STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review and interview, it was determined the facility staff failed to treat a resident with dignity (Resident #1). This was evident for 1 of 44 residents reviewed during a complaint survey. The findings include: Review of Resident #1's medical record on 3/10/25 revealed the Resident was admitted to the facility in October 2024 with a diagnosis to include disease of the spinal cord. Further review of Resident #1's medical record revealed the facility staff assessed the Resident on 12/17/24 to be dependent on care for showering/bathing. During interview with Resident #1 on 3/11/25 at 2:00 PM, Resident #1 stated recently he/she was left in the shower room naked and uncovered facing the door. Resident #1 went on to say he/she remembered 2 nursing assistants had placed him/her naked in a shower chair, turned on the water and left him/her uncovered when Nurse #22 needed them to help with a new admission. Resident #1 was not positive the names of the 2 nursing assistants but did remember GNA #71 is the staff member who discovered him/her. Resident #1 stated he/she did not like the way he/she was treated. During interview with GNA #71 on 3/12/25 at 3:04 PM, GNA #71 stated remembered Nurse #22 asking for her to help give Resident #1 a shower. GNA #71 stated when she went into the shower room the Resident was facing the door naked and uncovered. GNA #71 stated Resident #1 stated I don't know what happened but they left me like this but I am glad it was you that walked in. GNA #71 stated she proceeded to give the Resident a shower and afterwards told Nurse #22 they should have at least covered him/her up. GNA #71 then took the Surveyor to the shower room and showed how the shower chair and the placement of the shower chair were facing the door. During interview with Nurse #22 on 3/12/25 at 4:57 PM, he stated he remembered asking GNA #71 to assist Resident #1 in getting a shower due to getting a new admission. Nurse #22 also stated GNA #71 did tell him that the Resident was left in the shower uncovered. The findings were reviewed with the Administrator on 3/17/25 at 2:00 PM.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on medical record review and staff interview It was determined the facility staff 1) failed to inform the resident and/or resident representative when there was a change in the resident's treatment plan related to medication, and 2) failed to inform the resident/representative of the risks and benefits of the medication and obtain consent prior to initiating psychotropic medication. This was evident for 2 (#12, #3) of 44 residents reviewed for complaints. The findings include: A psychotropic describes any drug that affects behavior, mood, thoughts, or perception Schedule II (C2) controlled drugs refer to drugs with a high potential for abuse and addiction that are regulated by the government and include anxiolytic (anti-anxiety) benzodiazepine medication and opioid (analgesic) (narcotic) medication. 1) On 3/11/25 at 9:00 AM, a review of complaint #MD00209003 alleged Resident #12, who was terminally ill, but not on hospice or receiving palliative care, was prescribed and administered Ativan (anxiolytic) and Morphine (Opioid) for end of life, without notifying the resident's representative, and obtaining consent. The complaint alleged that giving the medications together contributed to Resident #12's respiratory failure, and lead to the death of the resident. The complaint also alleged the facility staff failed to notify Resident #12's representative timely when the resident was transferred to the hospital. A review of Resident #12's electronic medical record (EMR) revealed Resident #12 was admitted to the facility in mid-August 2024 following a transfer from a sister facility and had multiple diagnoses, including hepatocellular carcinoma (liver cancer) and hepatic encephalopathy (brain disorder caused by liver dysfunction). The resident was discharged from the facility following his/her transfer to the hospital 3 days after admission. In a Nurse Practitioner (NP) Progress Note on 8/15/24 at 12:30 PM, Staff #64 NP documented Resident #12 was being transferred from another facility to the current facility on that day, and the NP was very familiar with Resident #12 because the NP provided care to him/her at the other facility. The NP wrote that Resident #12 was currently a full code, that resident's declining condition was discussed with the Director of Nurses (DON), and the DON would discuss end-of-life (EOL) care, which they believed was appropriate, with the resident's representative. The NP further wrote that s/he left C2 (controlled drugs) prescriptions for EOL medications with the DON because an NP on site [in the facility] tomorrow, with the stipulation that Resident #12's code status was changed to reflect this. A review of Resident #12's physician orders in the EMR revealed an 8/15/24 order for Lorazepam (Ativan) (anxiolytic) Oral Concentrate 2 MG (milligrams) /ML (milliliters) Give 0.5 ml orally every 2 hours as needed for restlessness; agitation for 14 Days related to end of life and an 8/15/24 order for Morphine Sulfate oral solution 100 MG/5ML, give 0.25 ml orally every 2 hours as needed for dyspnea (shortness of breath), end of life care. The EMR documented the orders for Lorazepam and Morphine were entered in the electronic record as active orders by the NP, Staff #64 on 8/15/24 at 12:15 pm. A review of Resident #12's August 2024 Medication Administration Record (MAR) revealed: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An 8/15/24 order for Lorazepam by mouth every 2 hours as needed for restlessness; agitation related to end of life for 14 days that was documented as given on 8/16/24 at 11:41 PM, and 8/18/24 at 1:00 AM - An 8/15/24 order for Morphine Sulfate oral solution by mouth every 2 hours as needed for dyspnea (shortness of breath) and end of life care with a start date of 8/15/24 at 12:15 PM was documented as given on 8/18/24 at 1:00 AM. Continued review of Resident #12's medical record failed to reveal documentation to that prior to initiating psychotropic medication for end-of-life care, the resident and/or resident representative was informed of the risks and benefits of the medication and consent was obtained On 3/18/25 at approximately 4:50 PM, the attending physician, Staff #66, was made aware of the above findings. At that time, Staff #66 reported s/he knew Resident #12 from the previous facility, that the resident had been diagnosed with liver cancer, and the physician felt for the family. Staff #66 stated that s/he became aware Resident #12 had been put on Ativan and Morphine when he saw the resident following his/her transfer to the facility, The physician stated s/he thought the NP wanted something more for the resident's pain and it never entered his/her head that the medications were for end-of-life, and Resident #12's family didn't want that. The physician stated that it was the providers job to talk to the families and s/he would never have left signed prescription for end-of-life care without first talking to the family. The above concerns were were discussed with the DON and Nursing Home Administrator (NHA) on 3/18/25 at 6:00 PM. The DON acknowledged the concerns at that time and offered no further comments. 2) On 3/14/25, at 9:00 AM, a review of complaint # MD00214414 alleged that Resident #3 and/or his/her representative were not notified when a new medication, Duloxetine (Cymbalta) (antidepressant), (treats neuropathic pain) was prescribed or consent obtained prior to the resident receiving the new medication. On 3/14/25 at 10:00 AM, a review of Resident #3's EMR revealed Resident #3 was admitted to the facility in late December 2024 following an acute hospitalization and discharged from the facility in late February 2025. The medical record documented that Resident #3 had multiple diagnoses including hypertension (high blood pressure (BP), cirrhosis of liver (scarring of liver), hepatic encephalopathy (brain disorder caused by liver dysfunction), kidney failure, and received hemodialysis (procedure to remove waste products and excess fluid from the body). Review of Resident #3's January 2025 MAR revealed a 1/23/25 order for Duloxetine by mouth one time a day for neuropathy that was documented as given in the AM on 6 (1/23, 1/24, 1/25, 1/26, 1/27, 1/28) occasions in January. The order was on hold from 1/29/25 to 1/31/25 then discontinued. In a NP Progress Note, on 1/22/25 at 10:05 PM, Staff #64, NP wrote that Resident #3 reported increased pain due to neuropathy and wrote that the resident was to start taking Duloxetine every day. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a physician visit progress note, on 1/29/25 at 2:55 AM, Staff #6, Physician, indicated Resident #3 requested to see the physician about his/her left shoulder pain, and the resident's spouse was concerned about the resident's mental status, The physician wrote the resident was on Oxycodone for pain and recently started on Cymbalta. The physician's assessment and plan indicated there were many factors with Resident #3's change in mental status from hepatic encephalopathy and medication and wrote that the Cymbalta would be held for now. Continued review of the medical record failed to reveal documentation that the resident and/or his/her representative had been informed when there was a change in the treatment plan, and new medication was prescribed. Continued review of Resident #3's medical record failed to reveal documentation to indicate the resident and/or the resident's representative had been informed that psychotropic medications had been ordered or the risks and benefits of psychotropic medication and failed to obtain consent prior to initiating the medication. On 3/18/25 at 4:44 PM, during an interview, Staff #66, Attending Physician, stated s/he spoken with Resident #3's spouse several times, and when the spouse was concerned with Resident #3 receiving the Cymbalta, the physician agreed with the spouse and put the Cymbalta on hold. Staff #66 also stated the Cymbalta was ordered by a different practitioner, and if the physician had ordered the medication, s/he would have notified the resident's representative right away. The DON and NHA were made aware of the above concerns on 3/18/25 at 6:35 PM. The DON and NHA acknowledged the concerns and offered no further comments at that time.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review and interview, the facility staff failed to notify a resident's physician of a change in status and failed to notify the physician when a medication was not available. This was evident for 2 (#30, #3) of 44 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #30's medical record on 3/12/25 revealed the Resident was admitted to the facility in May 2023 for rehabilitation. Further review of the Resident's record revealed a nurse's note on 5/27/23 at 2:49 PM stated, Resident reported during transfer back to bed from chair staff member accidentally stepped on his/her foot. Resident currently denying any pain on left foot. The existing bruise on right foot, xray done previously. Further review of Resident #30's medical record revealed no notification to the Resident's physician to determine if any further treatment should be ordered for the Resident's left foot. Interview with the Director of Nursing on 3/13/25 at 5:28 PM confirmed the facility staff failed to notify Resident #30's physician on 5/27/23 when the Resident had a change in condition.2) On 3/14/25, at 9:00 AM, a review of complaint # MD00214414 alleged the facility failed to inform and acquire consent from Resident #3 and his/her responsible party, when a medication was ordered for the resident, and prior to Resident #3 being given the medication. At 3/14/25 at 10:00 AM, a review Resident #3's electronic medical record) (EMR) revealed Resident #3 was admitted to the facility in late December 2024 following an acute hospitalization and discharged from the facility in late February 2025. The medical record documented that Resident #3 had multiple diagnoses including hypertension (high blood pressure (BP), cirrhosis of liver (scarring of liver), hepatic encephalopathy (brain disorder caused by liver dysfunction), kidney failure, and received