STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215007	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wicomico Nursing Home	900 Booth Street Salisbury, MD 21801

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 16177 Based on observations, interviews, and policy review, the facility failed to provide visual privacy during a bed bath for one of one resident (Resident (R) 56) reviewed for privacy of 30 sample residents. This failure increased the risk of residents feeling humiliated and embarrassed when being exposed to others during care. Findings include: Review of the Code of Maryland Regulations, dated 09/18/19 and provided as the facility's residents' rights policy, revealed A nursing facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, and in full recognition of the resident's individuality .personal privacy in personal care . Review of the Bed Bath procedure, dated 04/01/90, revealed Screen patient [pull curtains] .Remove clothing and cover with sheet, not exposing patient unnecessarily . Review of R56's electronic medical record (EMR) quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/02/24 revealed R56 was totally dependent on staff for bathing and R56 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. During the tour of the facility on 08/26/24 at 10:40 AM, this surveyor knocked on R56's room door when a staff member stated, yes? This surveyor announced herself and opened the previously closed door to see R56 lying on her bed completely naked and exposed while Geriatric Nurse Aide (GNA) 4 was providing a bed bath. R56 had no sheet or bed blanket covering her. The privacy curtain was not pulled and R56 was visible to the surveyor from the hallway. The window curtain was also not pulled exposing R56 to anyone walking outside (with no coverage) past her room. R56's room was ground level. During an interview on 08/26/24 at 11:00 AM, GNA4 verified that the curtains were not pulled nor was R56 covered while receiving a bed bath. During an interview on 08/26/24 at 11:05 AM, when asked if they were bothered by being exposed while receiving a bed bath, R56 stated, not so much unless a man saw [her/him] then no, no, no. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/24 at 10:20 AM, the Director of Nursing (DON) stated, Privacy and dignity during care is our expectation. Not only the privacy curtain but the window curtain should be pulled, and the resident should be covered during the bath.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177 Based on observations, interviews, record review, and policy review, the facility failed to maintain a restraint free environment for one of one resident (Resident (R) 51) reviewed for physical restraints out of 30 sample residents. This failure increased the potential for R51, if attempted, to not be able to leave her bed. The use of restraints increased the risk of negative outcomes such as decline in physical functioning, increased accident hazards and falls, a loss of autonomy, and increased withdrawal, depression, and/or reduced social contact. Findings include: Review of the Code of Maryland Regulations, dated 09/18/19 and provided as the facility's residents' rights policy, revealed a physical restraint means a device including material or equipment, attached or adjacent to a resident's body, that the resident cannot remove easily and that restricts the resident's freedom of movement .Physical restraints may be used only: as an integral part of the an individual medical treatment plan; if absolutely necessary to protect the resident or others from injury; if prescribed by a physician .if less restrictive alternatives were considered and appropriately ruled out by the physician . Review of the facility's undated policy titled, Restraint Appropriate Risks and Benefits revealed the facility is ultimately responsible for the appropriateness of and decision regarding restraint usage . Further review of this policy revealed lists of appropriate restrictive devices from least restrictive to most restrictive. A wheelchair against the bed was not listed as an appropriate restrictive device. Review of R51's electronic medical record (EMR) quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/24 revealed R51 was admitted to the facility on [DATE] with multiple diagnoses which included dementia. Further review of this MDS revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating R51 was severely cognitively impaired. Review of the EMR Care Plan tab revealed a care plan for falls, revised 07/24/24, for multiple falls from their wheelchair or bed, two falls resulted in major injuries. Cross Reference: F689 Free of Accident Hazards, Supervision for R51. The interventions for the fall care plan did not include using a physical restraint to prevent R51 from attempting to transfer in or out of bed. Observation on 08/29/24 at 6:45 AM revealed R51 sleeping in a low bed with a fall mat in place on the right side of the bed. Further observation revealed a quarter side rail up on the right side of the head of the bed (HOB) and the left side of the bed was against the wall. R51's wheelchair was observed against the quarter side rail at the HOB extending past the quarter side rail. The wheelchair was observed placed up against the HOB in such a way that R51 would not be able to get out of bed or into the chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/29/24 at 6:47 AM revealed Geriatric Nurse Aide (GNA) 1 walking into the hall from the nurses' station, entering R51's room, and moving the wheelchair away from the bed, and placing the wheelchair near the window. During an interview at the same time of the observation, when asked about the placement of the wheelchair against the HOB, GNA1 stated she had placed the wheelchair against the HOB because she [R51] leans over too far in the bed and falls out. During an interview on 08/29/24 at 7:00 AM, Registered Nurse (RN) 3 verified she was the nurse on the 11-7 (11:00 PM- 7:00 AM) shift and made rounds to observe the residents. RN3 stated she did see the wheelchair against the HOB but did not ask the GNA about the wheelchair nor did she move the wheelchair away from the HOB. RN3 was asked if the wheelchair against the HOB was an intervention to keep R51 from falling out of the bed. RN3 stated, No, the wheelchair is stored near the window or near the wall across from the foot of the bed. During an interview on 08/29/24 at 7:05 AM, the Infection Control Nurse/Staff Development (ICN/SD) nurse was notified of the observations and interviews concerning R51's wheelchair. The ICN/SD nurse stated. [the wheelchair against the HOB] is still a barrier [from getting out of bed] regardless if it was to keep her from falling out of the bed. During an interview on 08/29/24 at 10:45 AM, the Director of Nursing (DON) verified that the wheelchair was not to be placed against the bed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on record review and interview it was determined the facility failed to report allegations of an injury of unknown source within 2 hours of the discovery of possible abuse to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 2 (#24, #501) of 10 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 8/26/24 at 9:22 AM a review of facility reported incident MD00204622 revealed Resident #24 was noted to have a discoloration/bruise to the outer corner of the right eye on 4/11/24, which was a Thursday. Review of the facility's investigative packet revealed the discovery was on 4/11/24 at 10:40 AM. Also reviewed was an email confirmation that the initial report was sent to OHCQ on 4/11/24 at 5:05 PM, which was not within 2 hours of the discovery. Additionally, a 4/11/24 at 5:07 PM note written by the Director of Nursing (DON) documented, received a call back from [name of Resident #24's daughter]. This writer informed her that it had been reported that resident has a yellowish green discoloration to corner of right eye. [name of daughter] stated that she had noticed the discoloration to residents eye Sunday 4/7/24 and asked resident what happened. Resident #24 told the daughter, A man came in to [his/her] room and did it. The note also stated that Resident #24's daughter, did not report to anyone that she saw discoloration on residents' eye because she was picking her battles. This writer encouraged [name of daughter]to please report any discolorations or concerns that she may have. Four days elapsed between 4/7/24 and 4/11/24 and nursing staff failed to report any discoloration to the resident's eye to nursing administration until 4/11/24. Cross Reference F610. On 8/28/24 at 8:10 AM an interview was conducted with the DON. The surveyor pointed out that the report was not submitted within 2 hours. The DON stated that because Resident #24 always has behaviors, is always bruising because of combative behavior, and the number of medications that the resident is on for the behaviors, that they would be reporting every day. The surveyor asked if they didn't suspect some sort of abuse why did they go around to other resident rooms and ask if residents felt safe. The DON stated, we care about the care all of our residents receive. Review of the facility's investigative packet included a statement from the house supervisor and statements from (8) staff members that had worked on that unit. There were (10) additional staff members that had worked from Sunday to Thursday that had not been interviewed. No one reported a discoloration by the eye from Sunday when the daughter noticed it until Thursday when staff reported it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 12:00 PM the DON was asked, why didn't staff who worked with the resident on Sunday April 7th, Monday April 8th, Tuesday April 9th, and Wednesday April 10th report the discoloration. The DON stated, that is a good question, and I don't know why they didn't. 2) On 8/28/24 at 2:39 PM facility reported incident MD00204444 was reviewed and revealed on 3/28/24 at 12:30 PM a staff member reported that Resident #501 punched them under the chin causing a 10-centimeter laceration on top of Resident #501's right hand. Resident #501 alleged that the staff member scratched his/her hand and denied hitting the staff member. Review of the facility's investigation revealed an email confirmation for the initial report was dated 4/1/24 at 4:18 PM and the final report was dated 4/4/24 at 6:22 PM. The initial report was not submitted within 24 hours. On 8/28/24 at 2:55 PM an interview was conducted with the DON regarding the timely submission of the facility reported incident. The DON confirmed it was not submitted within 24 hours.

