical Nurse #6 and Unit Manager, Registered Nurse #11, who both acknowledged and confirmed understanding of the concerns. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and DON. 4) On 5/28/25 at approximately 9:45AM the surveyor conducted an interview with Maintenance Supervisor (MS) #26 at which time the surveyor requested for them to provide a copy of the facility's water management plan. On 5/28/25 at 10:22AM in response to the surveyor's request for a copy of the facility's water management plan, MS #26 provided water testing results to surveyors which revealed that on 8/9/24 the facility had received positive elevated test results for Legionella within several areas located within the facility. Review of maintenance records provided by the facility revealed steps taken to address the elevated results including installation of specialized shower heads, and a water treatment system. During an interview on 5/28/25 at 11:07AM of the facility Administrator, they reported to surveyors that they were not aware of the facility having a water management plan, but that they would check and see if they could locate one. During an interview on 5/28/25 at 12:30PM Registered Nurse, Infection Preventionist (RN, IP) #4 stated that the facility did not have a water management plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/28/25 at 3:27PM surveyors conducted an interview with the facility's Administrator, who in response to the surveyor's prior requests to provide the facility's water management plan, responded with the following information: I can't find it. After surveyor intervention, the Administrator informed and later provided surveyors with a copy of a contract for a water management company to perform the service of creating a water management plan for the facility which was dated 6/1/25. On 6/2/25 at 10:35AM surveyors conducted an interview with RN, IP #4 and the facility's Director of Nursing (DON), at which time an incomplete template for a facility water management plan was provided for surveyor review. Review of that template revealed the following areas which were left blank: compilation of the water management team, inventory of water system components with the identification of dead leg area locations (areas in which stagnant water is likely to harbor waterborne pathogens), incident response procedures, and monitoring procedures/grids. At this time surveyors shared concerns with RN, IP #4 and the DON who confirmed and acknowledged understanding of the concerns. On 6/2/25 at approximately 3:30PM the surveyor again reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing. Based on observation and interview and record review, it was determined the facility failed to ensure staff adherence to appropriate infection control measures consistent with accepted standards of practices during: 1) medication administration for 1 (Resident #26) out of 4 resident observations of medication administration; 2) equipment cleaning between resident use for 1 (Resident #63) out of 4 resident observations of medication administration; 3) staff performance of hand hygiene for 1 (Resident #20) out of 2 residents reviewed for accidents; and 4) the facility failed to ensure measures to minimize the risk of Legionella and other opportunistic pathogens in the building water system by having a documented water management program which has the potential to impact all residents. The findings include: 1) During observation rounds and staff interviews: On 5/28/25 at 1:40PM the surveyor observed Enhanced Barrier Precautions (EBP) signage was present and posted on the door to Resident #26's room that indicated a minimum mandatory standard: Everyone Must: Clean their hands, including before entering and when leaving the room. On 5/28/25 at 1:44PM surveyors observed Licensed Practical Nurse (LPN) #6 during medication administration at Baltimore hall #1, enter the room of Resident #26 without performing hand hygiene as indicated on the door signage. Surveyors observed LPN #6 sitting on the resident's bed to administer medications. LPN #6 placed the medication cup on the bedside table, the cup tipped over and one white round pill fell out of the cup; LPN #6 stated she would change out the medication, then exited the resident's room without performing hand hygiene. LPN #6 then went to the medication cart, obtained a clean pill from within the medication cart, re-entered the resident room without hand hygiene, sat on the bed again, and proceeded to give medications. The surveyor asked LPN #6 about the EBP sign and purpose; and LPN #6 stated that the EBP precautions were for Resident #26 who only has precautions for their foley catheter. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) On 5/29/25 at 9:20AM the surveyor observed Enhanced Barrier Precautions (EBP) signage was present and posted on the door to Resident #63's room that indicated a minimum mandatory standard: Everyone Must: Clean their hands, including before entering and when leaving the room. On 5/29/25 at 9:24AM the surveyor observed Registered Nurse (RN) #5 exit another resident room with a vital sign machine and then proceeded to Resident #63's room to complete vital signs; the machine was not cleaned between resident use and RN #5 did not clean hands upon entering or exiting Resident #63's room during vital signs. The surveyor then observed RN #5 during medication administration for Resident #63, and RN #5 failed to clean hands as indicated on the sign when entering Resident #63's room a second time. On 6/2/25 at approximately 3:30PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on personnel record reviews and staff interviews, it was determined that the facility failed to have a system in place to ensure that Geriatric Nursing Assistants (GNA) received at least 12 hours of in-service training annually. This was evident for 3 (GNAs #16, 17, and 18) out of 3 GNA's reviewed during the facility's recertification survey. The findings include: On 5/30/25 at 3:30PM, a personnel record review revealed that GNA #16, 17, and 18 did not receive the required, annual, 12-hour, nurse aide, in-service training. On 5/30/25 at 3:35PM, Human Resources Director (HRD) #12 was interviewed. During the interview, HRD #12 was made aware that there was no documentation indicating that GNA's #16, 17, and 18 received the required, annual, 12-hour, nurse aide, in-service training. HRD #12 indicated that the Nursing and Health Services Educator, Infection Prevention Nurse (RN, IP) #4 manages documentation of the required, annual, 12-hour, nurse aide, in-service training. On 5/30/25 at 3:42PM, RN, IP #4 was interviewed. During the interview, the surveyor made RN, IP #4 aware that there is no documentation indicating that GNA's #16, 17, and 18 received the required, annual, 12-hour, nurse aide, in-service training. RN, IP #4 indicated that she did not have documentation indicating that GNA's #16, 17, and 18 were provided with an additional 12 hours of nurse aide in-service training. Also, RN, IP #4 stated that she was not aware that the regulation requires the facility to provide GNAs with an additional 12 hours of nurse aide in-service training. On 5/30/25 at 3:47PM, Director of Nursing #2 was made aware that the facility does not have documentation indicating that GNA's #16, 17, and 18 received the required, annual, 12-hour, nurse aide, in-service training. HRD #12 indicated that she was not aware that the regulation requires the facility to provide GNA's with an additional 12 hours of nurse aide in-service training.