hemodialysis (procedure to remove waste products and excess fluid from the body). Review of Resident #3's January 205 electronic Medication Administration Record (eMAR) revealed a 12/27/24 order for Rifaximin 500 MG tablet by mouth two times a day, at 8:00 AM and 8:00 PM for encephalopathy. The MAR was signed off with the code 9 (other/see nurses notes) 12 (1/3, 1/12, 1/13, 1/19, 1/21, 1/22, 1/23, 1/25, 1/28, 1/29, 1/20 1/31/25) of 31 administrations scheduled at 8:00 AM, and 7 (1/12, 1/23, 1/24, 1/27, 1/28, 1/20, 1/31/25) of 31 administration times scheduled at 8:00 PM in January, indicating 19 of 62 scheduled administration times in January, Resident #3 was not given Rifaximin as ordered. Review of Resident 3's order administration notes populated when the Rifaximin order was signed 9, revealed documentation indicating that Rifaximin was not available in the facility for the staff to administer to the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident #3's EMR revealed, on 1/31/25 at 8:03 PM, in a Nurse Practitioner (NP) follow-up note, Staff #77, NP, wrote that Resident #3 continued with lethargy and low blood pressure, and the resident should be taking Rifaximin every day for hepatic encephalopathy. The NP wrote that, per the staff, the resident had not received Rifaximin because of expense and authorization was needed. The NP wrote s/he was told by with management that the medication was approved, and the resident would receive it, and that Resident #3's lethargy could be from not getting his/her prescribed Rifaximin. In an NP follow-up note on 2/3/25 at 11:17 PM, Staff #77, NP, wrote that Resident #3 was seen, that the resident appeared lethargic, and his/her lethargy could be hepatic encephalopathy. The NP wrote that s/he spoke with the nurse, and the resident was not getting Rifaximin because the medication was not available, however, staff had signed that Rifaximin had been given to the resident. A continued review of the medical record failed to find documentation to indicate the physician was notified when Resident #3 was not given Rifaximin as prescribed, or when the medication was unavailable. During an interview, on 3/18/25 at 4:44 PM, the above concerns were discussed with Resident #66's attending physician, Staff #66. At that time, Staff #66 stated he/she had not been notified that Resident #3 had not been getting Rifaximin as prescribed, and the physician had assumed the resident had been taking the medication. Staff #66 also stated that the physician should be called any time a resident was out of medication. The concerns with physician notification were discussed with the Director of Nurses (DON) and Nursing Home Administrator (NHA) on 3/18/25 at 6:35 PM. The DON and NHA acknowledged the concerns and offered no other comments at that time. Cross Reference F760

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 2) On 3/18/25 at 7:00 AM a review of complaint MD00208729 alleged that in July and August 2024 there were no washcloths, and the staff were tearing up bed sheets to use as washcloths. Review of complaint MD00204843 alleged there were no linens for bathing or incontinence care in January 2025. A review of the 2/27/25 resident council meeting minutes documented that minutes of previous council meeting were: EVS (environmental services) not bringing residents clothes back to residents after they are washed. New business was, residents do not get wash towels when they ask aides for them. A review of the 11/22/24 resident council meeting minutes documented, clothes not being given back from laundry, clothes not being picked up from laundry. A review of the 9/26/24 resident council meeting minutes documented, Residents complained of not getting their laundry back for extended periods of time. On 3/18/25 at 7:20 AM an interview was conducted with the Environmental Services Manager, Staff #7. Staff #7 was asked if there was a linen shortage and he stated, yes, earlier this year. Being able to order enough linen due to rips and stains. We have a budget. We had enough but didn't have enough to keep up. We have linen based of off census. On 3/18/25 at 7:30 AM an interview with geriatric nursing assistant (GNA) #55 revealed, we are always short linen. On 3/18/25 at 9:12 AM an interview was conducted with GNA #19 and GNA #20 who stated, we have linen issues all the time. We come in and there is no linen until 10:00 AM. At least every other day it happens. We had to cut up towels sometimes to use as washcloths. We have complained to upper management. It has been going on for at least the last 6 months and longer. If a resident has a blowout you have to go to another unit to get linen. There are not enough washcloths. We get two washcloths every day per person. Once a shift is when we get linen, and it runs out quickly. On 3/18/25 at 9:15 AM an interview of GNA #57 revealed, linen is a struggle. In the morning there is none left. They are only working with 1 dryer and 1 washer. We run out a lot. We have to go down to laundry and get the linen. On 3/18/25 at 9:18 AM an interview with GNA #18 and GNA #15 was conducted. They stated, some days are better than others and then some days we barely get any linen. We are short washcloths, towels, and fitted sheets. We barely get 1 washcloth per person. We may get 6 washcloths each and then we have to use a towel, half as a washcloth and the other half to dry. This has been going on for the past 6 months to a year. On 3/18/25 at 9:45 AM an interview was conducted with Staff #58. Staff #58 stated, we only have 1 working washing machine and 1 working dryer. It is off and on. There are 4 washers and 4 dryers. Someone is here today working on them. This has been going on for at least 2 months. There are supposed to be 2 to 3 washcloths per patient. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/18/25 at 9:47 AM an interview was conducted with Staff #59. Staff #59 stated that the issue with linen, has been going on for a while now, greater than 6 months. There currently is 1 working washing machine and 1 working dryer. Someone came last week, when surveyors entered the building, and ordered a part and are back today to fix it. Staff does complain about being short on linen. It is a problem between being short linen and only 1 machine working at a time. The residents complain that their personal clothes are taking longer to get back. The turnover is supposed to be 72 hours, but it may take longer. We have to take turns using the machines. We have to have the linen carts ready by 3 for the next shift. The 11-7 shift is out of luck. Trying to get linen out but there is not enough for the 11-7 shift. On 3/18/25 at 9:48 AM observation was made of the washing machines in the laundry room. There was only 1 machine that was in use. There were repair men in the room working on the other machines. On 3/18/25 at 9:50 AM the surveyor asked Staff #7 and Staff #34 how long the problem with the washing machines and dryer had been going on and they both looked at the surveyor. The surveyor asked, a while and they both shook their heads yes. The Surveyor said, budget issues and both looked and shook their heads, yes, in agreement. On 3/18/25 at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the concern. Based on observation of resident rooms, staff interview, review of a complaint, and review of resident council meeting minutes, it was determined the facility staff failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and provide necessary linens for the residents. This was evident on 4 of 4 nursing units observed during a complaint survey. The findings include: 1) During a tour with Staff #11 on 3/10/25 of the Homestead Unit, the Surveyor noted along with a non-working call bell system, the rooms also were in need of repairs. The Surveyor began a tour with Staff #11 on 3/11/25 at 10:30 AM of the Homestead Unit. The Surveyor with confirmation from Staff #11 noted the following observations: room [ROOM NUMBER]-ripped fall mats, wallpaper coming off the wall room [ROOM NUMBER]-ceiling tile cracked over the toilet room [ROOM NUMBER]-corner of heater vent loose exposing pipes and insulation room [ROOM NUMBER]-air conditioner had peeling electric tape around the system room [ROOM NUMBER]-no mirror above the sink, cracks in wall above heater, rusted ceiling vents room [ROOM NUMBER]-call bell out of the wall with wires exposed, heater vent cover loose room [ROOM NUMBER]-tile missing on floor, hole in drywall, light bulb out above toilet, fan rusted (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER]-hole in dry wall, wall in disrepair around sink leaving exposed wood room [ROOM NUMBER]-corner of heater vent loose, molding coming off wall, hole in ceiling tile room [ROOM NUMBER]-broken tile around bathroom sink, corner of heater vent loose room [ROOM NUMBER]-corner of heater vent loose, stained ceiling tiles room [ROOM NUMBER]-corner of heater vent loose room [ROOM NUMBER]-molding loose room [ROOM NUMBER]-corner of heater vent loose room [ROOM NUMBER]-holes in wall, air conditioner had peeling electric tape around the system, black colored markings noted around air conditioner, wall paper and ceiling/wall room [ROOM NUMBER]-corner of heater vent loose, paint chipping room [ROOM NUMBER]- air conditioner had peeling electric tape around the system, uncovered outlet room [ROOM NUMBER]-corner of heater vent loose, stains on ceilings Activities Room-cover to outlet off, molding in disrepair around sink Common Area in front of nursing station-noted black colored markings on ceiling tiles The findings were reviewed with the Administrator on 3/11/25 at 11:15 AM. At that time the Administrator stated Staff #11 had also confirmed the findings with the Administrator.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 3) On 3/10/25 at 8:16 PM a review of facility reported incident MD00207981 was conducted, and it alleged that verbal abuse towards Resident #18 was overheard from a unit manager and a wound nurse on 7/23/24 at 10:30 AM. Licensed Practical Nurse (LPN) #23 was overheard telling Resident #18 that he/she needed to get up and also told Resident #18 not to dismiss her. A written statement from Nurse Practitioner (NP) #68 documented that LPN #23 stated to the resident, if you don't get out of this bed and move your arms and legs you will never walk again. Resident #18 responded, okay. LPN #23 responded by saying, you don't answer me like that; that's dismissing me, and I won't be dismissed. A written statement from the previous unit manager (UM) #31 documented, this writer observed [name of LPN #23] being verbally aggressive towards a resident. She was telling the resident [he/she] needed to do more for [him/herself]. When the resident said okay, nurse was very rude telling [him/her] that [he/she] does not get to dismiss her, saying okay is being dismissive to the nurse. I feel she was very rude to the resident. A written statement from Resident #18 documented, nurse came in and told me I needed to more for myself. When I said okay, she looked at me weird and told me not to dismiss her. The facility documented that LPN #23 admitted saying the word dismissive to Resident #18. Review of a psychiatric visit dated 7/23/24 documented Resident #18 had a history of insomnia, depression, and anxiety. The note documented that Resident #18 reported being upset due to an incident that happened with his/her nurse. Resident #18 reported feeling sad about how the nurse spoke to the resident, however Resident #18 was unable to remember the nurse's exact words or the name of the nurse. Resident #18 reported to the psychiatrist that the nurse's words affected his/her mood that day. Review of LPN #23's personnel file revealed the LPN was terminated from the facility on 7/23/24 and reported to the Board of Nursing. On 3/11/25 at 1:53 PM an interview was conducted with Staff #31. Staff #31 stated the nurse was telling Resident #18 that the resident needed to get up for their own good and the nurse was nasty about it, and it made the resident feel uncomfortable and really bad. Staff #31 stated the resident was in tears and that is why Staff #31 reported it to the Director of Nursing (DON). Staff #31 stated she did not say anything to LPN #23 because, she was not very people friendly. The Nursing