STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215364	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Capital Region	1051 Brightseat Road Landover, MD 20785

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews, Ombudsman interview and surveyor record reviews it was determined that the facility failed to provide notification to the facility's Ombudsman of Resident transfers and discharges to the hospital. This finding was found to be evident in 8 out of 8 hospitalizations for 4 (Resident #9, #10, #14 and #17) out of 4 Residents reviewed for discharge process.The findings include: On 1/20/26 at 8 AM, the surveyor reviewed the facility census and noted that Resident #9 was not in the facility and in the hospital. On further review it appeared that Resident #9 was admitted to the hospital several times in the last few months and are as follows: 11/7/25 12/13/25 1/14/26 The surveyor requested documentation that the Ombudsman was notified of Resident #9 transfers in November and December of 2025. On 1/23/26 at 8:18 AM, the surveyor conducted an interview with the Nursing Home Administration (NHA). During the interview the NHA confirmed that transfers were not being communicated to the Ombudsman for the November and December dates and January 2026 would be relayed to the Ombudsman timely. The surveyor conducted a phone interview with the local Ombudsman for the facility at 9:56 AM on 1/21/2026. The Ombudsman stated that she was not notified of Resident transfers and discharges to the hospital, but she was notified of involuntary discharges. The surveyor conducted a record review of Resident #10's medical record on 1/22/2026 at 2:00 PM. The review revealed that Resident #10 was discharged to the hospital on 8/8/2025 and 10/2/2025. There was no documentation in Resident #10's medical record that the Ombudsman was notified of these discharges. On 1/22/2026 at 2:15 PM the surveyor conducted a record review of Resident #14's medical record. Review of Resident #14's medical record revealed that Resident was transferred to the hospital on [DATE] and 11/3/2025. There was no documentation in Resident #14's medical record that the Ombudsman was notified of these transfers to the hospital. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #17's medical record was conducted by the surveyor on 1/22/2026 at 2:35 PM. The review revealed that Resident #17 was discharged to the hospital on 9/21/2025 and 12/24/2025. There was no documentation in Resident #17's medical record that the Ombudsman was notified of these discharges to the hospital. In an interview with the Licensed Nursing Home Administrator (LNHA) on 1/23/2026 at 8:18 AM the LNHA provided the surveyor with an email notification to the Ombudsman time stamped 7:50 AM on 1/23/2026 with the subject, Notice of Discharges for August 2025 – January 2026. LNHA stated that this process of notifying the Ombudsman of transfers and discharges had not been completed by the facility due to the change in the personnel in the Social Services Department. Additionally, the LNHA stated that going forward the Ombudsman will be notified of transfers and discharges monthly. No additional information was provided by the facility at the time of survey exit.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, surveyor record reviews, review of facility policies, and interviews it was determined that the facility failed to provide services to meet professional standards during 1) medication ordering 2) medication administration documenting 3) medication order clarification 4) medication administering and 5) documenting care and services provided to a Resident accurately. These findings were found to be evident in 3 (Residents #168, #15 & #16) out of 7 Residents reviewed for unnecessary medications, 2 (Residents #138 & #103) out of 4 Residents observed for medication administration and 1 (Resident #96) out of 5 Residents reviewed for respiratory care and services. Controlled Drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. It is required that controlled substances that are removed or disposed of have strict compliance procedures to prevent diversion. Facilities must maintain detailed records of administration and/or destruction, including the method, date, and witnesses. Dialysis is a medical treatment that filters waste and excess fluid from the blood. Dialysis is needed when the kidneys fail to do so. A side effect from dialysis can be a drop in blood pressure. Multi-dose insulin pens are handheld devices that contain a prefilled insulin cartridge for multiple injections combined with a needle. This pen allows users to dial specific dosages. A new needle is used for each dose given and the pen is designed for single-person use. The new needle is primed before every injection to remove air bubbles and ensure the needle allows the flow of insulin. Standard priming dose is 2 units of insulin. The findings include: 1) On 1/20/26 at 8:47 AM, the surveyor conducted an interview with Resident #168. During the interview Resident #168 stated that he/she had been taking pain medications related to a recent surgery. On 1/22/26 at 11:19 AM, the surveyor reviewed Resident #168's medical record. The review revealed on 1/10/26 Resident # 168 had an order written for Oxycodone 10mg, with instructions, give 1 tablet by mouth every 4 hours as needed for pain of 5-10 on a pain scale. On further review, this same order was written again on 1/16/26. However, the order written on 1/10/26 was not discontinued so Resident #168 had two current orders for the same medication. Next the surveyor reviewed Resident #168's January 2026 Medication Administration Record (MAR). The review revealed Resident #168 had 20 documented administrations of oxycodone from 1/11/26-1/21/26. On 1/18/26 through 1/20/26 the facility staff documented administration of oxycodone on both orders. On 1/19/26 one administration was documented as given at 10:13 PM (on the 1/10/26 order) and an additional dose was documented as given at 10:14 PM (on the 1/16/26 order). The same medication was given one minute apart. On 1/22/26 at 12:53 PM, the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5 and the Director of Nursing (DON). During the interview the surveyor asked why there were two of the same orders for oxycodone in Resident #168's medical record and if there was a process to verify with the providers the necessity for both orders. Both Staff #5 and the DON stated that they would look into that matter. On 1/22/26 at 2:06 PM, the surveyor conducted a follow-up interview with the DON. The DON stated that the second order was written because the pharmacy required a new prescription due 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	medication being a controlled substance. The DON stated that when the new order was written the older order should have been discontinued. 2) On 1/22/26 at 12:53 PM, the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5 and the Director of Nursing (DON). During the interview the surveyor requested Resident #168's controlled drug receipt/record/disposition forms for all of Resident #168's oxycodone supply. Next the surveyor reviewed the controlled drug verification forms (including pulls from facility supply) along with the MAR. The review revealed that oxycodone 10mg was signed out as removed on the controlled drug receipt however, there was no corresponding documentation as administered on Resident #168's MAR on the days and times as follows: 1/11/26 removed at 7:13 AM (facility stock) 1/12/26 removed at 12 PM 1/12/26 removed at 9 PM 1/14/26 removed at 4:18 AM 1/14/26 removed at 11 AM 1/16/26 removed at 11:19 PM (facility stock) 1/19/26 removed at 9:30 AM 1/19/26 removed at 4:40 PM (dose on MAR at 10:13 PM & 10:14 PM)(pulled dose at 10 PM) 1/20/26 removed at 12:30 PM 1/21/26 removed at 1 AM. On 1/23/26 the surveyor reviewed the facility's Medication Administration policy. The policy stated that after medications are administered, to document medication administration with initials on the Medication Administration Record (MAR) and do so immediately after administering medications to each resident. On 1/23/26 at 8:38 AM, the surveyor conducted an interview with the DON and reviewed the concerns that oxycodone was removed 9 times without a corresponding administration in Resident #168's MAR. The DON agreed it was a concern and stated the facility staff would receive education on expectations of documenting controlled substances after administering them. 3) On 1/23/26 at 9:07 AM, the surveyor reviewed Resident #15's medical record. The review revealed that Resident #15 went to dialysis treatments on Tuesdays, Thursdays and Saturdays. On further review it was noted an order was written to start on 12/23/25 at 9 AM that stated, Nephrologist requested to hold blood pressure medication prior to dialysis due to hypotension. (low blood pressure) The instructions were to be done once a day every Tuesday, Thursday and Saturday (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on dialysis days. On review of the orders resident # 15 had three blood pressure medications ordered. First order read, Hydralazine 50 mg, give one tablet by mouth three times per day for hypertension (high blood pressure) with