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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. 31145 Based on review of facility administrative records, facility investigations, and staff interview, it was determined the facility failed to thoroughly investigate incidents of injuries of unknown origin. This was evident for 2 (#24, #505) of 10 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 8/26/24 at 9:22 AM a review of facility reported incident MD00204622 revealed Resident #24 was noted to have a discoloration to the outer corner of the right eye on 4/11/24, which was a Thursday. Resident #24's daughter was informed of the injury and stated that she noticed redness to the sclera and the discoloration to the right eye on 4/7/24, which was a Sunday. Review of the facility's investigative packet included a master list of residents that were interviewed asking if they felt safe in their room, a statement from the house supervisor, and statements from (8) staff members that had worked on that unit. There were (10) additional staff members that had worked from Sunday to Thursday that had not been interviewed. No one reported a discoloration by the eye from Sunday when the daughter noticed it until Thursday when staff reported it. Cross Reference F609 On 8/28/24 at 12:00 PM the Director of Nursing (DON) showed the surveyor that there were staff interviews related to the bruise. The surveyor brought up to the DON that the daughter stated she noticed the discoloration on Sunday 4/7/24 per the DON's note dated 4/11/24. The DON was asked, why didn't staff who worked with the resident on Sunday April 7th, Monday April 8th, Tuesday April 9th, and Wednesday April 10th report the discoloration. The DON stated, that is a good question, and I don't know why they didn't. 2) On 8/27/24 at 12:00 PM a review of facility reported incident MD00191985 revealed Resident #505 sustained a fall on 5/3/23 in the morning. Review of a 5/3/23 at 11:28 AM nursing note documented that Resident #505 was found by 2 GNAs (geriatric nursing assistants) on the floor near the wheelchair with a cup of coffee spilled in front of the resident. Review of the facility's investigative packet revealed an incident/accident report, a written statement from the nurse assigned to the resident on 5/3/23, a copy of the x-ray report, notes and documentation from the hospital, and the resident's medication list. There were no interviews from the 2 GNAs that found the resident on the floor or any other staff member that may have seen the resident prior to the fall. On 8/29/24 at 10:35 AM an interview was conducted with the Assistant Director of Nursing (ADON). The surveyor went through the investigative packed with the ADON. The ADON was asked about what she would include in the investigation. The ADON stated, statement from employee that had patient and the GNAs involved, the nurse, and the last time they saw the resident in their normal position. I would look at their meds. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed what was in the packet and showed the ADON there were no GNA interviews. The ADON stated she would have expected GNA statements and/or statements from others who saw the resident prior to the fall. The ADON confirmed it was an incomplete investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#504) of 10 residents reviewed for facility reported incidents during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 8/27/24 at 7:55 AM Resident #504's medical record was reviewed and revealed on 6/1/23 at 10:05 PM, Resident #504 was, standing at room door and void[ed] out into the hallway, hollered at staff w/redirection. On 6/3/23 at 12:40 PM it was documented, sometimes combative and angry and exit seeking. On 6/6/23 at 10:26 AM a Social Service Note documented the resident had behaviors of wandering and a wanderguard was placed, had inappropriate language, and verbal threat to hit staff. On 6/7/23 at 9:58 AM a note documented, Resident removed oxygen x1 this am and attempted to exit the side door, setting off the alarm. Review of the MDS with an assessment reference date (ARD) of 6/7/23, Section E0200B verbal behavioral symptoms directed towards, others documented 0 Behavior not exhibited. Section E0900 Wandering, documented 0. Behavior not exhibited. This was an error. On 6/16/23 at 5:47 AM a note documented, refused to allow a BP check stating, get the hell away from me. On 6/16/23 at 11:33 PM a note documented that the resident adamantly refused to wear [his/her] oxygen, swatting at this writer when it was being applied and refused vitals. On 6/17/23 at 12:50 PM it was documented, often aggressive and exit seeking behaviors. On 6/17/23 at 10:02 PM it was documented, Patient has been exit seeking all shift. Can be aggressive and angry, has also been towards staff and residents. On 6/19/23 9:05 PM it was documented, Redirected several times during this shift for taking off O2 and also for wandering into peers' areas. On 6/20/23 at 7:30 PM it was documented, Patient can be aggressive and exit seeking, recommend 1-1 patient companion for patient safety. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS with an ARD of 6/22/23: Section E0200 A, physical behavioral symptoms marked 0. Behavior not exhibited. Section E0800 Rejection of Care - documented, 0. Behavior not exhibited. Section E0900 Wandering - documented, 0. Behavior not exhibited. On 8/29/24 at 2:08 PM an interview was conducted with the Social Worker who stated, I usually do that portion of the MDS, but I was working 2 jobs at the time, and I was overwhelmed so I had someone helping me. I realized after a while that my helper was documenting in the progress notes, but wasn't coding it correct on the MDS, so I stopped her from doing any more MDS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31145 Based on record review, observation, and staff interview it was determined that facility staff 1) failed to update care plans when there were changes in resident needs or preferences and 2) failed to thoroughly evaluate and revise resident plans of care after each assessment. This was evident for 6 (#40, #27, #34, #28, #504, #505) of 10 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1) On 8/26/24 at 10:00 AM Resident #40's medical record was reviewed and revealed an August 2024 physician's order for, Geri sleeves to bilat arms at all times. May remove for care, then reapply, every shift for skin discoloration. Geri-sleeves protect the upper extremities from abrasions, bruises, snags, and skin tears. Review of Resident #40's care plan, has potential for impairment to skin integrity r/t fragile skin, urinary incontinence, impaired mobility had 5 interventions. The care plan was not updated to reflect the use of Geri-sleeves. On 8/20/24 at 12:52 PM an interview was conducted with the Assistant Director of Nursing (ADON) who stated the resident had extremely thin, fragile skin and they have tried the leg sleeves, and the resident keeps taking them off and the resident has Geri sleeves that he/she refuses or removes. 2) On 8/26/24 at 11:16 AM Resident #27's medical record was reviewed and revealed on the evening of 6/9/23 Resident #27 was found face down on floor in [his/her] private room with visible bleeding from a facial wound. Resident #27 was send to the emergency room and found to have a left orbital floor/rib fracture with left maxillary sinus fracture. Review of Resident #27's care plan, at risk for falls related to gait/balance problems had 6 interventions that were dated prior to the 6/9/23 fall. There were no new interventions after the fall. On 8/26/24 at 9:05 AM observation was made of the resident eating breakfast in bed. There was a fall mat on the floor to the right side of the bed. The care plan was not updated to reflect the use of fall mats. On 8/26/24 at 3:30 PM a second observation was made, and Resident #27 was observed being wheeled in a wheelchair by an activity's aide. The resident did not have leg rests on the wheelchair. The leg rests were observed on the floor in the resident's room, however there was no signage about if the leg rests should be on or off the wheelchair. The care plan was not updated to reflect the use of leg rests. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/26/24 at 12:40 PM a review of facility reported incident MD00192657 documented Resident #34 sustained a fall on 5/19/23. The resident was found sitting upright on buttocks with knees flexed outward, in the 100 hallway near the bathroom. Later in the day Resident #34 complained of low back and buttock pain. X-rays were taken which revealed an age-indeterminate compression fracture. The resident was to begin physical therapy. Review of the facility's investigation documented that Resident #34 was last seen by the attending GNA lying in bed in fetal position asleep. [Resident #34] is one person assist however [he/she] is non-compliant and will transfer [him/herself] from bed to bathroom with walker. To prevent this incident from happening again GNA should round more on resident and offer frequent toileting. Review of Resident #34's care plan at risk for falls was not updated to reflect rounding more on the resident and the offer of frequent toileting. On 8/29/24 at 12:37 PM an interview was conducted with the DON (Director of Nursing) who was asked what was done when someone fell . The DON stated the staff was expected to do a full assessment to determine if the resident could be moved or sent out, fill out an incident report, notify family, notify physician, document a progress note and an incident report that is forwarded to the DON. The DON stated, when I get the incident report, I check to make sure the family and physician were notified and make sure it is care planned. I actually look at the care plan when there is a fall. We discuss the interventions, the MDS Coordinator updates the interventions and sometimes I update the interventions, but the nurses don't. The DON was informed of the care plans that were not updated. 4) On 8/26/24 at 2:22 PM facility reported incident MD00194543 was reviewed and revealed Resident #28 sustained an injury while being transported during activities. The facility documented in their report that Resident #28, who was non-ambulatory, was being transferred to an activity via a wheelchair by an activity's aide. Resident #28 was holding his/her legs up when they became too heavy for him/her to hold up. Resident #28 dropped his/her legs to the ground, and they were caught up in the wheelchair per the aide. Resident #28 yelled out and the aide pulled the wheelchair backwards and asked the resident what was wrong. Resident #28 stated that, [his/her] knee hurt. The wheelchair did not have leg rests on the wheelchair. Review of Resident #28's at risk for falls care plan related to gait/balance problems, psychoactive drug use, and unaware of safety needs, had 6 interventions; anticipate and meet the resident's needs.Be sure the resident's call light is within reach for assistance as needed. The resident needs prompt response to all requests for assistance. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening, and improved mobility. Ensure that the the resident is wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes and the resident needs a safe environment. The interventions on the care plan were not resident centered for Resident #28 and the care plan was not updated after the incident to reflect the use of wheelchair leg rests. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) On 8/27/24 at 7:55 AM Resident #504's medical record was reviewed and revealed on 6/10/23 between the hours of 1:00 PM and 3:30 PM Resident #504 became very agitated and was found on the floor twice. Resident #504 was aggressive and not easily redirected. Resident #504 would not allow a full neuro assessment to determine if the resident had hit his/her head and was possibly suffering with an acute head injury. Resident #504 was sent to the emergency room for evaluation. Resident #504 was also evaluated for a hip injury and change in mental status. The resident returned to the facility with no fracture and no acute head injury. Continued review of Resident #504's medical record revealed Resident #504 had 6 falls from 3/24/23 to 6/10/23. Review of Resident #504's at risk for falls care plan only had 4 interventions that were initiated on 3/9/23. There were no additional interventions added to the care plan to aid in the prevention of further falls. Further review of Resident #504's care plans revealed a care plan, The resident has Shortness of Breath r/t recent hospitalization with pneumonia and COPD that was initiated on 2/3/22. The care plan had 7 interventions, however, was not updated to reflect oxygen use and how much oxygen the resident was to receive. There were no interventions about oxygen equipment change, oxygen cord length for when mobilized in the wheelchair and nothing about the inhalers the resident received according to the physician's orders and Medication Administration Record (MAR). They documented the resident received the inhalers Albuterol Sulfate every 4 hours when needed for shortness of breath and Ipratropium-Albuterol Sol. Inhaler every 12 hours when needed for wheezing and shortness of breath. On 8/28/24 at 9:21 AM an interview was conducted with the MDS coordinator who stated that everyone can create and update the care plan. The MDS coordinator was informed of the concerns related to not updating the care plan and she stated, as far as care plans, we were doing things for distraction, we just did not document it in the care plan. 6) On 8/27/24 at 12:00 PM a review of facility reported incident MD00191985 documented Resident #505 sustained a fall from the wheelchair prior to going to dialysis. The resident attempted to transfer self out of the chair and was found on the floor. Initially the resident did not complain of pain and was able to move all extremities. Later in the day, while at dialysis, the resident complained of pain and was sent to the emergency room where x-rays confirmed a right femoral neck intertrochanteric fracture. Review of Resident #505's care plan at risk for falls r/t poor safety awareness was not updated after the fall for additional interventions to keep the resident safe from injury. On 8/29/24 at 7:10 AM GNA #7 was interviewed and stated Resident #505, wanted what [he/she] wanted. [He/she] was not cooperative with anything. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 8:00 AM an interview was conducted with the MDS coordinator about who updates the care plans. The MDS Coordinator stated, when the shift supervisor is here Monday through Friday, depending on how busy the night was or if she was working on the floor, she will leave a report. I go to IDT meeting every morning and if there were changes, we would update the care plan. The MDS Coordinator stated that the DON looks at falls and brings to IDT. The DON adds fall to care plan, and we talk about it in IDT.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on a review of a facility reported incident, medical record review, facility documentation review, observation and staff interviews, it was determined the facility failed to keep a dependent resident free from injury while transporting to activities in a wheelchair, which resulted in actual harm to Resident (R) #28. The failure of facility staff to place leg rests on a wheelchair while transporting a resident resulted in a fracture in the lower leg. This was evident for 1 of 30 sampled residents. The facility failed to ensure a resident was free from accident hazards by not identifying new fall interventions for one of three residents (R51) reviewed for falls resulting in a head laceration and pubic fracture. The facility failed to provide leg rests for the residents identified as requiring leg rests for injury prevention for one of one residents (R57) reviewed for wheelchair safety of 30 sampled residents. The findings include: 1. On 8/26/24 at 2:22 PM facility reported incident MD00194543 was reviewed and revealed Resident #28 sustained an injury while being transported during activities. The facility documented in their report that Resident #28, who was non-ambulatory, was being transferred to an activity via a wheelchair by an activity's aide. Resident #28 was holding his/her legs up when they became too heavy for him/her to hold up. Resident #28 dropped his/her legs to the ground, and they were caught up in the wheelchair per the aide. Resident #28 yelled out and the aide pulled the wheelchair backwards and asked the resident what was wrong. Resident #28 stated that, [his/her] knee hurt. The wheelchair did not have leg rests on the wheelchair. On 8/26/24 at 2:22 PM AM a review of Resident #28's medical record was conducted and revealed Resident #28 was admitted to the facility in March 2023 with diagnoses that included unspecified dementia, age-related osteoporosis, and a history of a right tibial fracture in 2021. Review of a 7/17/23 nurse's note documented, patient was brought to the nurse ' s station at approximately 1515 (3:15 PM) with an injury to [his/her] RLE (right lower extremity) and right knee. Area is red and beginning to swell. Patient is complaining of 8/10 RLE pain. Stat (immediate) x-rays to RLE were ordered. Review of a 7/17/23 nurse's note documented, portable x-ray was completed at right extremity, noted to be positive tibia fx. (fracture). The physician ordered for Resident #28 to be sent to the emergency room . At 8:30 PM Resident #28 was sent to the emergency room via 911. The note documented that the resident was in extreme pain and had been given medication with no relief. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 7/17/23 Orthopedic Surgery Consult performed at the hospital on 7/17/23 at 10:52 PM documented, PMH (past medical history) significant for dementia and conservatively managed right proximal tibia fracture in July 2021, nursing home resident, primarily wheelchair dependent who presents for evaluation of right lower leg pain after apparent twisting incident in wheelchair at NH (Nursing Home). Mild swelling proximal lower leg with hematoma. No breaks in skin. Obvious pain with any passive motion of right knee. CT right lower leg without contrast: findings: comminuted fracture of the proximal tibia with displacement and diffuse osteopenia. There is osteoarthritis with osteophytes and narrowing of the knee compartments. Proximal tibia fracture with mild displacement. An X-ray of the right lower leg due to leg pain, right leg pain had the results, Osteopenia (low bone loss) and fractures of the proximal tibia with osteoarthritis (Osteoarthritis is a degenerative joint disease, in which the tissues in the joint break down over time). The conclusion was, Acute appearing proximal tibia fracture. The plan from the physician at the hospital stated, recommend conservative management of above injury. Appears [he/she] re-fractured area of proximal tibia which is not entirely surprising given advanced osteoporosis. Osteoporosis is a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures (broken bones). Review of Activity Aide #1' s written statement documented, I was taking resident outside for an outdoor stroll when [he/she] hollered in pain. I stopped, looked down, noticed [his/her] legs gave out and went under wheelchair. I then backed up wheelchair. [He/she] then told me that [his/her] right knee hurt a lot. I then went inside to retrieve [his/her] leg rests, since [he/she] did not have any leg rests on wheelchair. Once leg rests were on, I took [him/her] straight to the nurse. On 8/26/24 at 3:05 PM an interview was conducted with the Director of Physical Therapy (DPT). The DPT was asked who was responsible for the maintenance or determination of leg rests for residents in wheelchairs. The DPT stated, If a resident is referred to rehab or noticed by us, we would do an assessment. Everyone gets leg rests unless they self-propel. It would go to nursing and be care planned. On 8/26/24 at 3:10 PM an interview was conducted with the Activities Director (AD) who stated Activity Aide #1 no longer worked at the facility. The AD stated the incident with Resident #28 and the wheelchair was an isolated incident. The AD stated that some residents can hold their feet up and let you know when they are tired. The AD stated the activity ' s aide was taking the resident outside. They were on the front sidewalk heading to the patio. I think the resident got tired of holding [his/her] feet up and just let them down. The feet went under the wheelchair. On 8/26/24 at 3:22 PM and 8/27/24 at 10:19 AM calls were placed to Activity Aide #1 with no answer. As of 8/29/24 at 4:45 PM the aide failed to return the surveyor's call. Continued review of the facility's investigation revealed a Clinical Huddle Review dated 7/21/23 that documented 10 items for discussion during the review. The last item on the huddle was, recent leg injury related to non-use of leg rests. New protocol being implemented next week. There were 23 signatures of staff that attended. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident #39's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #28's quarterly MDS with an assessment reference date of 5/11/23 documented Resident #28 was extensive assistance with 2 people for locomotion on and off the unit and total dependence with 2 people off the unit. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the Resident #28's care. Review of Resident #28's at risk for falls care plan related to gait/balance problems, psychoactive drug use, and unaware of safety needs, had 6 interventions; anticipate and meet the resident's needs. Be sure the resident's call light is within reach for assistance as needed. The resident needs prompt response to all requests for assistance. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening, and improved mobility. Ensure that the the resident is wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes and the resident needs a safe environment. The interventions on the care plan were not resident centered for Resident #28 and the care plan was not updated after the incident to reflect the use of wheelchair leg rests. On 8/27/24 at 1:25 PM an interview was conducted with the Director of Nursing (DON) who stated, that day [he/she] was holding [his/her] legs up and then let them down. It was an activity assistant. Typically, [he/she] is taken out of the room to another area. That day [he/she] was taken outside and maybe it was too far. The DON and the surveyor went out the front door where the incident occurred. There was a silver transition strip approximately 5 inches wide where the sliding glass doors automatically open and close. Resident #28 was pushed over the transition strip onto a piece of brown outdoor rug that was sitting on top of the concrete. The DON stated it happened there and not at the point where the sidewalk slopes mildly downhill toward the sitting area where residents can sit by the trees. On 8/27/24 at 4:05 PM the Nursing Home Administrator (NHA) gave the surveyor a copy of the Resident transport while in facility or on Campus from the Nursing Procedure Manual. Procedure number 3 documented, all residents will be evaluated by the Rehabilitation Team to determine the safest mode of transportation to be used within the facility. Number 4 stated, all residents that require a wheelchair as their safest mode of transport will be further evaluated by the team to determine the need for foot pedals/leg rests during transport. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/29/24 at 12:00 PM an interview was conducted with the resident's attending physician. When asked about the leg rests the physician stated, the resident probably should have had leg rests on the wheelchair since [he/she] was going a distance and outside. The resident's legs may get tired so the leg rests should be on the chair. 40902 2. Review of a facility policy titled, Resident transport while in facility or on Campus, revision date July 2023, revealed, Objective: To ensure the safe transportation of a resident within the facility. To determine the least restrictive and safest mobility transport for the resident. To promote the highest level of independence for the resident with regards to mobility when out of bed .Wheelchairs, and leg rests . All wheelchairs will have matching leg rests/foot pedals labeled . The residents that are required to have foot pedals/leg rests on their wheelchair when they are in it, will have a sign designating this placed at the head of their bed. Review of R51's Face Sheet, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including difficulty in walking, muscle weakness, repeated fall, and dementia. Review of R51's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/24 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 99 out of 15 which indicated the resident was severely cognitively impaired. Review of R51's care plan located under the Care Plan tab of the EMR and dated 02/01/23, revealed The resident was at risk for falls related to gait and balance issues and poor safety awareness. Interventions in place were anticipate and meet resident's needs, be sure the residents call light was within reach and encourage resident to use it, educate the resident and family about safety reminders and what to do when a fall occurred, ensure the resident was wearing appropriate footwear, follow facility protocol, and the resident needs a safe environment. Further review revealed no updated fall interventions since it was implemented on 02/01/23. a. Review of a Nurse's Note located in the EMR under the "Notes" tab, written by Licensed Practical Nurse (LPN) 1 on 03/09/24 at 10:47 AM, revealed GNA [Geriatric Nurse Aide] reported to nurses' station that resident was noted on floor. The resident was last seen in her wheelchair 2 minutes before falling. Injury noted to left side of her face with large amount of bleeding coming from the site. Resident was not removed from the floor until EMTs arrived, but a nurse was applying pressure to stop the bleeding. 