Home Administrator was informed on 3/18/25 at 5:15 PM. Based on review of a facility-reported incident, medical record review, and interviews, it was determined that the facility failed to keep vulnerable residents on the dementia unit free from physical abuse, which resulted in harm to the residents. This was evident for 3 out of 44 residents (#14, #24, and #18) reviewed during a complaint survey. Findings include: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1a) On 3/11/25 at 10:22 AM, a review of the medical record was conducted for Resident #15. Resident #15 had a history of refusing medication except for seizure medications. He/She takes medications when he/she feels like it. Resident #15 resided in the dementia unit. His/her BIMs (Brief Interview for Mental Status) score was 11/15, indicating he/she had some memory loss. Resident #15 was able to communicate with staff. Resident #15 preferred to be by themselves and did not like other residents entering his/her room. Medical record review conducted for Resident #14 on 03/13/25 at 2:52 PM revealed Resident #14 was admitted to the facility with a diagnosis of dementia, restlessness, and agitation. Further review revealed a progress note that documented on 4/3/24 at approximately 2:30 AM the staff heard yelling and screaming down the hall. Staff observed Resident #14 being punched by Resident #15 in the hallway. The aide observed blood coming from Resident #14 ' s mouth. A red mark was on the face of Resident #14 and a scratch was observed behind Resident #14 ' s left ear. Police were called and responded; however, Resident #15 would not speak to the police. A psych evaluation was ordered for Resident #15. A psychiatric evaluation was conducted on 4/18/24. Resident #15 stated, I do not belong here. When the crazies leave me alone I am ok. He/she denied all altercations but refused to take medications. In addition, on 7/28/24, Nurse Staff #70 on the unit heard yelling and screaming and went to see what was going on. Resident #14 was hit by Resident #15 for going into his/her room. Police were called and responded. Resident #14 was taken to the hospital for evaluation, received stitches, and was sent back to the facility. 1b) On 3/14/25 at 10:00 AM, a medical record review was conducted for Resident #24. Resident #24 had a BIMs score of 99, meaning he/she rarely understands. On 4/13/24, staff saw Resident #24 leaving the room of Resident #15. Resident #24 had a red mark on his/her face after leaving the room. Police were contacted and responded. Resident #15 admitted to hitting all the residents, stating, They were in my room, and I don't like that. An interview was held with the Medical Director, Staff #9, and the Nursing Home Administrator on 3/13/25 at 9:27 AM. The Medical Director stated, I know him/her very well. He/she had a fall resulting in a head injury prior to coming to the facility. I am aware of at least three residents that he/she struck and I reviewed the incidents that happened at the facility. He/she didn't take his/her psych medicine, he/she only took his/her seizure medication. After the first incident I would have expected a psych eval, behavior medication. I would talk to him/her about their meds and do a meds evaluation. I would care plan his/her behaviors. After the second or third time, depending on the circumstances, I would look for alternative settings. Is this the right place for him/her? Looking in retrospect, he/she probably should have had interventions put in place and we could have looked at a more appropriate setting. It was discussed in a risk meeting. There should have been interventions put in place. On 3/13/25 at 9:47 AM, the Medical Director stated, On 4/3/24, we spoke to the Nurse Practitioner (NP) about alternative placement. There was another incident on 06/07/24 and the resident remained in the facility. On 7/30/24 another resident was struck and Resident #15 remained in the facility. The Advanced Practice Registered Nurse (APRN) who conducted the psych evaluation on 4/18/24 revealed, Resident is not a danger to self or others but would benefit from continued behavioral health. There was no incident report for this incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2) On 3/10/25 at 8:16 PM, a review of facility-reported incident MD00207981 was conducted, and it alleged that verbal abuse toward Resident #18 was overheard from a Unit Manager and a Wound Nurse on 7/23/24 at 10:30 AM. Licensed Practical Nurse (LPN) #23 was overheard telling Resident #18 that he/she needed to get up and also told Resident #18 not to dismiss her. A written statement from Nurse Practitioner (NP) #68 documented that LPN #23 stated to the resident, If you don't get out of this bed and move your arms and legs you will never walk again. Resident #18 responded, Okay. LPN #23 responded by saying, You don't answer me like that; that's dismissing me, and I won't be dismissed. A written statement from the previous Unit Manager (UM) #31 documented, This writer observed [name of LPN #23] being verbally aggressive towards a resident. She was telling the resident [he/she] needed to do more for [him/herself]. When the resident said okay, the nurse was very rude, telling [him/her] that [he/she] does not get to dismiss her. Saying okay is being dismissive to the nurse. I feel she was very rude to the resident. A written statement from Resident #18 documented, A nurse came in and told me I needed to do more for myself. When I said okay, she looked at me weird and told me not to dismiss her. The facility documented that LPN #23 admitted saying the word dismissive to Resident #18. Review of a psychiatric visit dated 7/23/24 documented Resident #18 had a history of insomnia, depression, and anxiety. The note documented that Resident #18 reported being upset due to an incident that happened with his/her nurse. Resident #18 reported feeling sad about how the nurse spoke to the resident; however, Resident #18 was unable to remember the nurse's exact words or the name of the nurse. Resident #18 reported to the psychiatrist that the nurse's words affected his/her mood that day. Review of LPN #23's personnel file revealed the LPN was terminated from the facility on 7/23/24 and reported to the Board of Nursing. On 3/11/25 at 1:53 PM, an interview was conducted with Staff #31. Staff #31 stated the nurse was telling Resident #18 that the resident needed to get up for their own good and the nurse was nasty about it, and it made the resident feel uncomfortable and really bad. Staff #31 stated the resident was in tears and that is why Staff #31 reported it to the Director of Nursing (DON). Staff #31 stated she did not say anything to LPN #23 because, She was not very people friendly. The Nursing Home Administrator was informed on 3/18/25 at 5:15 PM.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident complaint, and interviews with facility staff, it was determined that the faciity failed to keep residents personal items safe. This was evident for 1 out of 1 resident (#2) with misappropriation of property. Findings include: On 2/4/25 Resident #2 entered the facility. Resident resided on the dementia unit in room [ROOM NUMBER] A. Resident had just been discharged from the hospital with the following diagnosis: Severe Sepsis with shock, Pneumonia, Autoimmune hepatitis, Pericardial effusion, anemia, volume overload, covid positive, hyponatremia, Folate deficiency, Hypomagnesemia, hypokalemia. Resident has a Bims score of 14/15 conductd on 2/13/25. (Bims is a mini mental score, indicating resident is alert and orriented.) On 3/12/25 at 4:31 pm, a review of Resident's #2's medical chart was reviewed. The complaint states resident's wallet was stolen. It had all her/his insurance cards, credit cards and debit card. On 2/12/24 nurses note states purse was locked up at nurses station because they put her/him in a room with a dementia patient and the other resident kept taking Resident #2 her/his things. Her/his purse was stripped bare. So they locked it up but it had mysteriously disappeared. The responsible party stated that the asst. social worker was suppose to contact the family, but that never happened. Resident also had a partial top plate in her/his mouth but when she/he fell out of bed one night. She/he said she/he lost it when the male nurse tossed her/him back in the bed. Resident #2 cannot identify male nurse. Also missing were 2 blankets, a pillow, a battery charger pact, kindle charger, phone charger her /his top partial teeth and some clothing items. 2/12/25 Resident's purse with $63 dollars in it was handed over to oncoming nurse to lock up in the nurse's med cart. On 3/12/25 Unit manager Staff # 28 looked for the purse on her unit and could not find. Purse was found at [NAME] facility with resident. Administrator found a Wallet when she came here to work in July of 2024. There was no name on the wallet and no one reported a missing wallet. The wallet had 36.00 cash inside but nothing else, Administrator sent a picture of the wallet to [NAME] where the resident currently lives to see if she can identy wallet. Other missing item will be looked for. The administrator also stated that this facility has not been filling out inventory sheets when residents are admitted .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on reviews of facility reported incidents, record review and interview it was determined the facility failed to have documentation of when the final report was submitted to the regulatory agency, Office of Health Care Quality (OHCQ) and failed to report allegations of abuse within 2 hours of the allegation to OHCQ. This was evident for 3 (#17, #8, #29) residents reviewed for 5 of 18 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 3/10/25 at 9:52 PM a review of facility reported incident MD00208337 was conducted and revealed Resident #17 was found to have a right hip fracture on 8/2/24. On 3/10/25 at 1:30 PM the NHA was interviewed and stated that she could only find the initial email confirmation of when the incident was sent to OHCQ which was on 8/2/24 at 9:07 AM. The NHA could not provide documentation as to when the final report was submitted to OHCQ. 2) On 3/10/25 at 10:10 AM a review of complaint MD00212393 was conducted and revealed a police officer came to the facility after being called by Resident #8. Resident #8 made an allegation to the police officer that he/she had been abused by staff on 11/1/24 at an unknown time. According to the police officer, the police officer notified RN #48 of the allegations. On 3/17/25 at 11:26 AM an interview was conducted with the NHA inquiring if a self-report had been sent to OHCQ regarding the incident. The NHA stated RN #48 did not notify her about the incident. 3) On 3/14/25 at 9:50 AM a review of facility reported incident MD00211056 was conducted and revealed Resident #8 alleged that he/she was assaulted by a GNA who handled him/her roughly on 10/16/24 at approximately 4:00 PM. Review of the investigative paperwork that was provided to the surveyor from the Nursing Home Administrator (NHA) revealed the NHA became aware of the incident on 10/20/24 at 3:43 PM via email and the former Director of Nursing (DON) became aware via email on 10/20/24 at 4:14 PM. Review of the email confirmation documented the initial report was submitted to OHCQ on 10/21/24 at 2:33 PM which was not within 2 hours of the alleged assault. On 3/14/25 at 10:15 AM an interview was conducted with the NHA. The NHA stated she reviewed the email when she and the former DON became aware of the incident. The NHA was informed that the report was not submitted to OHCQ within 2 hrs. The NHA stated she had been away for a couple of days and opened her email on a Sunday. The NHA was informed that the former DON responded to the email one half hour after being informed and she could have reported it to OHCQ if the NHA was off. 4) On 3/18/25 at 3:33 PM a review of facility reported incident MD00196064 was conducted and revealed Resident #29 was at the hospital for a medical condition and alleged to hospital staff that he/she was assaulted while sleeping on 8/21/23 while residing at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/10/25 at 12:10 PM the NHA stated she could not find the investigation file with the investigation, therefore it was unknown if the report was sent timely to OHCQ. The NHA stated she was not employed at the facility at the time. 5) A review of facility reported incident MD00187740 on 3/11/25 revealed on 1/1/23 GNA #75 reported she observed 2 unknown residents tied to chairs in the Homestead Unit. Futher review of the facility investigation revealed GNA #75 did not report this allegation to anyone until 1/8/23 when she reported to LPN #74 who encouraged the GNA to report to Administration. Further review of the facility investigation revealed GNA #75 did not report the incident and LPN #74 did not report the incident until 1/12/23 to the former Director of Nursing (Staff #76). Interview with the Administrator on 3/14/25 at 7:35 AM confirmed the facility staff failed to report an allegation of abuse to the Administration in a timely manner.