instructions to hold for systolic blood pressure below 110, second order, Nifedipine extended release 60 mg, give once per day for hypertension with instruction to hold if systolic blood pressure below 110 and the third order was, carvedilol 12.5 mg give twice per day and to hold systolic blood pressure below 110 and pulse below 60. Next the surveyor reviewed the January 2026 Medication Administration Record (MAR). The review revealed that all three blood pressure medications, scheduled to be administered at 9am, were given on 1/1/26, 1/3/26 and 1/15/26. However, on these same days it was documented that the blood pressure medications were held on the order that stated nephrologist requested to hold blood pressure medication prior to dialysis due to hypotension. Both orders could not be done at the same time. On 1/23/26 at 1:13 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that when there are contraindicating orders it is the responsibility of the staff to clarify the orders. She further stated that education would be started with staff on the expectations of clarifying orders. On 1/23/26 at 2:25 PM the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5. During the interview Staff #5 stated that after reviewing administration time report it appears that on 1/1/25 Resident #15's received all three blood pressure medications before dialysis, even though the order to hold was also checked as done. Staff #5 reported on further review of the administration time report, on both 1/3/26 and 1/15/26 it appeared that the medication were given at 9AM on the MAR before dialysis however, the time stamped report demonstrates they were given after Resident #15 dialysis treatment. This report also documented on 1/15/25 Resident #15's 9AM and 2PM hydralazine orders were both administered at the same time at 1:30 PM. Staff #5 confirmed that having the ability to document that medications were held at the same time as having the ability to document the medications as given can lead to misinterpretation of the orders and the orders should have been clarified. 4) On 1/28/26 at 8:38 AM, the surveyor observed Licensed Practical Nurse (LPN) # 20 prepare medications for Resident #138. The surveyor observed LPN #20 take Resident #138's multidose lispro (short acting) insulin pen and apply the needle. Next the surveyor observed LPN #20 dial up 4 units and inject the needle into Resident #138's abdominal subcutaneous tissue (fat tissue). The surveyor noted that LPN #20 did not clean the port prior to applying the needle or prime the needle prior to dialing in the prescribed insulin dose. On 1/28/26 at 9:01 AM, the surveyor conducted an interview with LPN #20 and asked if the pen was supposed to be cleaned before applying the needle and also asked if the multidose insulin pen should have been primed before use. LPN #20 stated the pen should have been cleaned prior to use, however stated that there was no need to prime the insulin pen. On 1/28/26 at 9:03 AM, the surveyor observed Licensed Practical Nurse (LPN) # 21 prepare medications for Resident #103. The surveyor observed LPN #21 take Resident #103's multidose glargine (long acting) insulin pen and apply the needle. Next the surveyor observed LPN #21 dial up 12 units and inject the needle into Resident #103's abdominal subcutaneous tissue (fat tissue). 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 noted that LPN #21 did not clean the port prior to applying the needle or prime the needle prior to dialing in the prescribed insulin dose. On 1/28/26 at 9:27 AM, the surveyor conducted an interview with LPN #21 and asked if the pen was supposed to be cleaned before applying the needle and also asked if the multidose insulin pen should have been primed before use. LPN #21 stated when she used multidose vials she cleans and primes the needles but did not for multidose insulin pens. On 1/28/26 at 11:00 AM, the surveyor interviewed the Infection Preventionist (IP) #18. During the interview IP #18 confirmed that it was the expectation that nurses using multidose insulin pens should clean the port with an alcohol wipe prior to applying the needle as well as prime the needle with 2 units of insulin prior to dialing the ordered dose to ensure accuracy in dosing. The surveyor reviewed the observations with IP #18. She stated that education would be initiated for staff that utilize multidose insulin pens. Cross Reference F755 F757 F880 5) A Ventilator is a machine that helps or takes over the function of breathing for a person who is unable to breathe adequately on their own. The ventilator is controlled by a healthcare professional to deliver air and oxygen into the person's lungs using a breathing tube or mask. On tour of the PCU Nursing Unit on 1/20/2026 at 9:56 AM the surveyor observed a ventilator at Resident #96's bedside; the ventilator was not in use. The surveyor conducted a record review of Resident #96's medical record on 1/23/2026 at 10:24 AM. Record review revealed that there was documentation in the nursing progress notes under the Skilled Charting Summary from 12/18/2025 – 12/25/2025 that Resident #96 was on mechanical ventilation; however, there was no documentation on the December 2025 pulmonary administration record by respiratory services that indicated that Resident #96 was using a ventilator. Minimum Data Set (MDS) assessment is a mandatory, comprehensive health assessment for Residents in Medicare/Medicaid certified nursing homes, gathering data on their functional, physical, and psychosocial status to develop care plans and monitor quality. The MDS assessment is conducted by nursing home staff upon admission, quarterly, annually, and with significant condition changes. Further review of the medical record on 1/23/2026 revealed that the Annual MDS assessment dated [DATE] was not coded that Resident #96 used a mechanical ventilator. Additionally, on 1/23/2026 the surveyor reviewed the facility's policy and procedure for mechanical ventilation dated 9/1/2018. The policy indicated that facility's Respiratory Services staff manages the ventilators. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Respiratory Services on 1/23/2025 at 1:05 PM the surveyor asked if Resident #96 was on a ventilator in December of 2025 and he stated that the Resident was not on a ventilator in December according to respiratory therapy documentation on the pulmonary administration record. Additionally, he stated that Resident #96 was recently on the ventilator for 24 hours on 1/9/2026 for respiratory distress and that was why the ventilator was at the Resident's bedside. The surveyor confirmed with the Director that the respiratory services department manages the ventilators. In an interview with the Director of Nursing (DON) on 1/23/2026 at 1:40 PM the surveyor conveyed that Resident #96 was not on a ventilator during the month of December 2025 according to respiratory services and MDS assessment. The surveyor further conveyed that the nursing staff was documenting in the Skilled Charting Summary progress notes that Resident #96 was on mechanical ventilation in December 2025. The DON stated that this was incorrect documentation in nursing progress notes as Resident #96 was not on mechanical ventilation in December 2025. On 1/27/2026 at 11:00 AM the Licensed Nursing Home Administrator (LNHA) was notified of the incorrect documentation in the nursing progress notes from the nursing staff in December 2025 regarding the mechanical ventilation for Resident #96. The LNHA acknowledged the surveyor. The surveyor conducted a follow-up review of Resident #96's medical record on 1/28/2026 at 2:15 PM. According to the Skilled Charting Summary dated 1/24/2026 at 23:52 nursing staff documented that Resident #96 was on mechanical ventilation. In an interview with the Regional Clinical Services Manager (RCSM) at 2:25 PM on 1/28/2026 the surveyor conveyed that the nursing staff was still documenting that Resident #96 was on mechanical ventilation as there was a Skilled Charting Summary progress note dated 1/24/2026 at 23:52. The RCSM reviewed the progress notes for Resident #96 and stated, yes, I see that, will review with nursing staff, and confirmed that Resident was not on a ventilator. No additional information was provided by the facility at the time of exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, Resident and staff interviews and surveyor record reviews it was determined that the facility failed to provide proper respiratory care and services for Residents. This finding was found to be evident in 5 (Resident #1, 4, 7, 96 and 140) out of 10 Residents reviewed for respiratory care and services.The findings include:1) Ventilator is a machine that helps or takes over the function of breathing for a person who is unable to breathe adequately on their own. The ventilator is controlled by a healthcare professional to deliver air and oxygen into the lungs using a breathing tube or mask.On tour of the PCU Nursing Unit at 9:56 AM on 1/20/2026 the surveyor observed an emergency tank of oxygen attached with straps to the ventilator stand at Residents #1, #7 and #96's bedside. There was no oxygen usage signage on these Resident room doors.The surveyor conducted a record review of Residents #1, #7 and #96's