911 was called immediately, resident daughter and physician were notified. Review of Incident report, provided by the facility and dated 03/09/24 at 10:35 AM, revealed staff notified nurse that resident was on the floor bleeding. When the nurse arrived at resident's room resident was lying on right side of face and large amount of bleeding, called 911, resident's daughter and physician. No additional interventions were added to the care plan. Review of a Nurse's Note located in the EMR under the "Notes" tab, written by Registered Nurse (RN) 5 on 03/14/24 at 11:28 PM, revealed Resident returned via transport without incident. Resident returned with head Injury from fall left with a laceration to the left side of scalp and one stitch to repair laceration. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. Review of a Nurse's Note located in the EMR under the "Notes" tab, written by Registered Nurse (RN) 5 on 03/14/24 at 11:28 PM, revealed Called to resident's room by attending GNA at approximately 6:45pm. Found resident flat on their back and laying under the bedside table. Resident states they tried to put themselves to bed. Passive range of motion done to all extremities; no pain noted at this time. No marks noted either. Resident was calm and denied any pain. Lifted with staff assistance to bed. Review of Incident report, provided by the facility and dated 03/14/24 at 6:45 PM, revealed called to residents room, resident lying flat on back under the bedside table, states they were trying to transfer from wheelchair to bed. No additional interventions were added to the care plan. c. Review of a Nurse's Note, located in the EMR under the "Notes" tab, written by LPN2 on 03/17/24 at 6:54 AM, revealed, Approximately 2:15 AM while during rounds resident was noted sitting in an upright position on his/her bedside mat wrapped up in her blankets. When asked, the resident what happened they stated, I rolled to get up to go cook breakfast and this is where I landed. Full head to toe assessment with ROM complete. No injuries noted. Resident is Alert and pleasantly confused. Neuro assessment sheet started. The physician assistant and daughter made aware. Review of Incident report, provided by the facility and dated 03/17/24 at 2:15 AM, revealed, resident found lying on bedside mat during hourly rounds. Resident stated they was getting up to cook. No injury noted, range of motion completed. The physician assistant and daughter made aware. No additional interventions were added to the care plan. d. Review of a Nurse's Note located in the EMR under the "Notes" tab, written by RN2 on 03/27/24 at 9:41 PM, revealed Resident found sitting on floor mat at the bedside with back against the bed. Resident was assessed no injuries or open areas noted. Resident assisted in the bed with two assists. Resident was turned on their left side with pillow placed behind back to offload his/her bottom. Residents' daughter called and made aware. The physician has been notified. Review of Incident report, provided by the facility and dated 03/27/24 at 9:30 PM, revealed, resident found sitting on bottom on floor mat by staff, no injuries noted. Resident was assisted back into bed by staff. No additional interventions were added to the care plan. e. Review of a Nurse's Note, located in the EMR under the "Notes" tab, written by LPN1 on 06/08/24 at 10:21 PM, revealed 6:30 PM called to resident's room, resident noted to be lying on left side between wheelchair and cooling unit, small amount of blood noted at forehead, initially resident denied pain and was independently moving all extremities, resident was lifted from lying position to bed and then began complaining of pain at both hip and my groin, daughter notified and requested that resident be sent to emergency room , physician notified. Review of Incident report, provided by the facility and dated 06/08/24 at 6:30 PM, revealed, see progress note. No additional interventions were added to the care plan. Review of a Nurse's Note located in the EMR under the "Notes" tab, written by LPN1 on 06/08/24 at 10:28 PM revealed, called received from hospice nurse who was notified of emergency room visit. Resident does have pubic fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/28/24 at 12:04 PM, GNA3 stated staff had access to the Kardex and could see interventions there. She said if there was an intervention on the care plan that was not on the Kardex they may be informed by staff. She said R51 was a high fall risk, and that staff tried to keep her up at the nurse's station. She also said there was a mirror in the room that helped staff to see if he/she was trying to get up when they were walking in the room. She said R51 did not like her brief wet and the resident would get up and try to go to the bathroom. She said the mirror was recently put in the resident's room but there was no additional supervision or toileting for R51 by staff. She said she was unable to remember the fall R51 had on 03/09/24 but knew R51 had a few falls. She said there were no huddles or discussion with GNA staff about falls, or patterns or identifying new interventions, but stated the staff that find the resident after they have fallen must write a statement. During an interview on 08/28/24 at 12:29 PM, GNA2 said interventions were posted up in the resident's room and when there were changes that would be verbally communicated during shift-to-shift report. R51 had a weighted blanket on resident's lap when she was in the wheelchair, and she had a low bed and floor mats. She said she would lay the weighted blanket on him/her at times when he/and would get up the minute he/she wanted to. R51 would not know what to do with the call light due to her impaired cognition. She said she had not experienced staff including GNA's about falls discussion/interventions or fall investigation. During an interview on 08/28/24 at 1:21 PM, RN1 said R51 had floor mats and a low bed in place for fall preventions and when the resident was in their wheelchair staff kept an eye on them. He/She said staff would peek in on them every couple of hours due to he/she being a high fall risk. She did not remember the fall that occurred on 03/27/24 but she said there was no discussion after the fall about new interventions. But she said R52 had poor safety awareness and would call out for various people or things, frequently took their legs out of the bed, moved a lot in the bed, and would slide out of the bed onto the mat. But she was unaware of any new interventions implemented after the fall on 03/27/24. During an interview on 08/28/24 at 3:16 PM, LPN1 said staff tried to keep R51 in line of vision when they was out of the room, and there was a mirror (placed after the fall on 06/08/24) and there was a sitter provided by the family. Staff would check on them every two hours. She said R51 would not know how to use the call light, and he/she would get up when he/she wanted to get up. On 06/08/24 she was called to R51 room by a GNA (unsure who) and she found R51 on the floor on their side and there was blood, and it appeared R51 had hit her head on the ac [air conditioning] unit. She said at that time R51 denied pian, and their range of motion was fine, and there were no visual signs of pain. Staff lifted him/her from her lying position, and at that time R51 started complaining of pain in their groin. She stated R51 did not have a low bed at the time and that they had a regular hospital bed. She said she would have documented if there was a mat was on the floor at the time of the fall and she did not. Unsure about new fall interventions. During an interview on 08/28/24 at 3:39 PM, RN5 stated she was also the 3:00 PM-11:00 PM supervisor. She said R51's family provided a sitter that came in between 4:00 PM-5:00 PM and stayed until after dinner or until bedtime sometimes. She stated staff also checked on her frequently and would peek into the room when they passed by. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/29/24 at 11:01 AM the MDS Coordinator (MDS) said they have identified an issue that identified interventions were not making it onto the care plan, but they were unsure why. She said that after a new intervention was identified that was communicated to staff during shift to shift, but she said it would be a problem for any new staff or staff not working that day because they would have no idea about the new intervention in place if it was not actually listed on the care plan. She said staff were trying to keep R51 out of their room in the wheelchair and involved with activities. She said there should have been new interventions identified after each fall. She was unsure why she never caught that there have not been any new fall interventions implemented since 2023 when she reviewed the care plans quarterly. She reviewed all the falls Incident reports and stated she was not aware of any new interventions that were implemented after each fall. She said was aware R51 was a fall risk and had falls with injuries. During an interview on 08/29/24 at 12:05 PM, the attending physician stated he was aware that R51 has had falls, but he couldn't remember the falls specifically. He said he was sure there was some discussion about the falls, and he would have expected the facility to have identified new interventions after the falls occurred to try and prevent the injuries that occurred. During an interview on 08/29/24 at 12:37 PM, the Director of Nursing (DON) stated there was lot of discussion about new fall interventions for R51 after their falls, but she said there was no documentation about those discussions. She said staff were supposed to check in on the R51 frequently but that was only verbally communicated to staff and there was no documentation of that. And she was unable to say for sure that all staff were made aware of this. But she agreed that if it was put on the care plan all staff would be aware and that would be best practice. She said the facility did need to do better with their documentation and she admitted that when she looked at the care plan after a fall, she was just looking that the date of the fall was listed on it. She said even though she reviewed the care plan after each fall she never realized that there had not been an update since February 2023. 26446 3. Review of the EMR admission MDS with an ARD of 07/11/24 revealed R57 was admitted to the facility on [DATE] with multiple diagnoses which included dementia and a cervical (neck) fracture. Further review of this MDS revealed R57 was totally dependent on staff for all Activities of Daily Living (ADLs) except for eating and scored three out of 15 on the BIMS indicating R57 was severely impaired cognitively. Observation on 08/27/24 at 10:10 AM revealed Activity Aide (AA) 1 wheeling R57 in his/her wheelchair down the hall and out the front door of the facility. There were no leg rests on the wheelchair and R57 was holding his/her legs up off the floor. Review of the facility floor plan and the lengths of the hallways, provided by the Maintenance Director (MD), revealed AA1 wheeled R57 down the 400 hall into and through the 300 hall and through the main lobby and out the front door for more than 200 feet. During an interview on 08/27/24 at 10:15 AM, AA1 verified that she had received training to use leg rests when wheeling residents regardless if the resident was able to self-propel with their feet. AA1 verified that she had wheeled R57 without using leg rests requiring R57 to keep her legs elevated during transport. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/27/24 at 10:15 AM, the Infection Control Nurse/Staff Development (ICN/SD) verified the observation and that the staff had been trained to use leg rests for all residents during transport in a wheelchair. During an interview on 08/28/24 10:07 AM, the Director of Rehabilitation (DOR) stated that all residents were provided leg rests, and all residents should have leg rests on their wheelchairs unless the resident was self-propelling the wheelchair. The DOR stated that the rehabilitation staff evaluated the residents for their ability to self-propel the wheelchair with their feet. The DOR stated R57 had been evaluated and was appropriate to self-propel their wheelchair with her feet. The DOR stated that the facility policy was that anytime a staff member was pushing a resident in a wheelchair there were to be leg rests for the resident to rest their feet instead of having to keep them elevated off the floor. The DOR stated that sometimes residents would ask staff to push them once the resident was self-propelling. The DOR stated that staff should return to the resident's room and retrieve the leg rests before pushing the resident. The DOR stated that the leg rests were stored in the resident's room usually in the closet or a drawer. During an observation on 08/28/24 at 11:00 AM, RN1 verified there were no leg rests in R57's room. During an interview on 08/28/24 at 11:38 AM, the Medical Director verified that the facility's policy was for leg rests to be used when pushing a resident in a wheelchair. During an interview on 08/29/24 at 11:59 AM, the Attending Physician for all the residents in the facility verified that leg rests were to be used when wheeling a resident in the event the resident lowers their legs and [the leg] would get caught and injured. Surveyor: [NAME], [NAME] 16177

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wicomico Nursing Home	900 Booth Street Salisbury, MD 21801

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, resident and staff interviews, and record review, the facility failed to ensure routine and 24-hour emergency dental care was provided or obtained from an outside resource to meet the needs for one of one resident (Resident (R) 55) reviewed for dental care out of 30 sampled residents resulting in significant weight loss. The facility failed to provide prompt dental services to a resident with identified dental pain by ensuring dental services were properly and timely arranged and completed to ensure continuity of care was provided to the resident. Findings include: Review of R55's Face Sheet located in the resident's electronic medical record (EMR) Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included left and right hip contracture, right knee contracture, congestive heart failure, and adjustment disorder with anxiety. Review of R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/24/24 located in the resident's EMR under the MDS tab indicated the facility assessed R4 to have a Brief Interview for Mental Status (BIMS) score was eight out of 15, indicating R55 was moderately cognitively impaired. The MDS also indicated R55 was on a regular textured diet and had no dental concerns. Review of R55's Care Plan, last revised 12/05/23, indicated the resident had the potential for acute pain related to a history of fractures. The interventions included to administer analgesia .as ordered, to monitor and document for probable cause of each pain episode, to monitor/record/report to nurse any signs or symptoms of non-verbal pain, loss of appetite, refusal to eat and weight loss, and to notify the physician if interventions were unsuccessful or if current complaint was a significant change from the resident's past experience of pain. The care plan failed to identify changes in dental pain. Review of R55's Care Plan, dated 02/22/24, without revision in the EMR under the Care Plan tab, indicated the resident had an unplanned/unexpected weight loss related to poor food intake. The interventions included alerting the dietitian if consumption was between 0-25% for more than 48 hours, monitoring and evaluating any weight loss. The care plan failed to identify a decline due to dental concerns. Review of R55's Nursing Progress Notes, dated 07/24/24, revealed the resident complained of tooth pain, upon assessment the resident was noted with decay at left molar/tooth chipped. The Nurse Practitioner was made aware, and a new order was made for Anbesol as needed and 360 dental consult. The family was notified. Review of R55's Physician's Order and Signature Sheet, dated 07/29/24, documented a dental consult-left lower tooth pain/decayed tooth. Anbesol every 2 hours as needed for tooth pain. Review of R55's Nursing Progress Notes, dated 07/30/24, [He/She] was medicated this afternoon for complaint of dental and LE [lower extremity] pain with prn [as needed] Norco with good effect. An additional note stated Anbesol was applied for tooth pain. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Review of R55's Nursing Progress Notes, dated 07/30/24, revealed to follow-up with 360 dental related to dental pain and decay one time only on 07/31/24 .360 not here today. Review of R55's Physician Progress Note, dated 08/01/24, revealed Patient seen for follow-up today. Patient complaining of toothache. Has not been eating very well because of dental pain. Dental pain likely secondary to tooth infection. Will treat with a course of Augmentin. Review of R55's Nursing Progress Notes, dated 08/01/24, revealed the resident complained of left lower gum pain related to left lower molar and that resident was scheduled to see 360 dental group on 08/14/24. The resident was medicated with as needed Norco for pain and also topical analgesic for left molar gum pain. The resident stated he/she could not eat her lunch related to dental pain. He/She was given a soft sandwich and ordered a mechanical soft diet. Review of R55's Nursing Progress Notes, dated 08/02/24, revealed the resident had complained of .lower molar pain, to see a new order for Augmentin (antibiotic) and resident had a pending dental consult. Review of R55's Nursing Progress Notes, dated 08/03/24, revealed .left lower dental pain. He/She declined her lunch. He/She is due to see the 360 dental on August 14th. Review of R55's Dietitian Progress Notes, dated 08/07/24, revealed Resident has mouth pain due to dental issues. Her meal intake is 0-50% currently. He/She has not wanted to eat since the pain started. He/She is on an antibiotic for the tooth. HIs/Her diet was also downgraded to Soft with Ground Meat due to the dental pain. Will upgrade diet as soon as dental issue has been resolved. Review of R55's Nursing Progress Notes, dated 08/11/24, revealed the resident completed prescribed antibiotics on 08/10/24. Review of R55's Summary Report, dated 08/14/24, also documented that the 360 dental group had Not Seen Resident was not seen due to time constraint. Review of R55's Nursing Progress Notes, dated 08/20/24, revealed the resident was scheduled to be seen by 360 dental group on 08/14/24 but was not seen due to time constraints. Review of R55's Dietitian Progress Notes, dated 08/22/24, revealed [His/Her] diet is Soft with Ground Meat due to dental pain currently. Resident wants to continue with this diet. HE/She had also taken Augmentin for the dental discomfort . Annual Dietary Evaluation: Height 62 inches. Weight 138.2 # (pounds). July weight was 145 # (pounds). Resident has had a 5% weight loss in one month. Review of R55's Plan of Care Note, completed by the MDS Coordinator (MDS) on 08/23/24, revealed Then when this nurse performed an oral assessment she pointed to her bottom left tooth in the back and stated it hurts. He/She rated her worst pain as a 10 and stated it rarely affects her sleep or activities. Review of R55's Nursing Progress Notes, dated 08/27/24, revealed, pain to bilateral knees and tooth . medicated for c/o [complaint of] tooth pain .tooth pain to lower gumline. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Review of R55's Nursing Progress Notes, dated 08/28/24, revealed .lower tooth pain .c/o pain and discomfort to left lower tooth. Review of R55's medical record failed to identify any ongoing communication or attempt by the facility to resolve the resident's dental concern after antibiotic medication was completed on 08/10/24, the resident was not seen by the 360 dental group on 08/14/24 and continued to be in documented pain without resolution. Review of R55's medical record failed to identify any follow-up or communication with the family or outside resources to provide dental care in the community to address the acute change in condition in a timely manner. During an observation and interview on 08/27/24 at 11:04 AM, R55 stated he/she had dental pain and was supposed to see the dentist at the facility on 08/30/24. He/She said they were receiving pain medication and gel for the dental pain. He/She was observed touching and rubbing the left side of her lower jaw, grimacing, during the interview. During an observation and interview on 08/28/24 at 12:40 PM, R55 was observed in his/her room with their lunch tray placed in front of them on their bedside table, untouched. His/Her meal ticket revealed they was on a Soft diet. He/She said that they were uncomfortable and did not want to eat because he/she had tooth pain. He/She stated that they did not understand why they had not seen the dentist yet. He/She was again observed holding and rubbing the lower left side of his/her jaw while they grimaced in pain. During an observation and interview on 08/29/24 at 11:25 AM, R55 stated they had pain in her tooth, especially when their tongue touched it. R55 said that they needed to be seen by a dentist, because they had enough wrong already without the tooth pain. He/She was again observed rubbing and holding their lower left jaw while grimacing. During an interview on 08/28/24 at 12:44 PM, the Admissions Coordinator (ADM) stated that the facility nursing staff would go to the Medical Records/Scheduling (MR) if a resident needed an appointment with dental. During an interview on 08/28/24 at 12:50 PM, the Medical Records/Social Services (MR/SS) said that the facility had been trying to get R55 seen by a dentist. She stated that the facility used a dental group called 360 that had been in to see residents recently, and that the dental group would have a list of residents they intended to see when they arrived. The MR/SS confirmed that R55 was not seen by the dental group on the most recent visit in August. She stated that if the dental group documented that they could not see a resident due to a time constraint it was because the dental group had other facilities to go to. She said that she had contacted the resident's family member during this current week to determine who R55 had seen for dental care in the community prior to admission, but still needed to contact that dental provider to see if they could see the resident. During a subsequent interview on 08/28/24 at 1:27 PM, the MR/SS stated that she had just spoken to Accounting (AC) and R55 would not qualify for dental services by the 360 dental group until September 2024, so there should not have been any documentation of 360 dental group coming in to see the resident. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/28/24 at 2:00 PM, Geriatric Medication Assistant (GMA) said that she was familiar with R55. She confirmed that the resident had been complaining of lower left tooth pain for a few weeks. She stated that the resident had a darkened tooth that appeared to be broken and decayed. The GMA said that the resident had been prescribed antibiotics for the tooth because they thought it might be an infection. He/She stated that the resident had finished their antibiotics a while ago and still had the pain. He/She said that the resident still had a problem, and not just an infection. He/She stated the resident had a tough time eating because of it, and that nurses often had to provide the resident pain medication for the problem. The GMA was not aware if the resident had been seen by a dentist yet or not. During an interview on 08/28/24 at 2:40 PM, the AC said that R55 did not have coverage with the 360 dental group, and that the resident's representative had come into the facility on [DATE] to sign the application so that they could be seen with the dental group. She said the resident would not be covered until the following month and would not have been qualified to be scheduled to be seen by 360 dental group in August 2024. The AC said that the Medical Records/Scheduling (MR) should have known that R55 could not been seen by the 360 dental group by the middle of August 2024. She was not aware of why documentation continued to show the R55 was going to be seen by this dental group. During an interview on 08/28/24 at 3:22 PM, the MR said that she handled scheduling and transportation for residents. She said that nurses let her know who needs an appointment. She stated that for dental needs, she would look on her list to see if the resident was on the 360 dental group list and if they were not, she would try to find out who the resident