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 7) On 3/12/25 at 12:27 PM a chart review was conducted for Resident #21. According to facility report, resident reported , he/she was touched inappropriately on his/her butt by GNA a few days ago. Employee was suspended pending investigation, R.P. and Doctor notified, Ombudsman notified. Resident and staff interviews were obtained. A head to toe assessment was conducted and psyc services were contacted. Facility found that the reported incident did not occur as there was no evidence to prove this. On 3/12/25 at 1 PM this surveyor spoke with the administrator, who stated she has no incident report in regards to this. Resident stated during interview with him/her on 3/12/25 at 12:30 PM, this did not happen again as he/she has not seen the GNA since. 8) On 3/11/25 at 2:30 PM a record review was conducted for Resident #24. On 4/3/24, at approximately 2:30 AM the aide and nurse had heard yelling. They ran down the hallway and observed Resident #24 allegedly being punched in the face by another resident (#15). The residents were immediately separated. The aide observed blood coming from resident's mouth, a mark on the left side of his/her face and a scratch behind his/her left ear. There is no incident report , interviews or any other information connected to this. Administrator aware. 9) On 3/13/25 at 2:52 PM, a chart review was conducted for Resident #41. On 7/21/24, Resident # 39 had been wandering around the unit. Suddenly a nurse heard a screaming from outside room [ROOM NUMBER]B loudly telling resident to stay away from his/her room. Pt. was observed walking faster 2 rooms away from 321B room. 321B was also walking faster chasing the pt. and had tried to push her/him. Resident #15 in room [ROOM NUMBER]B was told to stop pushing her/him and needs to keep his/her hands off. Resident #15 in 321B screaming, stated pt. came into his/her room while he/she was watching TV. Resident #15 in 321B was told Resident #39 is confused that she/he did not know what she/he was doing but Resident #15 continued to screem to keep Resident #39 away from his/her room. No injury noted since nurse was able to de-escalated the situation. DON (Diecctor of Nursing) and Dr. was made aware of situation. Staff will continue to monitor Resident #39 and Resident #15 for the remaining of shift. Surveyor spoke to administrator on 3/13/25 at 3 PM, about incident report and administrator stated 'no incident report was done, and there are no interviews. 10) On 3/11/25 at 11:22 AM a medical chart review was conducted for Resident #39. On 7/21/24, Resident #39 went into Resident #15's room and got pushed out of the room by Resident #15. No injuries were noted to Resident #39. Resident #39's BIMS as of 7/2/24 was 10/15 which indicated moderate cognitive impairment. No incident report filed. Administrator was uaware of incident.11). Review of facility reported incident MD00184663 on 3/10/25 revealed on 10/7/22 the facility reported the smell of gas at the facility. Per the report the gas griddle was repaired and staff were educated. On 3/10/25 the Administrator was asked for any evidence of an investigation into the incident including interviews, repairs and education. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 3/10/25 at 12:15 PM confirmed she began working at the facility in July 2024 and has no file or futher information of the incident. 12) Review of facility reported incident MD00206032 on 3/10/25 revealed on 5/24/24 the facility reported Resident #23 suffered a fall with injury. On 3/10/25 the Administrator was asked for any evidence of an investigation into the incident including interviews, audits and education. Interview with the Administrator on 3/10/25 at 12:15 PM confirmed she began working at the facility in July 2024 and has no file or futher information of the incident. Based on review of facility reported incidents, medical records, and staff interview, it was determined the facility failed to provide documentation that allegations of abuse, injuries of unknown origin, and a gas leak were thoroughly investigated. This was evident for 9 (#17, #8, #16, #29, #21, #24, #41, #39, #23) of 44 residents reviewed and for 1 facility reported incident that involved the kitchen during a complaint survey. The findings include: 1) On 3/10/25 at 9:52 AM a review of facility reported incident MD00208337 was conducted and revealed Resident #17 was found to have a right hip fracture on 8/2/24. On 3/10/25 at 1:30 PM the NHA (Nursing Home Administrator) was interviewed and stated that she could not find any paperwork regarding the incident. 2) On 3/10/25 at 10:10 AM a review of complaint MD00212393 was conducted and revealed a police officer came to the facility after being called by Resident #8. Resident #8 made an allegation to the police officer that he/she had been abused by staff on 11/1/24 at an unknown time. According to the police officer, the police officer notified RN #48 of the allegations. On 3/17/25 at 11:26 AM an interview was conducted with the NHA inquiring if a self-report had been sent to OHCQ regarding the incident. The NHA stated RN #48 did not notify her about the incident, therefore an investigation was not done. 3) On 3/10/25 at 10:12 AM a review of facility reported incident MD00208329 was conducted and revealed Resident #16 fell from a chair resulting in a fracture of the tip of the nasal bones. Review of the investigative packet that was given to the surveyor was void of an investigation. On 3/10/25 at 12:10: PM the NHA stated she could not find the investigation. She stated that she had just started at the facility and the previous Assistant Director of Nursing who handled the intake no longer worked at the facility. 4) On 3/10/25 at 11:16 AM a review of facility reported incident MD00204171 was conducted and revealed a Clinical Team Member received a text message on 4/1/24 at approximately 6:30 AM that stated Resident #8 had a bruise focal to the right wrist and the resident reported that the staff was rough during care on 3/30/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation revealed that 4 staff were interviewed, which included the accused geriatric nursing assistant (GNA) who did not work that day, a second GNA, and a licensed practical nurse (LPN). The 2 witnesses for the second GNA were not interviewed. There were no resident interviews from the unit where Resident #8 resided and no skin assessments from residents who were not interviewable. On 3/10/25 at 10:30 AM an interview was conducted with the NHA. The NHA confirmed that the investigation was incomplete and that she was not employed at the facility at that time. 5) On 3/14/25 at 9:50 AM a review of facility reported incident MD00211056 was conducted and revealed Resident #8 alleged that he/she was assaulted by a GNA who handled him/her roughly. Review of the facility's investigation revealed staff were interviewed about the incident, however there were no residents interviewed on the unit that would have been in the accused GNA's assignment. On 3/14/25 at 10:15 AM an interview was conducted with the NHA who confirmed there was no other documentation related to the incident. 6) On 3/18/25 at 3:33 PM a review of facility reported incident MD00196064 was conducted and revealed Resident #29 was at the hospital for a medical condition and alleged that he/she was assaulted while sleeping on 8/21/23. On 3/10/25 at 12:10 PM the NHA stated she could not find the investigative file with the investigation. The NHA stated she was not employed at the facility at the time and had looked through the office and files and could not find the paperwork.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on medical record review and interview, it was determined the facility staff failed to conduct a complete and accurate assessment by failing to assess a resident's cognition, mood, and behavior on a quarterly assessment. This was evident for 1 (#16) of 44 residents reviewed for 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 these individualized needs, and that the care is provided as planned to meet the needs of each resident. On 3/12/25 at 10:24 AM a review of Resident #16's medical record was conducted. Resident #16 was admitted to the facility in October 2022 with diagnoses that included, but were not limited to, Bipolar disorder, dementia, and Wernicke's encephalopathy. Review of Resident #16's medical record revealed Resident #16 had behaviors while a resident at the facility. A 12/23/24 nurse practitioner note documented the resident had behavior disturbances and was prescribed Seroquel 75 mg. twice per day that had just been increased. Review of Resident #16's quarterly MDS assessments, Section C, Cognition and Section D, Mood, and Section E, behavior, with an assesment reference date of 1/15/25, were not assessed which made the assessments incomplete. On 3/18/25 at 5:20 PM an interview was conducted with LPN #8, MDS Coordinator. LPN #8 validated that the resident had behaviors and stated that the social worker typically completed that section of the MDS, however the social worker was out and no one assessed the resident's behavior.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 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 2 (#16, #17) of 44 residents reviewed for complaints 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. 1) On 3/10/25 at 10:12 AM a review of Resident #16's medical record revealed a quarterly MDS assessment with an assessment reference date of 1/13/24. Review of Section E behaviors, E0200 coded behavior not exhibited. Behaviors that would be coded in Section E0200, A. would be physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) or E0200B, Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). A 1/7/24 at 5:04 AM behavioral note for Resident #16 documented, behavior: 5:04 AM, hitting, throwing things and cussing at staff. While shift change, resident runs into another resident chair with [his/her] wheel chair and continues to go backwards full force while staff tries to redirect [him/her] but [he/she] ignores them and starts to throw objects at staff. It was documented that the behavior was not redirectable at that time and interventions were not attempted due to the resident being too aggressive at that time. On 3/18/25 at 5:20 PM an interview was conducted with Staff #8, MDS coordinator who confirmed the error. 2) On 3/10/25 at 9:10 PM a review of facility reported incident MD00208337 was conducted and revealed Resident #17 was found to have a right hip fracture and was sent to the emergency room on 8/1/24 according to the census tab in the electronic medical record. Review of the discharge return anticipated MDS with an assessment reference date of 8/1/24, Section J1900, Number of falls since prior assessment, was coded 1 injury (except) major. This was inaccurate as it should have been coded for a major injury which included a bone fracture. On 3/11/25 at 8:37 AM an interview was conducted with the MDS Coordinator who confirmed that the MDS was coded incorrectly and should have been coded a hip fracture. The Nursing Home Administrator and Director of Nursing were informed on 3/18/25 at 5:15 PM.