medical record on 1/22/2026, specifically the physician orders. There were active physician orders in Resident #1, #7 and #96's medical records that indicated Respiratory Therapy to ensure emergency supplies are at bedside: full E cylinder oxygen tank on ventilator every shift, ensure tank is at least 1500 pounds full.In an interview with a Respiratory Therapist (RT) employee #15 and the PCU Nurse Manager at 8:00 AM on 1/23/2026 the surveyor conveyed that Residents #1, #7 and #96 had emergency tanks of oxygen strapped to the ventilator stand in their rooms, but there was no oxygen usage signage posted on these Resident room doors. The RT and PCU Manager acknowledged the surveyor and stated that they would follow up on this.The surveyor at 8:20 AM on 1/23/2026 conveyed to the Licensed Nursing Home Administrator (LNHA) that there were emergency tanks of oxygen in Resident rooms on the PCU Unit, but there was no oxygen usage signage on these Resident room doors. The LNHA stated that the facility was working on this. 2) On tour of Arena Way Nursing Unit at 11:50 AM on 1/20/2026 the surveyor observed Resident #140 sitting in the wheelchair in Resident room in no distress. There was an oxygen concentrator next to Resident #140's bed and the oxygen tubing and the oxygen humidifier bottle were not labeled and dated. Additionally, there was no oxygen usage signage on Resident #140's room door.Resident #140 stated to the surveyor that he/she does not use oxygen.In an interview with the interim Nurse Manager for the Arena Unit on 1/20/2026 at 12:05 PM, she observed the oxygen concentrator in Resident #140's room and stated that Resident does not use oxygen anymore. The surveyor conveyed that the oxygen tubing and humidifier bottle were not labeled and dated and that there was no oxygen signage on the door. The Nurse Manager removed the oxygen concentrator from Resident #140's room.At 1:15 PM on 1/22/2026 the surveyor conducted a record review of Resident #140's medical record. Review of the medical record revealed that Resident #140 did not have an active physician order for oxygen. Additionally, the surveyor reviewed the facility's policy and procedure for Oxygen Therapy. The policy indicated that a physician order must be written before therapy was initiated, and that all oxygen tubing must be labeled with Resident name and date. 3) Tracheostomy tube (breathing tube) is an artificial airway inserted into the trachea (windpipe) through an opening/stoma made by a surgical opening/incision in the neck. On tour of PCU Nursing Unit at 10:44 AM on 1/21/2026 the surveyor observed Resident #4 in bed, watching television in no distress. Resident #4 had a ventilator attached to the tracheostomy tube. There was an emergency tank of oxygen attached with straps to the ventilator stand at Resident #4's bedside. There was no oxygen usage signage on the Resident room door.The surveyor conducted a record review of Resident #4's medical record at 8:30 AM on 1/23/2026. Review of the medical record revealed that Resident #4 did not have an active physician order for tracheostomy care. Additionally, the surveyor reviewed the facility's policy and procedure for Tracheostomy Care. The policy indicated that tracheostomy care was performed twice a day and PRN (as needed) per physician order.In an interview with the Regional Clinical Services Manager (RCSM) at 12:00 PM on 1/23/2026 the surveyor conveyed to the RCSM that Resident #4 had a tracheostomy, and that there was no physician order for tracheostomy care. The RCSM acknowledged the surveyor and reviewed Resident #4's physician orders and confirmed that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was not a physician order for tracheostomy care.No additional information was provided to by the facility at the time of survey exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility staff interview and record review, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations. This was identified during multiple observations of the kitchen and dining areas on the annual survey. The findings include: On 1/20/26 at 8:48 AM the surveyor conducted the initial tour of the kitchen. On the tour, the surveyor observed:A multi- nozzle beverage dispenser with black substance on each nozzleAn ice scoop was observed horizontally on top of the ice machine. The scoop was not in a position for proper drainage between uses.On 1/20/26 at 9:00 AM, the surveyor shared concerns with Food Service Director (FSD).On 01/28/2026 at 8:20 AM the surveyor observed 4 white blankets, separately folded, resting under the boiler free steamer. The surveyor made the FSD aware and the FSD removed them immediately.At 8:23 AM the surveyor reviewed the food service temperature logs for food items prepared for each meal service. The review revealed that the documentation failed to identify each item's temperature that was measured. The FSD confirmed that each item that was temped should have been listed next to the temperature that was recorded.On 01/28/2026 at 9:06 AM the surveyor and the FSD toured the Arena Way cafe's kitchen service area. The surveyor observed a refrigerator for resident's/visitor's use which showed an internal thermometer with a temperature reading of shows 54 degrees Fahrenheit. The refrigerator's external digital temperature display showed 36 degrees Fahrenheit. The internal thermometer was inspected and noted to have a cracked glass on face of thermometer. The FSD removed the damaged thermometer and stated that it would be replaced.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, facility staff interview and record review, it was determined that the facility failed to appropriately document food temperature logs to prevent foodborne illness. This was identified during multiple observations of the kitchen and dining areas on the annual survey. The findings include:A follow-up tour of the kitchen was conducted with the Food Service Director (FSD) on 1/28/26 at 7:40 AM which revealed:At 7:58 AM the surveyor asked the FSD how staff ensure proper chemical sanitization within the 3- compartment sink. The FSD attempted to test the chemical levels in the sanitization part of the 30compartment sink and the test revealed that there was not enough chemical detected to sanitize any dishes. The FSD attempted to pump the chemical solution into the sink and test the levels in the sanitization sink and the levels were again too low (less than 200 parts per million (ppm). The FSD attempted to manually add the chemical solution to the sanitization part of the 3-compartment sink and test the levels of the chemical which then revealed the required the 200-300 ppm. At 8:06 AM the surveyor reviewed the 3 Compartment Sink Chemical Sanitizer logs which revealed, Alert the Food Service Director IMMEDIATELY if bleach sanitizer is NOT in the recommended range. The recommended range was listed as 200-300 ppm. Review of the daily documentation of each meal service (Breakfast, Lunch and Dinner) for the month of January 2026 showed:1/25/26 Breakfast 500 ppm; Lunch 400 ppm; Dinner 400 ppm1/26/26 Breakfast 400 ppm; Lunch 400 ppm; Dinner 400 ppm1/27/26 Lunch 400 ppm and Dinner 400 ppmOn 1/28/26 at 8:11 AM the surveyor shared concerns with the FSD. The FSD confirmed that their vendor for the 3-compartment sink's sanitizer device would be contacted and that staff would be notified to sanitize all kitchen pots, pans, trays, eating/drinking and cooking utensils were to be washed in the dishwasher while the 3 compartment sink was inoperable.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review. it was determined that the facility staff failed to ensure residents' dignity, honor the exercise of residents' rights, and provide necessary in-house podiatry service in a timely manner. This was found to be evident of 1 (Resident #13) out of 2 reviewed for dignity of care during an annual survey. The findings are as follows:During an initial observation on 01/20/2026 at 10:34 AM, it was noted that Resident #13's bed linen had multiple yellow drainage stains originating from a wound on the right heel. Additionally, the resident was found to have severely overgrown and thickened toenails on both feet.During a subsequent interview, the resident stated they were unable to trim their own nails and had informed staff of this need upon admission. Regional Clinical Services Staff #23 was in the room witnessing the drainage on the resident's bed-drawsheet and the overgrown toenails and indicated that she would follow up on these issues.A record review conducted on 01/20/2026 at 11:02 AM, indicated that Resident #13 was admitted to this facility on 12/26/2025 with past medical history of cardiomyopathy of Chronic Heart Failures, severe obesity (BMI > 40), type 2 diabetes mellitus with renal manifestation and a right heel wound. admission orders showed that Medical Staff #31 ordered podiatry a consult as applicable. Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women. BMI is just one piece of the puzzle. It's based on height and weight but doesn't consider muscle mass, bone density, or body composition. In adults age [AGE] years or older: Underweight: BMI is less than 18.5, Normal weight: BMI is 18.5 to 24.9, Overweight: BMI is 25 to 29.9 and Obesity: BMI is 30 or moreDuring an interview on 1/22/2026 at 10:07 AM, Regional Clinical Services Staff #23 reported that facility staff had initially failed to schedule the in-house podiatry visit for Resident #13. The resident finally was added to the upcoming podiatry schedule on 1/20/2026. Furthermore, staff received re-education regarding the requirement to always maintain clean bed linens A record review conducted on 1/22/2026 at 3:15 PM, noted that Podiatry Staff #32 performed a full assessment and trimmed Resident #13's overdue toenails, which were mycotic, elongated, and discolored. The left great toe and second toenails were found to be incurvated, requiring daily dressing and wound care. Further order review, Medical Staff #31 issued a follow-up order for the ingrown nail on the left great toe. The prescribed wound care includes cleaning the area with wound cleanser, patting it dry, applying Bacitracin ointment, and covering it with dry dressing daily for 14 days and as needed. During an interview on 01/29/2026 at 11:00 AM, Staff #23 acknowledged that the floor staff delayed triggering/scheduling in-house podiatry services for Resident #13 following their admission on [DATE]. Staff #23 noted that Podiatry Staff #32 reported the resident's progressed toenails were in incurvated condition.During the final interview held on 01/29/2026 at 1:05 PM, the Administrator was notified of several areas of non-compliance. These included failures to ensure residents' dignity, honor the exercise of residents' rights, and provide necessary in-house podiatry services in a timely manner, noting delays Podiatry service of nearly one month. The Administrator validated these concerns as deficient practices.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to obtain a resident's advanced directive. This was evident in 1 (Resident #15) of 5 residents reviewed for Advanced Directives during an annual survey. An advance directive is a legal document, such as a living will or durable power of attorney for healthcare. These documents specify preferences for medical care, including life-sustaining treatments, and/or indicate individuals who are chosen to make decisions if you become unable to communicate decisions. The findings include: On [DATE] at 7:34 AM, the surveyor reviewed Resident #15's paper medical record. The review revealed that Resident #15's Maryland Order for Life Sustaining Treatment (MOLST) form indicated that Resident's choices were based on the patient's advanced directive. However, the surveyor was unable to find the advanced directive in the medical record. On [DATE] at 7:25 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor requested the Advanced Directives (AD) referenced in Resident #15's MOLST. She stated she would reach out to the social worker. On [DATE] at 7:45 AM, the surveyor interviewed the Director of Social Work (SW) #10. During the interview SW #10 stated that when a resident is admitted the social workers are responsible for assessing if a resident has advanced directives. She further stated that she could not recall if Resident #15 had AD's and would follow-up. On [DATE] at 10:23 AM, the surveyor reviewed Resident #15's electronic medical record. The review revealed a note written by Social Worker (SW) #38 just after Resident #15 was admitted . The note stated that Resident # 15 was not able to understand Cardiac Pulmonary Resuscitation (CPR) procedures and that appropriate certifications were initiated. It further stated that SW #15 reached out to Resident #15's family member to obtain wishes for code status. Nowhere in the note did it indicate that the facility reached out to inquire if Resident #15 had advanced directives even with the current MOLST stating the decision was based on the Resident's advanced directives. On [DATE] at 3 PM, the surveyor conducted a follow-up interview with the NHA. During the interview the NHA stated that the facility reached out to Resident #15's family member and obtained Resident #15's Health Care Power of Attorney (HPOA) dated [DATE]. She agreed that HPOA (a type of AD) should have been attempted to be obtained on admission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and facility staff interview it was determined that the facility failed to ensure a safe/clean/comfortable/homelike environment for Residents. This finding was found to be evident in 1 Resident room (room [ROOM NUMBER]) out of 23 Resident rooms reviewed during tour of the PCU unit. The findings include:While rounding on the PCU Nursing Unit on 1/20/2026 at 1:15 PM, it was observed that the wall next to the bathroom in room [ROOM NUMBER] was severely marred and chipped including the doorframe to the bathroom.The TELS platform connects facility teams to data including work orders, assets, compliance, and capital planning all in one place. TELS is a facilities management system designed to streamline and simplify work order creation, tracking, and completion, and to assist with managing preventative maintenance (PM) programs.In an interview with the PCU Nurse Manager at 9:15 AM on 1/28/2026, she stated that the marred and chipped wall in room [ROOM NUMBER] was from the Hoyer lift and the shower stretcher. The PCU Nurse Manager stated that she would enter the repair in TELS for maintenance.At 9:05 AM on 1/30/2026 the surveyor and the PCU Nurse Manager observed maintenance staff in room [ROOM NUMBER] repairing the wall next to the bathroom.No additional information was provided by the facility at the time of survey exit.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy documentation, facility employee files and interview with facility staff it was determined that the facility failed to have an effective system in place to ensure criminal background checks were completed prior to allowing an employee to work with residents. This was evident for 1 out of 5 facility employee files reviewed during the annual survey. The findings include:Review of the facility's Abuse Prohibition policy revealed the following: Screening Prospective employees will have a background screening completed per Human Resource Policies for applicant screening.On 1/28/26 at 10 AM review of geriatric nursing assistant (GNA) #16's employee file revealed the employee was hired on 8/14/24.Review of GNA #16's timesheet data revealed worked with residents on August 14, 15, 16,19, 20, 21, 23, 25, 26, 27, 28, 29, 2024; and September 2 and 3, 2024.Further review of the employee's file revealed a criminal background check document that initiated and completed on 9/25/24.During an interview conducted on 1/28/26 at 1:36 PM, the Nursing Home Administrator (NHA) confirmed that GNA 16's first day of scheduled work was 8/14/24. The administrator also confirmed that all current employee files are in review.

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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 surveyor record review and facility staff interviews it was determined that the facility failed to ensure that a comprehensive care plan was developed and implemented on a Resident. This finding was found to be evident in 1 (Resident #140) out of 2 Residents reviewed for a comprehensive care plan for dialysis. The findings include:Hemodialysis is a procedure used to treat individuals with acute or chronic kidney failure. Hemodialysis uses a machine and a specialized filter (dialyzer) to remove waste, toxins, and excess fluid from the blood. Hemodialysis replaces kidney function. Hemodialysis requires vascular access, usually through an arteriovenous (AV) fistula. An AV fistula is an abnormal, direct connection between an artery and a vein. Additionally, a permacath may be used for hemodialysis. A permacath is a special catheter used for short-term dialysis treatment. The catheter is placed inside a blood vessel in the neck or under the collarbone and threaded into the right side of the heart.The surveyor conducted a record review of Resident #140's medical record on 1/22/2026 at 9:15 AM. During review of the medical record, it was revealed that Resident #140 did not have a care plan problem that addressed hemodialysis, specifically care coordination, care of the dialysis access site and emergency care. On 1/22/2026 at 10:15 AM the surveyor reviewed the facility's policy and procedure for Hemodialysis and Care of Resident. The policy addressed care planning and care coordination between the facility and the dialysis center, and nursing care of Residents with dialysis access (AV fistula, Permacath).Further review of Resident #140's medical record on 1/22/2026 revealed that there were physician orders for hemodialysis 3 times a week on Monday, Wednesday and Friday and monitor right chest permacath site every shift. This care coordination was not addressed in a dialysis comprehensive care plan.In an interview with the Regional Clinical Services Manager (RCSM) on 1/22/2026 at 10:50 AM the surveyor conveyed that there was no comprehensive care plan for dialysis care for Resident #140. The RCSM reviewed Resident #140's care plan and acknowledged to the surveyor that there was not a specific care plan problem that addressed dialysis care for Resident #140.No additional information was provided by the facility at the time of survey exit.