used to see in the community and try to connect them back to that old dentist. The MR stated that the 360 dental group usually contacted her with a list of residents they would be seeing on their next visit, which she would then place at the nurse stations to let staff know who is going to be seen. She said that the facility also had a wheelchair van and Medicare transportation that they could use to send residents out for dental appointments. She stated that if a resident had an acute dental need, she would let a dentist know as soon as possible so they can be seen but could not recall any residents recently having an acute situation. The MR said that she had not been working when R55's tooth became a problem, but when she returned on 08/12/24 she found out the resident had not qualified to be seen by the 360 dental group until 09/01/24. She stated that she had been told that sometimes the resident had pain and sometimes she did not, so she did not feel it was urgent to get her seen acutely. She said that in morning meetings she was told that the resident was not being seen by the dentist. The MR said that on 08/27/24 she found out that the delay in dental care needed to be pursued by communicating with the family. She confirmed that she was not aware that the resident was in that much pain. During an interview on 08/28/24 at 3:45 PM, the Director of Nursing (DON) said that the facility had 360 dental group come to the facility to see the Medicaid and private pay residents that wanted to be seen. She said they generated a list, and if a resident had complaints, they put them on the list, too. The Director of Nursing said that the Attending Physician was made aware of anything unusual. She said that if the resident was not on the 360 dental group list they would send the resident to the community for dental services. She said that R55's dental concern was a new problem and that she had been complaining about her pain. She confirmed that the resident had been on antibiotics and that they thought she was supposed to be seen by the 360 dental group when they came in recently, but they left the facility without seeing her. She stated that the resident had a cavity and needed to be seen. She said that the family was involved, and that the facility was giving the resident medication for tooth pain. The Director of Nursing confirmed that if a resident had dental pain the facility would try to get them in right away, and not hold off on treatment. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/28/24 at 4:05 PM, Licensed Practical Nurse (LPN) 1 said that R55 had told her that part of the resident's tooth had broken off a while ago, and that she had dental pain. LPN1 said that she had been under the impression that R55 was being seen by a dentist, and did not realize the resident still had not been seen. She said that R55 received Tylenol, Norco, and Tramadol as needed for the dental pain, including in the last few days. The LPN1 said that the resident had been prescribed antibiotics, which she assumed was to be administered so that he/she could be seen afterwards for a dental procedure. During an interview on 08/29/24 at 10:22 AM, the DON confirmed that the facility did not have a policy that addressed dental concerns. During an interview on 08/29/24 at 10:31 AM, the Registered Dietitian (RD) stated that R55 had a problem with their tooth. She said it was giving the resident pain. The RD said that she believed that the facility was trying to get the resident a dental appointment since they had not been qualified to see the 360 dental group. She said that the resident's diet had been downgraded because of the dental pain, and that the resident needed to be seen to address the tooth pain. The RD said R55 had regular pain concerns, but the tooth pain was a new concern. She said that she hoped that after the resident was seen by a dentist, she could get her back onto a regular diet so she could continue to eat. The RD confirmed that the resident had lost weight during this time. She confirmed that the confusion in getting the resident seen by a dentist for dental pain had delayed in R55 getting seen promptly. During an interview on 08/29/24 at 11:10 AM, the Minimum Data Set Coordinator (MDS) said that R55's bottom tooth was bothering them, and he/she was supposed to see the 360 dental group when they came in, but they did not get to see them. She stated that she had observed the tooth to be discolored, and that the resident had complained of tooth pain after she had looked in R55's mouth. During an interview on 08/29/24 at 11:56 AM, the Attending Physician stated that the facility had 360 dental group come into the facility to see residents, but that the dental group had not seen the resident in August 2024 due to an insurance or something. He stated that he had prescribed R55 antibiotics early on with the plan of then seeing the dentist. The Attending Physician confirmed that he would have expected the resident to have been seen by a dentist by now. During a phone interview on 08/29/24 at 12:17 PM, a resident representative for R55 said that the facility had contacted her this current week to see who the resident had seen for dental care in the past. She said that the resident had broken her tooth, and that it had been going on for over a month. She stated that she thought R55 was going to be seen by the '360 dental group approximately August 14. The resident representative stated that the dental concern should be addressed sooner rather than later. During an interview on 08/29/24 at 3:52 PM, the Administrator said that the facility used 360 dental group for residents. She said that if a resident needed to be seen by a dentist, MR and/or MR/SS did the paperwork. The Administrator stated that if a resident needed dental emergency services, they could get it done because they did not let anyone stay in pain.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on observation, interview, and policy review, CPAP (continues positive airway pressure)/ nebulizer masks were not properly stored for two of two residents (R5 and R26) reviewed for respiratory care out of 30 sample residents. The failure to properly store CPAP and nebulizer masks increased the potential for respiratory infections. Findings include: Review of R5's undated Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE]. Diagnoses included asthma. Review of R5's annual MDS with an ARD of 05/10/24 revealed the facility assessed the resident to have a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. During observations on 08/26/24 at 10:36 AM, 08/27/24 at 9:42 AM and 08/28/24 at 2:33 PM, R5's CPAP-mask was lying on top of the dresser at the right side of the bed uncovered. Review of R26's undated Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE]. Diagnoses included unspecified dementia, muscle weakness, and morbid obesity. Review of R26's annual MDS with an ARD of 07/05/24 revealed the facility assessed the resident to have a BIMS score of eight out of 15 which indicated the resident was moderately cognitively impaired. During observations on 08/26/24 at 10:31 AM, 08/27/24 at 9:42 AM, and 08/28/24 at 2:33 PM R26's nebulizer mask was in the same place on top of dresser at left side of the bed uncovered. During an observation and interview on 08/28/24 at 2:22 PM, Registered Nurse (RN) 4 verified the nebulizer mask was left uncovered on the R26's dresser and stated that it should have been placed inside a bag for infection control. She stated that she had been in the room during the day and looked at the top of the dresser right behind the nebulizer mask, but she never observed the mask had been left out uncovered. She also walked to R5's room and verified R5's CPAP mask was left uncovered on the resident's dresser and stated that it should have been placed inside a bag for infection control. She stated that she had been in the room during the day, but she never observed the mask had been left out uncovered. She stated it was her responsibility as the morning nurse to ensure they are cleaned and covered properly when not in use. During an interview on 08/29/24 at 1:00 PM, the DON stated they just updated the facility policy for the CPAP masks because they discovered they were not being cleaned during the 3-11 (3:00 PM- 11:00 PM) shift. She stated they should have been stored in a plastic bag and changed weekly for infection control. She stated she did not have a policy about how they should be stored.