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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** 3) 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. a) On 3/10/25 at 10:12 AM a review of Resident #16's medical record was conducted and revealed there were quarterly MDS assessments done on 1/15/25 and 10/15/24. Review of Resident #16's medical record failed to produce documentation that there was a care plan meeting held after the MDS assessments. On 3/12/25 at 11:51 AM Staff #27, the Social Work Assistant, was interviewed and stated that care plan meeting sign-in sheets were normally scanned and put in the miscellaneous section of the electronic medical record if a meeting was held. Staff #27 stated that they did not have a care plan meeting in January 2025 because Staff #27 was by herself and she had to do everything related to social services. Staff #27 also stated that she attempted to contact Resident #16's mother multiple times to have a care plan meeting in October 2024 and she could not get in touch with her. Staff #27 was asked if the IDT had a care plan meeting in October 2024 and the response was, no. b) Further review of Resident #16's medical record on 3/10/25 at 10:12 AM revealed on 8/1/24 Resident #16 had a fall. Resident #16 was getting up from a chair and fell face forward onto the floor and sustained an acute mildly displaced fracture of the tip of the nasal bones. On 3/11/25 at 2:22 PM, Resident #16, who had a fall, as stated above on 8/1/24 at 4:30 PM out of a geri-chair, was observed trying to get out of the geri-chair that was located in the back of the common area of the dementia unit. Review of care plans for Resident #16, at risk for falls r/t Gait/balance problems, Psychoactive drug use and impulsiveness, failed to have specific resident centered interventions in place, for this cognitively impaired resident, about monitoring the resident while in a geri-chair. On 3/11/25 at 4:45 PM the issue was discussed with the Nursing Home Administrator and Director of Nursing who confirmed the findings. Based on medical record review, interviews, and observation, it was determined the facility failed to have regular care plan meetings and failed to update interventions on the care plan. This was evident for 3 (#21, #15, #16) out of 44 residents reviewed during a complaint survey. The findings include: 1) The Stepmom of Resident #21 called to say, the patient was admitted to the facility in April in 2024 and has had only one care plan meeting on 8/19/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24, the Interdisplinary Team met, including social services assistant and nursing to complete a quarterly care plan meeting. Resident was present and is alert and oriented. Family was present including his/her sister. Social services discussed MOLST - resident is a Full Code. BIMS is 15/15. Discharge plan is to continue long term care at facility - eventually resident would like to possible transfer to [NAME] to be closer to family. Therapy discussed - if resident experiences a fall or decline, therapy will reevaluate. Diet discussed - resident's diet is carb controlled, regular texture and thin liquids - NO PORK! Nursing discussed resident treatments and medications. Resident states they feel they are treated with dignity and respect. Resident and family were provided a copy of the resident's care plan and order summary. Concerns addressed included resident needed nails trimmed, he/she continues to receive pork despite kitchen being aware that he /she cannot have it, and activities needs to complete menu with him. It has been 7 months since last CP meeting was held. (last meeting 8/19/24). Social worker, staff # 27 was interviewed on 3/12/25 at 12:27 PM and asked why it has been so long since last Care Plan meeting and she did not have a responce other than saying a care plan meeting is scheduled in next few days. Administrator was asked the same question on the same day and stated she knew nothing about it. 2) Resident #15 entered into the facility on [DATE] and discharged [DATE]. He/She has a diagnosis of alchol abuse and substance abuse and attacking other residents who come into his/her room. On 4/3/24 and 4/13/24 Resident #15 hit Resident #24. There was no interventions or CP for Resident #15. On 6/7/24 resident hit Resident #16 who he/she hit for wandering into his/her room. No Care Plan or interventions. On 7/28/24 resident hit Resident #14 who wandered into his/her room. No care plan or interventions. On 7/21/24 and 8/26/24 Resident #15 hit Resident #41 for going into his/her room. On 8/12/24 new administrator wrote a care plan and put in place a doorbell to residents room and a stop sign on residents front door. These are the only 2 interventions on Resident #15 Care plan. Unit manager was interviewed but did not know these residents as she just joined the facility. An interview was held with the Medical Director, Staff # 9 on 3/13/25 at 9:27 AM: ' I know him very well. He/she is currently at Mannokin and that is the building I see the patient at. He/she had a fall resulting in a head injury prior to coming to the facility. I am aware of at least 3 residents that he/she struck and I reviewed the incidents that happen at the facility. He/she didn't take his/her psych medicine, he/she only took his seizure medication. After the first incident I would have expected psych eval, behavior medication. I would talk to him about his meds. Do a meds evaluation. I would care plan his behaviors. After the 2nd or 3rd time it depending on the circumstances I would look for alternative settings. Is this the right place for him?' 'Looking in retrospect he/she probably should have interventions put in place and we could have looked at a more appropriate setting. It was discussed in risk meeting. There should have been interventions put in place. '

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review or pertinent documents, medical record review and interview, it was determined that 1) the practitioner failed to follow professional standards of clinical practice by prescribing end-of-life medication to a full code resident without ensuring the resident and/or resident representative were fully informed about the use of end-of-life medications, and 2) the facility nursing staff failed to follow professional standards of nursing practice when administering psychotropic medication by failing to document in the medication administration record when the medication was given to a resident. This was evident for 1 (#12) of 44 residents reviewed during a complaint survey. The findings include: Schedule II (C2) controlled drugs refer to drugs with a high potential for abuse and addiction that are regulated by the government and include anxiolytic (anti-anxiety) benzodiazepine medication and opioid (analgesic) (narcotic) medication. A psychotropic describes any drug that affects behavior, mood, thoughts, or perception On [DATE] at 9:00 AM, a review of complaint #MD00209003 alleged Resident #12, who was terminally ill, but not on hospice or receiving palliative care, was prescribed and administered Ativan (anxiolytic) and Morphine (Opioid) for end of life , without notifying the resident's representative, and obtaining consent. The complaint alleged that giving the medications together contributed to Resident #12's respiratory failure, and lead to the death of the resident. The complaint also alleged the facility staff failed to notify Resident #12's representative timely when the resident was transferred to the hospital. A review of Resident #12's electronic medical record (EMR) revealed Resident #12 was admitted to the facility in mid-[DATE] following a transfer from a sister facility and had multiple diagnoses, including hepatocellular carcinoma (liver cancer) and hepatic encephalopathy (brain disorder caused by liver dysfunction), and a history of blood transfusions. The resident was discharged from the facility following his/her transfer to the hospital 3 days after admission. Resident #12 had a MOLST (Maryland Orders for Life Sustaining Treatment) form that was signed and dated [DATE] and documented Resident #12 elected to Attempt CPR, indicating the resident was a full code. In a Nurse Practitioner (NP) Progress Note on [DATE] at 12:30 PM, Staff #64 NP documented Resident #12 was being transferred from another facility to the current facility on that day, and the NP was very familiar with Resident #12 because the NP provided care to him/her at the other facility. The NP wrote that Resident #12 was currently a full code, that resident's declining condition was discussed with the Director of Nurses (DON) (Staff #78) and the DON would discuss end-of-life (EOL) care, which they believed was appropriate, with the resident's representative. The NP further wrote that s/he left C2 (controlled drugs) prescriptions for EOL medications with the DON because an NP on site [in the facility] tomorrow, with the stipulation that Resident #12's code status was changed to reflect this. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:41 PM, a review of Resident #12's [DATE] Medication Administration Record (MAR) revealed orders for 2 psychotropic medications to be administered as needed for symptoms related to end of life symptoms. Resident #12's [DATE] MAR documented: - An [DATE] order for Lorazepam (Ativan) (Anxiolytic) by mouth every 2 hours as needed for restlessness; agitation related to end of life for 14 days that was documented as given on [DATE] at 11:41 PM, and [DATE] at 1:00 AM - An [DATE] order for Morphine Sulfate (Opioid) (narcotic) oral solution by mouth every 2 hours as needed for dyspnea (shortness of breath) and end of life care with a start date of [DATE] at 12:15 PM was documented as given on [DATE] at 1:00 AM. Both the Lorazepam and Morphine orders had been entered into the EMR by the NP, Staff #64 Continued review of the medical record revealed on [DATE] at 3:30 AM, in a nurse's note, the nurse documented that Resident #12 was restless in bed, trying to get out of bed, and the nurse assisted the resident's personal caregiver to reposition the resident. The nurse documented Lorazepam was given per PRN (as needed) order for end-of-life care for comfort. On [DATE] at 10:03 AM, in a change in condition note, the nurse wrote Resident #12 was unresponsive to verbal stimuli or sternal rub; vital signs unstable, and 911, the physician and the DON were notified, and the resident was sent to the emergency room. Continued review of Resident #12's medical record failed to reveal documentation to that prior to initiating psychotropic medication, the resident and/or resident representative was informed of the risks and benefits of the medication and consent was obtained, and no documentation was found in the medical record to indicate end of life care for Resident #12 discussed with the resident's representative prior to initiating the medications. In addition, there was no further documentation in the medical record to indicate the NP, Staff #64, followed up with the resident, the resident's responsible party or the DON following the implementation of the orders. On [DATE] at 12:47 PM, an interview was conducted with the NP, Staff #64 who stated s/he knew Resident #12 from the previous facility, that the resident was very sick, that s/he had a liver tumor and required repeated blood transfusions. The NP indicated that at the previous facility, the NP had numerous discussions with the family about the residents health, and the NP had not seen Resident #12 at the present facility, Staff #64 stated s/he had a conversation with the DON, Staff #78, that the resident was nearing end of life, that the practitioner had attempted to talk to the family and the resident's MOLST was a full code. The NP stated s/he wrote the prescriptions for morphine and lorazepam for Resident #12 for the resident for palliative care and EOL for the resident's comfort and gave the physical prescriptions to the DON with the stipulation they would be available if the MOLST was changed, the resident was in a lot of pain, or something changed. The NP indicated that the DON said s/he would talk to the family about changing the resident's code status and the NP wanted the prescriptions available if his/her MOLST was changed to palliative care. The NP stated s/he had not yet had that conversation with the family and was concerned if the MOLST was changed, a provider would not be available to write the prescriptions. The NP confirmed that s/he entered the EOL orders in the EMR as active orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:45 PM, the above concerns were discussed with the Medical Director, Staff #9, Physician, who stated s/he remembered the resident very well. At that time, Staff #9 expressed concerns with Resident #12 being administered medications for end of life, and stated that the resident should have gotten Narcan (medication that reverses Opioid overdose). On [DATE] at 9:25 AM, Staff #9, Medical Director stated that s/he wanted the surveyor to know that s/he took the concerns with the practitioner who prescribed the medications end-of-life care to Resident #12 very seriously and removed the practitioner from the facility. Staff #9 stated that the practitioner would not be back, and the practitioner's practice would be reviewed. On [DATE] at approximately 4:50 PM, the attending physician, Staff #66, was made aware of the above findings. At that time, Staff #66 reported s/he knew Resident #12 from the previous facility, that the resident had been diagnosed with liver cancer, and the physician felt for the family. Staff #66 stated that s/he became aware Resident #12 had been put on Ativan and Morphine when he saw the resident following his/her transfer to the facility, The physician stated s/he thought the NP wanted something more for the resident's pain and it never entered his/her head that the medications were for end-of-life, and Resident #12's family didn't want that. The physician stated that it was the providers job to talk to the families and s/he would never have left signed prescription for end-of-life care without first talking to the family. The above concerns were discussed with the Director of Nurses (DON) and Nursing Home Administrator (NHA) on [DATE] at 6:00 PM. The DON acknowledged the concerns at that time and offered no further comments. 