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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 surveyor record review and facility staff interviews it was determined that the facility failed to ensure timing, revision and updates of Resident care plans. This finding was found to be evident in 2 (Resident #1 and #140) out of 10 Residents reviewed for care plan timing and revision.The findings include:In an interview with Resident #1 at 9:29 AM on 1/21/2026 about care plan meeting, he/she stated that he/she has not attended a care plan meeting. Resident #1 was alert and oriented to person, place and time.The surveyor conducted a record review of Resident #1's medical record on 1/22/2026 at 7:56 AM. Review of the medical record revealed that Resident #1 was admitted to the facility on [DATE]. Further review of the medical record revealed that there was no documentation that a care plan meeting was held for Resident #1. In an interview with the Licensed Nursing Home Administrator (LNHA) on 1/22/2026 at 8:00 AM, the surveyor requested any documentation that a care plan meeting occurred for Resident #1. The LNHA presented the surveyor with a Resident Care Plan Attendance sheet dated 12/23/2026. The surveyor conveyed to the LNHA the date that was indicated on the care plan attendance sheet was 12/23/2026 and this date had not occurred yet. The LNHA stated that she would follow up on this.In a follow up interview with the LNHA at 9:33 AM on 1/22/2026, she stated that the facility does not have any documentation that a care plan was held for Resident #1. The surveyor conducted a record review of Resident #140's medical record at 9:15 AM on 1/22/2026. Review of the medical record revealed that Resident #140 had a current care plan for an anticoagulant medication (blood thinner). Further review of the medical record revealed that Resident #140 did not have a current physician order for an anticoagulant medication. Resident #140 had a discontinued physician order for an anticoagulant medication (Heparin) with a start date of 9/22/2025 for 4 weeks.In an interview with the Regional Clinical Services Manager (RCSM) on 1/22/2026 at 10:50 AM the surveyor conveyed that Resident #140 did not have a current physician order for an anticoagulant medication, but there was a current care plan problem for at risk for bleeding related to use of an anticoagulant medication. The RCSM reviewed Resident #140's care plan, acknowledged the surveyor and confirmed that Resident #140 did not have a current physician order for an anticoagulant medication.No additional information was provided by the facility at the time of exit.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, facility staff interview and record review it was determined that the facility failed to provide proper tube feeding management for a Resident. This finding was found to be evident for 1 (Resident #10) out of 3 Residents reviewed for tube feeding.The findings include:Gastrostomy tube (G-Tube)/feeding tube is a tube surgically placed into the stomach through an opening in the abdomen to provide nutrition, fluids and medication when a person cannot eat or drink safely by mouth.Enteral nutrition/feedings is a medical method of providing nutrition and fluids through the gastrointestinal (GI) tract using a feeding tube. The liquid formula contains essential nutrients like protein, carbohydrates, fats, vitamins, and minerals.On tour of the PCU Unit on 1/20/2026 at 8:50 AM the surveyor observed Resident #10 in bed in no distress. Hanging on a pole next to Resident #10's bed were 2 bags of fluid; one bag was labeled with the enteral feeding, and the other bag had a clear liquid substance contained in the bag. The clear liquid bag did not have a label on the bag.Follow-up observation of Resident #10 at 2:00 PM on 1/27/2026 revealed that the tube feeding water flush bag was labeled with contents, but there was no date on the label. In an interview with the PCU Nurse Manager on 1/27/2026 at 2:05 PM the surveyor asked what the expectation was for labeling the enteral feeding and tube feeding water flush bags. The PCU Nurse Manager stated that the enteral feeding bags and the water flush bags were to be labeled and dated. PCU Manager further stated that the labels do fall off the bags and that she reminded staff this morning to label the bags.On 1/27/2026 at 2:30 PM the surveyor conducted a record review of Resident #10's medical record. Record review revealed that Resident #10 had a physician order for enteral/tube feedings and water flushes via gastrostomy/feeding tube.The surveyor on 1/27/2026 at 3:30 PM reviewed the facility's policy and procedure - Tube Feeding Protocol. The policy indicated that fillable enteral bags are to be changed daily.No additional information was provided by the facility at the time of exit.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Number of residents sampled:Number of residents cited:Based on observation, record review and interviews it was determined the facility staff failed to provide appropriate care and services to a resident with intravenous access devices. This was evident for 1 (Resident #168) out of 2 residents reviewed for fluids and dehydration. A central venous catheter (CVC) is a long, flexible tube that a provider inserts into a vein. It can be found in the neck, chest, arm or groin. The tube leads to your vena cava, a large vein that empties into your heart. A CVC helps a person receive drugs, fluids, or blood, for long-term treatments. A type of CVC is a PICC (peripherally inserted central catheter). CVCs have risks which include infection, blood clots, vein inflammation and (rarely) displacement or vessel damage and need to be cared for appropriately. The findings include: On 1/20/26 at 8:40 AM, the surveyor conducted an interview with Resident #168. During the interview Resident #168 stated that he/she had recently been in the hospital. Next the surveyor observed that Resident #168 had a PICC line on his/her right upper inner arm. The surveyor noted the date on the dressing covering the PICCl line was 1/7. Resident #168 stated that the dressing was last changed in the hospital. On 1/20/26 at 8:55 AM, the surveyor and Resident #168's nurse, License Practical Nurse (LPN) #11 confirmed together that the last dressing change date on Resident #168's PICC line dressing was labeled 1/7. On 1/20/26 at 9:08 AM, the surveyor asked Unit Manager (UM) #22 when Resident #168's PICC line dressing change was supposed to be completed. UM #22 confirmed an order was in place for Resident #168 to have the dressing changed every 7 days on Wednesdays. Next the surveyor reviewed Resident # 168's January 2026 Treatment Administration Record (TAR). An order was written for PICC line dressing to be changed every week on Wednesday with the start date of 1/14/26. The surveyor reviewed the date 1/14/26 and noted the dressing change was coded see progress notes on 1/14/26. On review of the progress notes, the surveyor noted no written indication why Resident #168's PICC line dressing was not changed on 1/14/26 and why 20 days had gone by since the last dressing change. The surveyor reviewed the policy titled, Central Vascular Access Devices (CVAD) and Midline Catheter Dressing Changes. The policy first states that sterile dressings are applied and maintained for CVADs (PICCs) in order to secure and minimize site complication and to detect and prevent other complications associated with infusion therapy. The time frame written for dressings to be changed was every 5-7 days and as needed if dressing is compromised. On 1/22/26 at 8:19 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that the Registered Nurse or Licensed Practical Nurse assigned to the resident, on the day the PICC line dressing is due to be changed, is responsible for changing the dressing. She further stated the LPN #11 did not communicate to the next coming shift that the dressing was not completed and needed to be completed. The DON stated education was provided to LPN #11 on this expectation.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Number of residents sampled:Number of residents cited:Based on interview and record review it was determined that the facility failed to administer pain medications consistent with professional standards. This was found evident of 1 (Resident #168) out of 4 Residents reviewed for pain management during the survey. The findings include: On 1/20/26 at 8:47 AM, the surveyor conducted an interview with Resident #168. During the interview Resident #168 stated that he/she learned that he/she had to maintain a schedule with pain medication because if he/she waited too long to take the medication it was hard to bring the pain back down to an acceptable level. On 1/22/26 at 11:19 AM, the surveyor reviewed Resident #168's medical record. The review revealed on 1/10/26 Resident #168 had an order written for Oxycodone 10mg, with instructions, give 1 tablet by mouth every 4 hours as needed for pain of 5-10 on a pain scale. On further review this same order was written again on 1/16/26. Next the surveyor reviewed Resident #168's January 2026 Medication Administration Record (MAR) along with Resident #168's pain ratings. The review revealed Resident #168 had 20 documented administrations of oxycodone from 1/11/26-1/21/26. The review revealed that on 1/11/26 Resident #168 stated his/her pain was a 7/10 and at 1:07 AM an oxycodone was pulled and documented as given. Later that morning at 7 AM Resident #168 had his/her pain documented as 0/10 at 7 AM. At this same time another oxycodone was pulled, however there is no documentation that the medication was given. At 9:50 AM Resident #168 reported his/her pain was a 5/10. Again, no documentation that a pain medication was administered even though the rating and time frame qualified Resident #168 to be able to receive one. On further review on 1/18/26 at 6:25 AM Resident #168 rated his/her pain 0/10 and was given oxycodone at this time. On 11/19/26 both at 9:11AM, and 10:12 AM Resident #168 rated his/her pain a 5/10 with the last pain documented as being given on 1/18/26 at 12:56 PM. Per the oxycodone order Resident # 168 would have been able to receive pain medication. The Surveyor noted the next doses administered were given on 1/19/26 at 10:13 PM with a pain rating of 4/10 and again on 1/19/26 at 10:14 PM with a pain of 0/10. Both doses were out of the pain parameters and time frames in the oxycodone order. On 1/22/26 at 2:06 PM, the surveyor conducted an interview with the DON. The surveyor showed the DON that the pain medication was given outside the order parameters. The DON agreed that the pain medication was not given as ordered.

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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 record review and interviews it was determined that the facility failed to document medication administration according to procedures that ensure accurate disposition of medications. This was found evident of 28 of 48 narcotic medications removed for Residents #168 and #16. The findings include: On 1/20/26 at 8:47 AM, the surveyor conducted an interview with Resident #168. During the interview Resident #168 stated that he/she had been taking pain medications related to a recent surgery. On 1/22/26 at 11:19 AM, the surveyor reviewed Resident #168's medical record. The review revealed on 1/10/26 Resident # 168 had an order written for Oxycodone 10mg, with instructions, give 1 tablet by mouth every 4 hours as needed for pain of 5-10 on a pain scale. On further review this same order was written again on 1/16/26. Next the surveyor reviewed Resident #168's January 2026 Medication Administration Record (MAR). The review revealed Resident #168 had 20 documented administrations of oxycodone from 1/11/26-1/21/26. The surveyor requested to review the controlled drug receipt/record/disposition forms (and anything removed from the facility supply) for Resident #168 and compare it to Resident #168 Medication Administration Record (MAR). The review revealed that oxycodone 10mg was signed out as removed on the controlled drug receipt but there was no corresponding documentation as administered on the MAR on the days and times as follows:1. 1/11/26 removed at 7:13 AM (facility supply)2. 1/12/26 removed at 12 PM3. 1/12/26 removed at 9 PM4. 1/14/26 removed at 4:18 AM5. 1/14/26 removed at 11 AM6. 1/16/26 removed at 11:19 PM (facility supply)7. 1/19/26 removed at 9:30 AM-1/19/26 removed at 4:40 PM (dose on MAR at 10:13 PM & 10:14 PM)(pulled dose at 10 PM)8. 1/20/26 removed at 12:30 PM9. 1/21/26 removed at 1 AM. On 1/23/26 the surveyor reviewed the facility's Medication Administration policy. The policy stated, after medications are administered to document medication administration with initials on the Medication Administration Record (MAR) immediately after administering medications to each resident. On 1/23/26 at 8:38 AM, the surveyor conducted an interview with the DON and reviewed the concern that oxycodone was removed 9 times without a corresponding administration in Resident #168's MAR. 2. On 1/29/26 at 8:47 AM, the surveyor conducted and interview with Registered Nurse (RN) #24 and Unit Manager (UM) #22. During the interview the surveyor asked what the process was for obtaining and administering a controlled pain medication to a resident. Both staff confirmed that when a controlled pain medication is needed the nurse would have to unlock the box, remove the medications and complete a count and then document the count for that medication on the controlled drug receipt/record/disposition forms. Next the nurse would administer the medication and then chart that it was given in that Resident's Medication Administration Record (MAR). They both stated that at the change of shifts all controlled medications are counted with the on coming and outgoing shifts to ensure the count is accurate. The surveyor requested the controlled drug receipt/record/disposition form for Resident #16. Resident #16's oxycodone order was for 5mg to be given every 6 hours as needed for pain of 6-10. The form was dated 1/13/26-1/28/26. The surveyor compared the oxycodone documented as removed on Resident #16's controlled drug receipt/record/disposition form along with Resident #16's January 2026 Medication Administration Record (MAR). Listed below are doses of oxycodone removed but missing a corresponding documentation as administered on the MAR:1. 1/17/26 at 4:30pm2. 1/19/26 at 9:27 AM3. 1/21/26 at 6PM4. 1/21/26 at 00005. 1/23/26 at 10 AM6. 1/23/26 at 3 PM7. 1/24/26 5 PM8.1/2/526 at 5 PM9. 1/26/26 at 10 AM10. 1/27/26 at 10 AM11. 1/28/26 at 9:43 AM On further review it was noted that RN #24 had discrepancies on 1/26/26, 1/27/26 and 1/28/26. The surveyor noted 5 staff/different initials were noted to have discrepancies on the controlled drug receipt/record/disposition form compared to the MAR. On 1/29/26 at 9:04 AM, the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5. During the interview the surveyor reviewed the 11 discrepancy found and asked to speak to RN #24. On 1/29/26 at 11:01 AM, the surveyor conducted an interview with RN #24. During the interview she confirmed the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	correct process for pulling and recording controlled medication. When the surveyor reviewed the three days where oxycodone was pulled out for Resident #16 and not documented on the MAR as administered, RN #24 stated after she gave the medication she must have forgotten to sign it out in the MAR but was certain she gave the medications. On 1/29/26 at 11:08 AM the surveyor conducted an interview with the Director of Nursing (DON). The DON stated that the facility had already started in-service training on controlled substance procedures and expectations. Cross Reference F 658

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on review of the clinical record and staff interview, it was determined that the facility staff failed to adequately monitor a resident's drug regimen which allowed an unnecessary duplicate order for a medication. This finding was evident for 1 (Resident #168) of 6 residents reviewed for unnecessary medications during the survey. The findings include: On 1/20/26 at 8:47 AM, the surveyor conducted an interview with Resident #168. During the interview Resident #168 stated that he/she had been taking pain medications related to a recent surgery. On 1/22/26 at 11:19 AM, the surveyor reviewed Resident #168's medical record. The review revealed on 1/10/26 Resident # 168 had an order written for Oxycodone 10mg, with instructions, give 1 tablet by mouth every 4 hours as needed for pain of 5-10 on a pain scale. On further review this same order was written again on 1/16/26. However, the order written on 1/10/26 was not discontinued so Resident #168 had two current orders for same medication. Next the surveyor reviewed Resident #168's January 2026 Medication Administration Record (MAR). The review revealed Resident #168 had 20 documented administrations of oxycodone from 1/11/26-1/21/26. On 1/18/26 through 1/20/26 the facility staff documented administration of oxycodone on both orders. On 1/19/26 one administration was documented at 10:13 PM (on the 1/10/26 order) and an additional dose was documented as given at 10:14 PM (on the 1/16/26 order). The same medication was given one minute apart. On 1/22/26 at 12:53 PM, the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5 and the Director of Nursing (DON). During the interview the surveyor asked why there were two of the same orders for oxycodone in Resident #168's medical record and if there was a process to verify that the providers wanted both orders. Both Staff #5 and the DON stated that they would look into that matter. On 1/22/26 at 2:06 PM, the surveyor conducted a follow-up interview with the DON. The DON stated that the second order was written because the pharmacy required a new prescription due to the medication being a controlled substance. The DON stated that when the new order was written the older order should have been discontinued. Before the time of exit the surveyor relayed the concern that duplicate orders that were in place for resident #168 allowed the Resident to have the two documented administrations of oxycodone that were documented as given one minute apart. Cross Reference F658

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and facility staff interviews it was determined that the facility failed to ensure that medications were secured in a locked compartment and not expired. This finding was found to be evident on 2 (PCU and Vital Strong) out of 4 nursing units and review of the PCU medication room during the annual survey.The findings include: On tour of the PCU Unit at 1:35 PM on [DATE] the surveyor and the PCU Nursing Manager observed a medication cart unattended and unlocked with the top drawer of the medication cart opened outside of room [ROOM NUMBER]. The PCU Manager closed the top drawer of the medication cart and locked the medication cart as Registered Nurse (RN) #9 was exiting a Resident room. The PCU Manager stated to RN #9 that the medication cart was observed opened and should have been locked. In an interview with the PCU Manager at 1:40 PM on [DATE] the surveyor asked the PCU Manager what the expectation was for the medication carts to be secured when unattended by nursing staff. The PCU Manager stated that the medication carts were to be locked when unattended by the nurse and that this would be addressed with the staff. Intravenous (IV) is a medical term meaning within a vein, referring to the administration of fluids, medications, blood, or nutrition directly into the bloodstream via a needle or catheter inserted into a vein, allowing for rapid delivery throughout the body. At 8:15 AM on [DATE] the surveyor conducted a review of the PCU medication room with the PCU Nurse Manager in attendance. During review of the medication room, specifically the medication refrigerator, it was observed that a bag of Ertapenem 500 mg in 55 ml of normal saline (an intravenous antibiotic) was expired. The use by/expiration date was [DATE] on the label of the IV medication bag. The PCU Manager stated that she would notify the pharmacy and she removed the IV medication from the medication room. No additional information was provided by the facility at the time of survey exit. On [DATE] at 11:32 AM, the surveyor walked past the nurses' station, where several staff were gathered, and walked down the hallway starting with room [ROOM NUMBER]. The surveyor noted a medication cart, unattended, and pushed into a cove in the wall located near room [ROOM NUMBER]. The cart appeared to be unlocked. The surveyor was able to open the top draw which held medications. Upon opening the drawer Licensed Practical Nurse (LPN) #20 walked down the hallway from the nurses' station and stated that she was responsible for the medication cart. When asked if the cart was supposed to be left unlocked while not attended LPN #20 stated it should have been locked. She further stated she thought she was needed urgently at the nurses' station but confirmed she should have locked the cart before walking away. Following the observation the Nursing Home Administrator (NHA) was informed of the unattended unlocked medications cart.