2) Following review of Resident #12's medical record, a concurrent review of the controlled substance count sheet for the resident's prescribed Lorazepam, and morphine, and Resident #12's August MAR was conducted and revealed facility nursing staff failed to follow professional standards of nursing practice when administering psychotropic medication by failing to document in the medication administration record when the medication was given to a resident. Resident #12's [DATE] MAR documented: 2a) An [DATE] order for Lorazepam by mouth every 2 hours as needed for restlessness; agitation related to end of life for 14 days that was documented as given to the resident on [DATE] at 11:41 PM, and on [DATE] at 1:00 AM. A review of a controlled substance count sheet for Lorazepam 2 mg/ml revealed documentation that a dose of Lorazepam was removed for Resident #12 on [DATE] at 11:43 PM, on [DATE] at 1:00 AM, and on [DATE] at 3:00 AM. A concurrent review of Resident #12's August MAR revealed the Lorazepam removed from the count sheet on [DATE] at 3:00 AM was not documented as given on the MAR, indicating the nursing staff failed to document when the Lorazepam was administered to the resident. 2b) An [DATE] order for Morphine Sulfate (narcotic) oral solution by mouth, give every 2 hours as needed for dyspnea (shortness of breath) and end of life care with a start date of [DATE] at 12:15 PM was documented as given on [DATE] at 1:00 AM. A review of a controlled substance count sheet for Morphine Sulfate 100 mg/ml documented a dose of morphine was removed for Resident #12 on [DATE] at 1:00 AM and a dose of morphine was removed for Resident #12 on [DATE] at 3:00 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent review of Resident #12's August MAR revealed the Morphine removed from the count sheet on [DATE] at 3:00 AM, was not documented as given on the MAR, indicating the nursing staff failed to document when the Morphine was administered to the resident. The above concerns were discussed with the Director of Nurses (DON) and Nursing Home Administrator (NHA) on [DATE] at 6:00 PM. The DON acknowledged the concerns at that time and offered no further comments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review and interview, it was determined the facility failed to provide ADL (activities of daily living) care for residents who were dependant for all ADL care. This was evident for 4 (Resident #11, #8, #1, #36) out of 44 residents reviewed for complaints during a complaint survey. The findings include : 1) On 3/10/25 at 10:30 AM a medical record review was conducted for Resident #11. Family made a complaint that resident had not been bathed or received showers. Resident #11 needs extensive assistance with all activities of daily living. On 6/15/24 Neurocognitive Health evaluated Resident #11. The resident was found he/she can be difficult with care. She/he cannot drink from a glass as she/he will spill into her/his food. She/he plays with toddler toys, and music keeps her/him calm. Resident #11 will independently lay on the floor. Resident behaviors are worse at night Resident #11 was Hallucinating during apt. with Neurocognitive health apt. on 6/15/24. According to care records, resident had 1 shower 8/13/24 am shift; Resident #11 did not have shower or bed bath on 8/10/24 , 8/11/24, 8/14/24, 8/15/24, 8/17/24, 8/18/24. There was no bathing recorded for eve or night shift. Turn and reposition was not done on the following dates: 8/9/24, 8/12/24, 8/16/24, 8/19/24 Night shift 8/12/24, and eve shift 8/9/24; 8/11/24; 8/15/24 Toileting not done on the following dates: 8/12/24; 8/16/24, 8/19/24 Eve 8/9/24, 8/11/24 and 8/15/24 Night shift 8/10/12 and 8/12/24 The administrator and the unit manager of the dementia unit were interviewed on 3/10/24 at 10 AM and asked if they knew anything about this and both stated they were unaware resident was not receiving care.4) On 3/13/25 at 8:30 AM, a review of complaint #MD00209282 alleged Resident #36 did not receive adequate care at the facility On 3/13/25 at 8:48 AM, during an Interview, Resident #36 reported that s/he was not always able to get a shower on his/her shower days, and that staff told him/her it was because there wasn't enough help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 stated that s/he was able to wash him/herself, however, someone needed to put the resident in the shower, and they were supposed to stay in the room during his/her shower, in case the resident needed help. Resident #36 further stated that most of the time, the person who put him/her in the shower did not stay in the room during the resident's shower, and that once, when the aide didn't stay, the resident slipped in the shower and fell. On 3/13/25 at 3:30 PM, a review of Resident #36's medical record revealed Resident #36 resided in the facility for long term care since 2022, with diagnoses included muscle weakness and the resident used a wheelchair for mobility. A review of Resident #36's quarterly assessment with an assessment reference date of 12/22/24 documented that the resident had a BIMS (Brief Interview for Mental Status) score of 14, indicating the resident was cognitively intact and the assessment documented Resident #36 required supervision or touching assistance to shower/bathe (wash, rinse, dry) self. Review of Resident #36's care plans, revealed a care plan, [Resident #36] has an ADL self-care performance deficit with the intervention, the resident requires set up assistance by 1 staff [for] bathing/showering On 3/13/25 at 3:40 PM, a review of Resident #36's March 2025 geriatric nursing assistant (GNA) Documentation Survey Report, the intervention ADL Shower, revealed Resident #36's shower days were Mondays and Thursdays, on dayshift, and documented that from 3/1/25 thru 3/13/25, Resident #36 had received only a shower on one (3/3/25) of 4 potential shower days. There was no documentation found to indicate Resident #36 received a shower on Thursday, 3/6/25, Monday 3/10/25 and Thursday, 3/13/24. The above concerns were discussed with the DON on 3/18/25 at approximately 6:45 PM. The DON acknowledged the concerns at that time with no further comments offered. 3) Review of Resident #1's medical record on 3/10/25 revealed the Resident was admitted to the facility in October 2024 with a diagnosis to include disease of the spinal cord. Further review of Resident #1's medical record revealed the facility staff assessed the Resident to be dependent on care for showering/bathing. During interview with Resident #1 on 3/11/25 at 2:00 PM, the Resident stated he/she is not receiving showers 2 days a week like he/she would like and can remember going 16 days straight in February without a shower. Review of Resident #1's Documentation Survey Report for showers on 3/12/25 for January, February and March 2025 revealed the facility staff has not documented any showers given to Resident #1. Interview with the Director of Nursing on 3/12/25 at 12:00 PM confirmed the facility staff has no documentation they provided showers twice weekly for Resident #1 in January, February and March 2025. 2) On 3/10/25 at 10:10 AM a review of complaint MD00212393 alleged that Resident #8 was not receiving bed baths as needed. A review of complaint MD00210139 alleged that Resident #8 was bed bound, and it was alleged that Resident #8, was filthy and receiving no care and that staff were refusing to give the resident bed baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's medical record revealed the resident was admitted to the facility in March 2024 with diagnoses that included Ankylosing spondylitis (AS), which is a chronic inflammatory disease that primarily affects the spine, causing inflammation and potentially leading to the fusion of vertebrae, resulting in stiffness and reduced flexibility. 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. Review of Resident #8's 9/6/24 quarterly MDS assessment documented that Resident #8 was dependent on staff for all activitites of daily living care. Review of bathing records for Resident #8 documented that Resident #8 received a bed bath for 12 of 30 days in September 2024, 13 of 31 days in October 2024, 14 of 30 days in November 2024, and 12 of 31 days in December 2024. On 3/17/25 at 1:55 PM an interview was conducted with licensed practical nurse (LPN) #28. LPN stated that geriatric nursing assistants (GNA)s document if they give a shower or bed bath or if the resident refuses. LPN #28 stated that if a resident refuses a bed bath or shower then the GNAs were to tell the nurse, and the nurse was to document the refusal. On 3/18/25 at 7:05 AM an interview was conducted with the Director of Nursing (DON). The DON was asked if a resident was bedridden should a bed bath be offered or given every day. The DON stated that a bed bath should be given every day with AM care. If it is refused it should be documented. There should not be any blank spaces on the GNA documentation. Cross Reference F842 for all GNA documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Facility staff failed to follow-up on a medication for a specific medical condition. On [DATE] at 1:00 PM a review of Resident #8's medical record was conducted and revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included Ankylosing spondylitis (AS), which is a chronic inflammatory disease that primarily affects the spine, causing inflammation and potentially leading to the fusion of vertebrae, resulting in stiffness and reduced flexibility. Review of Resident #8's [DATE] Medication Administration Record (MAR) documented Resident #8 was to receive the medication Enbrel via injection from a prefilled syringe every Monday for Pain. A [DATE] and [DATE] nursing note documented that the medication Embrel was not available from the pharmacy. Enbrel is a prescription medication that belongs to a class of drugs called tumor necrosis factor (TNF) inhibitors. It is used to treat autoimmune conditions such as Rheumatoid arthritis (RA), Psoriatic arthritis (PsA), Ankylosing spondylitis, and Plaque psoriasis. Enbrel works by blocking the action of TNF, a protein that plays a role in inflammation. By inhibiting TNF, Enbrel can reduce inflammation and improve symptoms in autoimmune conditions. A [DATE] progress note from the previous Director of Nursing (DON) documented that the previous Assistant Director of Nursing (ADON) contacted the pharmacy to find out when the Embrel was to arrive and the pharmacy indicated it was too soon to