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Number of residents sampled:Number of residents cited:Based on observation, record review, and interview it was determined that the facility failed to obtain laboratory results in a timely manner. This was found evident in 1 (Resident #154) out of 2 residents reviewed for hydration. A peripheral intravenous (IV) catheter is a short, flexible tube inserted into a small vein for short-term (approximately 3-4 days) use to administer fluids, medications, or blood products. The findings include: On 1/20/26 at 9:31 AM, the surveyor observed Licensed Practical Nurse (LPN) #34 removed Resident #154's IV site. The surveyor asked LPN #34 why Resident #154 had an IV placed and was told that the resident just completed the course of IV fluids that was ordered for hydration. On 1/22/26 at 9:55 AM, the surveyor reviewed Resident #154's medical record. The review revealed a change of condition was written on 1/16/26 by LPN #35. The note stated that laboratory (lab) results were reviewed by the Nurse Practitioner #36 and an order was placed for Resident #154 to receive IV fluids and have a repeat lab of a Basic Metabolic Panel (BMP) on Tuesday (1/20/26). On 1/22/26 at 10:15 AM, the surveyor reviewed lab results in Resident #154's electronic medical record. The review revealed no record of labs resulting from the 1/20/26 BMP lab order. On 1/22/26 at 10:51 AM, the surveyor conducted an interview with Regional Clinical Services Manager Staff #5. During the interview the surveyor reviewed the concern that the labs results were not in Resident #154's medical record as well as there was no rationale or acknowledgement that the labs had not been reviewed or available to be reviewed. Staff # 5 stated he would look into the concern. On 1/22/26 at 11:51 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON was able to produce the lab results from the lab draw on 1/20/26. The surveyor noted the documentation on the lab results form stated the labs were run (process at the outside lab) on 1/20/26 at 11:44 AM. The sodium value was 145 (coded high) just out of the reference range of 134-144 and the Chloride value was 11 (coded high) with a reference range of 96-106. The surveyor asked the DON how she obtained the lab results. The DON stated she had to call the outside lab company and ask them to send results. She further stated that the facility's lab order book documented the outside lab staff drew the lab specimen on 1/20/26 and further stated she was not sure why the results were not uploaded into Resident #154's medical record. The surveyor reviewed the lab order lab book and noted there was no check mark or notation in the results received section and the doctor reviewed columns was left blank. The surveyor reviewed the concerns that Resident 154's labs were not in the medical record to review and that there was no indication any follow-up was done when the labs results were not available.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that facility staff failed to ensure that food menus were followed and prepared in advance to meet residents' meal choices. This was found to be evident of 2 (Resident #11 and #27) out of 10 Residents reviewed for food during an annual survey. The findings include: On 1/21/26 at 9:21 AM, the surveyor conducted an interview with Resident #11. During the interview the Resident alleged that sometimes he/she does not receive the food items that are listed on the meal ticket menu and sometimes his/her meal is delivered in disposable containers. The surveyor observed that Resident #11's breakfast was in a plastic square takeout container however it appeared that the order ticket menu was accurate with the Resident's meal. On 1/23/26 at 11:58 AM, the surveyor observed Unit Manager (UM) #22 deliver Resident #11's lunch tray and placed the lunch on Resident #11's over-the-bed table. UM #22 stated that she would be back with additional gravy for Resident #11. The surveyor reviewed Resident #11's meal ticket alongside the tray. Disposable ware was crossed out and Resident #11 had normal dishware on the lunch tray. In the note section it was written; provide extra side of gravy and butter with all meal trays. All menu items were on the tray in exception to the gray (in which UM #22 left to retrieve) and pureed peach cobbler. On 1/23/26 at 12:09 PM, the surveyor conducted an interview with UM #22. During the interview UM #22 stated that she had delivered the tray and noted the lack of gravy so she went to obtain it. When asked about the missing peach cobbler UM #22 did not know why it was not on the tray and would look into getting the peach cobbler for Resident #11 from the dining room food assembly line. She stated this is where Resident #11's food was plated. The surveyor noted that Resident #11 was able to obtain the menu items listed on the meal ticket, however, two of the items listed were missing at the time of original delivery and only provided when the error was noted. During an observation on 01/20/2026 at 9:14 AM, it was noted that Resident #27's breakfast tray was largely untouched, with only approximately10 percent intake. During an interview conducted at 9:20 AM later, Resident #27 complained frequent concerns regarding persistent feelings of hunger and a lack of available food. Additionally, the resident voiced concerns regarding their surgical healing process. The resident explained that while a soft bite size diet was initiated upon admission due to left arm surgery's restrictions and found the pureed bread and bite-sized options unappetizing and feel not receiving enough suitable food. The resident specifically requested to receive more chicken in each meal. A record review was conducted on 01/21/2026 at 3:06 PM. Resident #27 was admitted to the facility on [DATE] with a medical history including prostate cancer, bladder cancer and early-stage lung cancer. Additionally, the resident was status post surgeries for left arm and left femur fractures on 12/31/2025. A review of the diet order from 01/05/2026 indicated a soft, bite-sized texture, with regular bread (including crust) allowed. However, on 1/20/2026 Resident #27's lunch tray ticket listed minced or pureed roll/margarine which was contradicting with the diet order and this resident's (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preference. Regarding Resident #27, following their orthopedic surgeon visit on 01/16/2026, the restriction on arm usage was lifted. The resident was now permitted to use their left arm with a weight-bearing limit of up to 5 lbs. and active range of motion as tolerated. However, this change had not yet been reflected in the resident's diet orders. Since the arm usage restriction has been lifted, the resident was no longer required to have a soft bite-size diet. No updated dietary re-assessment notes was found from Dietician Staff #37. An observation of the lunch service in the residents' dining room on 1/22/2026 at 1:13 PM revealed that Resident #27 was sitting with other residents but did not eat the lunch entrée again. Instead, consuming on a small cake. According to the kitchen meal ticket listed a regular diet open-faced turkey sandwich with thick gravy, bite-sized soft vegetables, and a minced or pureed roll? Resident #27 confronted with the kitchen staff that the turkey sandwich had been pre-ordered but was nowhere to be found. Instead, a beef pasta dish was served in its place. Resident #27 expressed disappointment that the turkey sandwich was not provided. Consequently, this resident's total lunch intake on 1/22/2026 was less than 5 percent. During the final interview conducted on 01/22/2026 at 3:18 PM, the Administrator was made aware of the above findings and agreed with the identified deficiencies, noting that Resident #27 should have received meals/food items as choices/preference. It was validated these concerns that the kitchen staff failed to honor and update this resident's diet as required.

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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 record review and interviews, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards for accuracy. This was found evident in 1 (Resident #15) out of 55 residents reviewed during the survey. The findings include: On 1/21/26 at 8:22 AM, the surveyor conducted an interview with Resident #15's family member. During the interview the family member stated that Resident #15 had multiple chronic conditions and had been in and out of the hospital recently. On 1/22/26 at 8:13 AM, the surveyor reviewed Resident #15's medical record. The review revealed Resident #15 had a past medical history, that included but not limited to, end stage renal disease, dependence on dialysis, peripheral vascular disease (PVD) and history of colostomy (a surgical procedure that creates an opening in the abdominal and bringing and end of the large intestine to the exterior creating a stoma). Next the surveyor reviewed Resident #15's care plans. The review revealed that a care plan was placed in Resident # 15's care plan on 10/2/25 that stated, Resident #29 has actual alteration in gastrointestinal status related to colostomy. The surveyor noted that Resident #29 was another resident that resided in the facility. On 1/22/26 at 10:47 AM, the surveyor conducted an interview with the Regional Clinical Services Manager Staff #5. During the interview the surveyor asked how Resident #15's care plan had another resident's name listed. Staff #5 stated that the care plan itself was appropriate for Resident #15, however, the use of the other resident's name was done in error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews it was determined that 1) the facility failed to maintain practices to help prevent the transmission of infections and 2) failed to follow infection control protocols of the laundry process, maintain laundry dryers in sanitary and hazard free condition, and maintain a copy of the manufacturer's instructions for the washer and dryer. These findings were found to be evident in 2 out of 3 medication administration observations and 1 random observation of shared equipment, and in 3 out of 3 dryers observed during the annual survey. The findings include:1) On 1/28/26 at 8:38 AM, the surveyor observed License Practical Nurse (LPN) # 20 prepare medications for Resident #138. The surveyor observed LPN #20 take Resident #138's multidose lispro (short acting) insulin pen and apply the needle and then administer the medication. The surveyor noted that LPN #20 did not clean the port prior to applying the needle. On 1/28/26 at 9:01 AM, the surveyor conducted an interview with LPN #20 and asked if the pen was supposed to be cleaned before applying the needle. LPN #20 stated that the pen should have been cleaned prior to use. On 1/28/26 at 9:03 AM, the surveyor observed License Practical Nurse (LPN) #21 prepare medications for Resident #103. The surveyor observed LPN #21 take Resident #103's blood pressure with a portable blood pressure machine. After taking the blood pressure LPN #21 then prepared to administer Resident #103's glargine (long acting) insulin via an insulin pen. The surveyor observed LPN #21 take Resident #103's multidose insulin pen and apply the needle and then administer the mediation. The surveyor noted that LPN #21 did not clean the port prior to applying the needle. On 1/28/26 at 9:20 AM, the surveyor observed LPN #21 prepare and administer medications to Resident #173. Prior to administering the mediation LPN #21 was observed bring the portable blood pressure machine from Resident #103's room into Resident #173's room. The surveyor observed LPN #21 apply the same blood pressure cuff to Resident #173 that was used a few minutes earlier with Resident #103. No disinfecting or cleaning was noted of the blood pressure cuff or machine between the two residents. On 1/28/26 at 9:27 AM, the surveyor conducted an interview with LPN #21 and asked if the insulin pen was supposed to be cleaned before applying the needle. LPN #21 stated that when she used multidose vials she cleans the port but not for multidose insulin pens. The surveyor asked what the practice was for using shared equipment between residents. LPN #21 stated she should have wiped the blood pressure equipment between the two residents. On 1/28/26 at 11:00 AM, the surveyor interviewed the Infection Preventionist (IP) #18. During the interview IP #18 confirmed that it was the expectation that nurses using multidose insulin pens should clean the ports with an alcohol wipe prior to applying the needle. The surveyor reviewed infection control observations of not cleansing the ports before needle application and not wiping down shared equipment between residents. IP #18 stated that education would be initiated for staff to adhere to infection control practices. Cross Reference F658 2) During observation of the laundry room on 01/29/2026 at 10:07 AM, it was noted that three dryers (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had significant debris covering the interior drum walls. This included melted diapers, gloves, food, and other unidentified objects. Additionally, the washer and dryer maintenance logs were missing from the room. Interview, on 1/29/2026 at 10:20 AM, Laundry Staff #28 stated that all soiled laundry was placed in large carts on the residents' floors then covered before being transported via the utility elevator. Upon arrival at the laundry room, all dirty laundry was then placed directly into the washers. She stated that there was currently no proper sorting process in place for laundry, including items marked as contaminated because the detergent chemicals took care of everything. It was noted that the facility failed to handle heavily soiled/ contaminated linens or pads separately. Additionally, there are no processes for removing biohazardous or non-biohazardous objects and substances from laundry prior to washing. At that time, the surveyor requested the manufacturer's instruction manuals for the washer and dryer. Maintenance Staff #30 reported that the facility did not keep these manuals in hand. On 1/29/2026 at 11:35 AM, a follow-up interview was conducted with the Administrator. During this discussion, the Administrator acknowledged that the lack of proper sorting procedures for contaminated laundry and the failure to handle soiled linens and pads separately were unacceptable. Record review on 1/29/26 at 01:20 PM, revealed that the facility maintains service records for detergent chemicals regularly but did not have any service records on file for the dryer machines. No washer/dryer manufacturer's instruction manuals were received for review. Follow up on 1/30/2026 at 10:45 AM regarding debris from the drums. Environmental Director Staff #29 agreed that the facility failed to follow infection control protocols of the laundry process and did not sufficiently prevent fire hazards or maintain proper sanitation conditions. These issues have all been noted as deficiencies. To address these matters, the Environmental Director is currently coordinating with the washer/dryer company to remove all debris and to establish a regular service schedule. Additionally, she was in the process of re-training staff to ensure compliance. Final interview with the Administrator on 1/30/2026 at 11:32 AM, the Administrator agreed that the facility failed to follow infection control protocols of the laundry process and the facility failed to maintain and use laundry dryers in a sanitary and hazard-free condition, resulting in deficiency practice concerns.

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Future Care Capital Region	1051 Brightseat Road Landover, MD 20785

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and facility staff interviews it was determined that the facility failed to have a call light device accessible and functioning properly for Residents. This finding was found to be evident in 2 (Resident #96 and #125) out of 19 Residents reviewed for Resident call system.The findings include: During tour of the Resident rooms on the PCU Nursing Unit on 1/20/2026 at 1:15 PM the surveyor observed that Resident #96 was lying in bed, with head of bed (HOB) elevated and in no distress. The call light device was hanging on the bed frame at the HOB. In an interview with the PCU Nursing Unit Manager on 1/20/2026 at 1:30 PM, the surveyor conveyed that Resident #96 did not have an accessible call light device. The PCU Nursing Unit Manager and the surveyor observed Resident #96 in bed with the call light device hanging on the HOB bed frame. The PCU Nursing Unit Manager removed the call light device from the HOB bed frame and positioned the call light device to be accessible for Resident #96. The PCU Nursing Unit Manager stated that she would follow-up with the staff regarding call light accessibility for the Residents. No additional information was provided by the facility at the time of survey exit. On 01/21/26 at 8:05 AM, the surveyors observed Resident #125 yelling for help in their room. The surveyors observed that the call bell did not light up in the hallway when activated and did not produce an audible signal to alert staff. On 01/21/26 at 8:08 AM, the Assistant Director of Nursing (ADON) responded to surveyors request to assist the resident. During an interview on 01/21/26 at 8:10 AM, the ADON stated staff must ensure operational call bells. The ADON stated a technical issue was likely because staff conducted routine checks and call bells were last tested on [DATE] and identified no issues. The ADON further stated that staff would contact maintenance immediately to repair the resident's call bell or, if repair was not prompt, staff would relocate the resident to another room. On 01/21/26 at 9:01 AM, surveyors notified the Licensed Nursing Home Administrator, who began addressing the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215364	A. Building B. Wing	01/30/2026

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review it was determined that the facility staff failed to ensure the most recent survey results in a place readily accessible to residents, family members, and legal representatives of residents. This has the potential to affect all the residents and visitors within the facility.The findings include:On 01/21/2026 at 8:35 AM, the surveyor did not observe a survey results binder in the front lobby. The surveyor requested the survey binder at the receptionist desk. Guest Services Staff #8 removed it from a cabinet behind the desk and stated that the desk was manned 24/7.A review of the survey binder on 01/21/2026 at 8:40 AM revealed it did not contain the most recent recertification survey. The Administrator stated that the survey binder was not current and committed to updating it immediately. On 01/21/2026 at 8:58 AM, the Administrator provided an updated survey binder and stated that the facility would keep it at the front desk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review, and interview, it was determined that the facility failed to post the facility name and the total hours worked by staff on its Daily Staffing Schedule. This was evident for one (Vital Strong 1) of four units. The findings include: On 01/30/2026 at 7:45 AM, a review of the daily unit staffing and assignment form revealed that it did not include the facility name or the total number of hours worked by staff per shift.On 01/30/2026 at 7:52 AM, the surveyors observed a laminated report titled Nursing Staff Directly Responsible for Resident Care posted in the lobby. The report displayed the date, licensed nursing staff ratio, and the unlicensed nursing staff ratio written with a dry-erase marker; however, the resident census was not posted in the lobby.On 01/30/26 at 9:45 AM, the surveyors conducted a record review of staffing documentation. The review revealed that on 12/28/2025 (day shift), 01/02/2026 (evening shift), and on 01/06/2026 (night shift), nursing hours were not listed for one of four units. On 01/30/2026 at 10:10 AM, surveyors interviewed the Licensing Nursing Home Administrator (LNHA). The LNHA acknowledged that some of the posted assignment and staffing forms were incomplete. The LNHA stated that the expectation was for all forms to be fully completed prior to posting them on each unit. Additionally, the LNHA confirmed that the laminated report posted in the lobby was not a permanent record for public viewing, did not include the census, and did not meet regulatory requirements for posting nursing staffing hours.