fill and denied by the resident's insurance. It was documented that upon investigation, it appeared that the last facility the resident was in filled it just prior to the resident going to the emergency room. The previous facility received 4 standard dose injections. The medication was placed on a hold due to the interaction the resident would have with being put on Amoxicillin, however the resident was to continue to take this medication as prescribed once discharged from the hospital. This is why insurance was denying it. The facility agreed to pick up the cost of one injection until the insurance was able to cover. Resident #8 received the Embrel injection on [DATE]. Continued review of Resident #8's medical record revealed he/she received the Embrel on [DATE], [DATE], and [DATE]. On [DATE] and [DATE] progress notes documented that the medication was not available and they were waiting for pharmacy. A [DATE] nurse practitioner (NP) note documented the Embrel was no longer authorized by insurance, therefore they had to prescribe a different medication. A [DATE] NP note documented that Naprosen was a first line medication that could be prescribed. The NP also offered to the resident to receive steroid shots and have consults with orthopedics. Resident #8 refused. On [DATE] the NP wrote a note which stated, I will order Enbrel 50 mg SC qwk (every week). I am unsure what the issue is/was with insurance approval. If need be, I am happy to provide documentation to the insurance company as to the necessity of this medication. After the [DATE] note there was no further documentation about trying to get the Embrel prescription filled and approved by insurance. There were physician progress notes that documented Resident #8 used to be on Embrel, however nothing about trying to get it covered for the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:55 PM an interview was conducted with the Medical Director. The Medical Director stated he was still trying to figure out why Resident #8 has not been getting the Embrel. He said he would speak directly to the resident about it. The surveyor informed the Medical Director of the concern that there was no follow-up related to the medication and the Medical Director agree that there should have been follow-up. On [DATE] at 9:23 AM the Medical Director informed the surveyor that the Embrel was not preauthorized, and it dropped off and no one followed up on it. The Medical Director stated he would put the resident back in for the Embrel. The Medical Director stated, why [he/she] was not without it for the last year; I cannot say. It may prevent progression of hearing loss. [He/she] was on it for ankylosis to reduce the inflammation. There is nothing that stops it. The Embrel helps. On [DATE] at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the concern. Based on review of complaints, medical record review, and staff interview, it was determined the facility failed to properly perform neuro checks and document a change in condition for a resident following falls, failed to order oxygen for a resident, and failed to follow-up on medication for a specific medical condition. This was evident for 3 (#4,#26, #8) of 44 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #4's medical record on [DATE] revealed the Resident was admitted to the facility in [DATE] for rehabilitation following a 5 month hospitalization with a diagnosis to include delirium and respiratory failure. The facility staff failed to properly perform neuro checks after unwitnessed falls for Resident #4. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #4's medical record revealed the Resident had unwitnessed falls on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review of the Resident's medical record revealed after the initial assessment of the Resident there was no documented neuro checks of the Resident. Further review of Resident's medical record revealed no change of condition assessments were completed following the [DATE], [DATE], [DATE], [DATE], and [DATE] falls. A change of condition assessment would include the situation, vital sign evaluation, general background information, evaluations of mental status, functional, behavioral, neuro, skin and pain. It would also include a review of the findings and notification documentation to provider and representatives. Interview with the Director of Nursing on [DATE] at 2:45 PM confirmed the facility staff failed to complete neuro checks and changes of condition for Resident #4 from [DATE] until [DATE]. 2) The facility failed to obtain an order for oxygen on a regular basis or as need basis. On [DATE] at 10:40 AM a review of medical records was conducted. Resident #26 had a history of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FX 2nd cervical vertebra, protein calorie malnutrition, MRSA and VRE resistant, Sepsis from complication of leg amputation done at the hospital [DATE], Disc degeneration, Chronic ulcer left stump, Dialysis, end stage renal disease, COPD (chronic obstructive pulmonary disease), HTN (hypertention), and is dependent for all ADLs (Activities of daily living). On [DATE] resident was brought to dialysis by aid. The aid stated to ombudsman that although resident wears 02 in his room she forgot to bring tank to dialysis. Nurse in dialysis noticed resident was slumped over in wheelchair and lips were blue. She placed 02 on resident and called 911 and resident was sent to the hospital. Dialysis nurse is no longer here to interview. There was no order for oxygen ongoing or PRN according to MDS staff #8. Resident also had severe sepsis related to MRSA and VRE infection resistant wound to the left amputated stump. Resident went to dialysis on [DATE] but did not go to dialysis [DATE] and [DATE] because he didn't feel well. On [DATE] resident had a pulse ox of 83% on room air. On [DATE], Resident passed away at the facility. The death certificates states resident died from cardiopulmonary arrest and end stage renal disease. Administrator is aware and stated ok.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers. This is evident for 1 (#30) of 44 residents reviewed during a complaint survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. Review of Resident #30's medical record on 3/12/25 revealed the Resident was admitted to the facility in May 2023. Further review of Resident #30's medical record revealed the Resident was assessed by the Wound Nurse Practitioner (WNP) on 6/6/23 and determined to have a DTI to the left heel. Review of the weekly skin assessment revealed the facility staff failed to assess Resident #30's left heel DTI the week of July 3rd, 2023 to include measurements and the status of the pressure ulcer. Review of Resident #30's July 2023 Treatment Administration Records revealed no evidence the facility staff provided treatment to Resident left heel DTI on 7/7, 7/10, 7/16, and 7/18/23. Interview with the Director of Nursing on 3/13/25 at 5:28 PM confirmed the facility staff failed to assess Resident #30's left heel pressure ulcer on 7/3/23 and failed to provide treatments on 7/7, 7/10, 7/16, and 7/18/23.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on review of a complaint, medical record review, and interview, it was determined the facility staff failed to follow up and obtain a motorized wheelchair for a resident in a timely manner. This was evident for 1 (#5) of 44 residents reviewed during a complaint survey. The findings include: On 3/12/25 at 5:30 PM a review of complaint MD00213409 alleged that Resident #5 had a power wheelchair that was no longer working. Resident #5 was supposed to get a new power wheelchair, however still had not received the wheelchair and alleged that the facility was not going to pay for the wheelchair. Review of Resident #5's medical record revealed Resident #5 had been a resident at the facility since 2015 and had diagnoses that included, but were not limited to, multiple sclerosis, type 2 diabetes mellitus with hyperglycemia, arthritis, low back pain, peripheral vascular disease, chronic venous hypertension, and absence of the left toe. On 3/10/25 at 2:00 PM an interview was conducted with Resident #5 who stated he/she had been waiting on the facility to get his/her motorized wheelchair. Resident #5 stated that the facility ordered the wheelchair, and Medicaid had approved the wheelchair, but Resident #5 still didn't have the wheelchair, and it had been at least 4 months since it was ordered. On 3/13/25 at 11:00 AM an interview was conducted with the previous Director of Maintenance, Staff #33. Staff #33 stated that Resident #5's previous wheelchair stopped working and therapy was working with insurance to get a new wheelchair for the resident. On 3/13/25 at 11:05 AM an interview was conducted with the Director of Physical Therapy, Staff #35. Staff #35 stated the facility was applying for a new wheelchair and everything was submitted. The surveyor asked why it was taking so long to get the wheelchair. Staff #35 stated he did not know the status of the wheelchair or where the process fell off. On 3/13/25 at 3:44 PM an interview was conducted with the Regional Business Office Manager, Staff #13. Staff #13 stated the facility received prior authorization on 11/26/24 and the wheelchair was ordered. Staff #13 stated the previous business office manager was no longer the business office manager, so all of the information related to the wheelchair, including the invoice from the medical supply company was sent to an incorrect email. Staff #13 stated the previous business office manager worked at a sister facility and did not receive email that was directed to her from this facility. Staff #13 was asked if someone at this facility had access to receive the emails once the previous business office manager left. Staff #13 said there was some type of technical issues with emails. Staff #13 stated the wheelchair company reached out to someone new in the business office on 2/25/25 and informed them that the prior authorization was expiring on 2/25/25 and the invoice needed to be paid before the wheelchair could be delivered. That person failed to let anyone know that information. Staff #13 stated today was the first time she was hearing about the issue. Staff #13 stated, we usually receive updates prior to the authorization date ending. Several things fell through. She stated the only time she was involved was when they paid out of a resident's fund account. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #13 produced an email from the medical supply company dated 3/13/25 which stated, please see attached documentation for [name of Resident #5] for [his/her] power wheelchair. We will need payment from [name of facility] as soon as possible. Attached are the documents that you will need to submit to MA to get reimbursed. On 3/18/25 at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the delay in getting the resident's wheelchair.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview, and record review it was determined the facility failed to provide supervision to a cognitively impaired resident with a history of a fall with fracture. This was evident for 1 (#16) of 35 residents in the [NAME] Unit during a complaint survey. As result of these findings an Immediate Jeopardy was called at 4:45 PM on 3/11/25. The facility submitted a plan to remove the Immediacy on 3/11/25 at 8:30PM. The survey team verified completion of the plan on 3/14/25 at 11:08 AM with a compliance date of 3/13/25. The findings include: On 3/11/25 at 2:22 PM in the [NAME] Unit, which is a secured memory care unit, observation was made of Resident #16, who had a history of a fall out of Geri-chair on 8/1/24 at 4:30 PM, that resulted in an acute mildly displaced fracture of the tip of the nasal bones, trying to get out of a Geri-chair that was located in the back of the common area of the unit. There were no nursing staff visible on the unit. The only staff member was Housekeeper (HK) #25 who was sweeping the floors. HK #25 saw the resident and ran over to him/her and attempted to talk the resident into staying in the chair. The housekeeper then walked up to the nurse's station and was looking for staff. HK #25 walked down the opposite hallway calling for staff while the surveyor stood at an unlocked and unattended medication cart observing Resident #16. At that time Resident #16 had his/her legs half way out of the chair. The surveyor ran and stood in front of the Geri-chair and encouraged the resident to sit back in the chair. HK #25 continued to look for staff and could not find anyone. HK #25 returned to the common room and offered to watch Resident #16 until nursing staff came back to the area so the surveyor could stand by the unlocked medication cart until licensed staff could secure the cart. Cross Reference F761 On 3/11/25 at 2:29 PM the AIT (Administrator in Training) came back to the unit and walked up and saw the medication cart and attempted to lock it while the surveyor stood there. At that time the surveyor asked where the nurse on the unit was. The AIT said he would get the unit manager (UM). He was asked again where the nurse on the unit was, and he said I'll get the unit manager. At 2:30 PM the unit manager walked up to the surveyor and the surveyor asked where the nurse on the unit was. UM #28 stated the nurse on the unit left early and the UM was responsible for 2 units. It was revealed that UM #28 was doing patient care on another nursing unit at the time. The surveyor informed UM #28 about Resident #16 trying to get out of the Geri-chair. UM #28 asked where the nursing assistants were. At that time geriatric nursing assistant (GNA) #5 walked into the common area and was told to watch Resident #16. A second GNA, GNA #15 came up the hall and said she was in the middle of changing a resident while doing last rounds and had the bed in a high position and could not leave the resident. A third GNA, GNA #29 was in a resident room doing patient care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #16's medical record revealed the resident had diagnoses that included ataxia, bipolar disorder, unspecified dementia with agitation, and Wernicke's encephalopathy. According to the National Institute of Health (NIH), Wernicke's encephalopathy is traditionally associated with chronic alcohol abuse and characterized by some combination of ataxia (impaired coordination, balance, and movement), ophthalmoplegia (paralysis or weakness of eye muscles), and altered mental status. As stated above, Resident #16 had a fall on 8/1/24 that resulted in injury. Preceding nursing notes dated 7/27/24 documented that Resident #16 had ongoing behaviors that included trying to climb on the floor, sitting on floor, and scooting along on buttocks on the floor. A 7/31/24 health status note documented, increased behaviors, patient lowers self to the floor and constantly attempts to get out of [his/her] chair. An 8/1/24 at 4:50 PM note documented that the resident had a witnessed fall by staff. The resident was trying to get up from the chair and fell on the floor face down. A subsequent note from the Nurse Practitioner (NP) on 8/2/24 documented an acute mildly displaced fracture of the tip of the nasal bones. Nursing notes that lead up to the observation on 3/11/25 documented on 2/26/25 at 10:00 PM that Resident #16 had an episode of psychosis that was reported on 2/21/25 where the resident pulled a dresser down and at some point hit his/her nose which resulted in, slightly distal of the previous fracture without significant fracture fragment displacement. A 3/3/25 note written by the NP documented that the resident had agitation and restlessness and was sitting up in a chair in the common room, rocking back and forth and trying to climb out of the chair. The NP increased the medication Seroquel to 200 mg. twice a day. Seroquel is an antipsychotic medication. A 3/10/25 at 1:36 PM nurse's note and a 3/11/25 at 1:31 PM nurse's note documented that Resident #16 was combative with care and smearing feces on self and the bed. Observation was made in the morning on 3/11/25 at 9:45 AM of Resident #16 in his/her room wearing a hospital gown. Resident #16 had just flipped over the tray table that had a breakfast tray on top. There was fluid and food on the floor and the mattress on the floor. Resident #16 was sitting on the edge of the bed rocking back and forth. Resident #16 was seen by another surveyor smearing feces on the bed and wall. After this intervention the facility did not increase staff supervision of Resident #16. Review of Resident #16's care plan, at risk for falls r/t Gait/balance problems, Psychoactive drug use and impulsiveness, failed to have specific resident centered interventions in place, for this cognitively impaired resident, about monitoring the resident while in a geri-chair. Cross Reference F657 Surveyor and Housekeeper intervention prevented Resident #16 from getting out of the Geri chair without assistance and prevented the other cognitively impaired residents on the dementia unit from accessing the unlocked medication cart. After the Immediate Jeopardy was called the facility submitted a plan to remove the immediacy. The facility took the following actions to address the concerns and prevent any additional residents from suffering an adverse outcome: a) Resident #16 was provided one on one supervision until cleared by Behavioral Health and the medication cart was immediately locked on the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b) The staff educator conducted an audit on all falls residents who were cognitively impaired and at risk for falls to ensure that resident specific interventions were in place. Licensed nurses and CMAs were educated to ensure medication carts were secured on all units when unattended. c) The staff educator will educate all licensed nurses and CMAs on medication cart safety. d) Staff educator will educate all licensed staff to ensure common areas are supervised when residents are present in common area. e) Staff educator will educate all nurses, GNAs and CMAs to ensure that residents' specific interventions are in place for residents who are at risk for falls. f) Any licensed nurses, CMAs or GNAs who are currently on leave for medical, vacation, FMLA, or sickness will be educated prior to returning to work g) All med carts will be audited 2 times per day for 2 weeks and 10 times per month for 4 months h) All common areas will be audited to ensure supervision of residents is present 4 times per day for 2 weeks, then 10 times per month for 4 months. i) All cognitively impaired residents at risk for fall will be audited to ensure their resident specific interventions are in place 2 times a week for 4 weeks then monthly times 4. j) All residents will receive a falls evaluation on admission, quarterly and yearly by MDS. k) All results from the audits will be presented to the QAPI team monthly to be reviewed and revised monthly for 4 months.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on medical record review and interview, it was determined the facility staff failed to assess a resident for removal of a catheter. This was evident for 1 (#1) of 44 residents reviewed during a complaint survey. The findings include: Review of Resident #1's medical record on 3/10/25 revealed the Resident was admitted to the facility in October 2024 with a diagnosis to include neuromuscular dysfunction of bladder. Further review of Resident #1's medical record revealed the Resident was admitted to the facility with an indwelling urinary catheter. During interview with Resident #1 on 3/11/25 at 2:00 PM, the Resident stated he/she feels like he/she is having more feeling, can tell when urinating and stated was told there would be a voiding trial but it has not happened. A voiding trial is a procedure used to assess a patient's ability to urinate without the need for a urinary catheter. It is typically performed after a period of catheterization, such as after surgery or hospitalization. During interview with the Medical Director on 3/12/25 at 10:44 AM, the Medical Director stated he doesn't think the Resident will regain physical function or bladder control based on the Resident's spinal injuries suffered but does think a voiding trial is not a bad idea and has ordered one. After Surveyor intervention, a voiding trial was ordered for Resident #1 on 3/12/25.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on review of complaint, medical record review, and staff interview, it was determined the facility's registered dietician failed to document assessments in the resident's medical record and the facility currently failed to have a registered dietician that came on site to see resident's to see and assess residents for their current nutritional needs. This was evident for 1 (Resident #8) of 44 residents reviewed during a complaint survey and had the ability to affect all residents that resided in the facility. The findings include: On 3/17/25 at 11:15 AM a review of complaint MD00204843 alleged Resident #8 had not been given dinner and that the resident weighed 79 pounds. Review of the weight section of Resident #8's electronic medical record documented the last weight recorded for Resident #8 was on admission to the facility, 3/1/24, and Resident #8 weighed 176 pounds. Resident #8 has refused weights since admission. Review of Resident #8's medical record revealed there have been no nutritional notes or nutritional assessments from 3/4/24 to 3/7/25. Further review of the medical record revealed Resident #8 only received fish for breakfast, lunch, and dinner per request and peanut butter crackers to be consumed when taking medication. On 3/17/25 at 3:01 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated the previous dietician worked at the facility until September 2024 and that they only had a dietician that worked remotely. The NHA stated they were in the process of hiring a dietician that would come to the facility. The NHA stated the previous dietician resigned just after the NHA started working at the facility in July 2024. The NHA was informed there were no nutritional assessments documented in Resident #8's medical record from 3/4/24 to 3/7/25. On 3/18/25 at 7:30 AM an interview was conducted with the previous dietician, Staff #69. Staff #69 stated, I am surprised to know that there is no documentation. It is very surprising to me, and I cannot say one way or another. My practice, besides the initial assessment, is I would go and see them (the residents) and talk to them when they had an issue. [He/she] had a very specific diet that [he/she] followed, and I would do follow-ups every 3 months. If I had the time I did. I was full time until August. Staff #69 stated she did see Resident #8. Staff #69 was asked if she saw residents every 3 months and she said, I would say not always able to keep up with seeing residents every 3 months. I don't know if I did or not. There was a lot of turnovers. I tried to keep up. I left because I couldn't keep up and there wasn't enough time, and I felt I was not the best fit for that position. I couldn't get to all the documentation and see the residents as they needed to be seen. I was pulled into the kitchen countless times, working the tray line and managing the tray line. I would always go for what was immediately needed. On 3/18/25 at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the concern.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation review, resident council meeting minute reviews, staff and resident interviews, and observation, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 10 of 42 complaints submitted to the Office of Health Care Quality (OHCQ), the regulatory agency, multiple staff interviews, 3 of the 4 resident council meeting minutes reviewed and review of staffing schedules and employee time punches. This deficient practice had the potential to affect all residents. The findings include: 1) Ten out of forty-two complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this survey alleged the facility did not have sufficient nursing staff to provide essential care to the residents that resided at the facility. Complaints consisted of geriatric nursing assistants (GNAs) having 15 to 30 residents to take care of during any given shift. There were concerns that the residents were not receiving timely care, were not receiving showers and bed baths, call bells were not answered timely, and resident food was cold because staff did not pass out to residents in a timely manner. 2) Review of the Resident Census and Conditions CMS 672 form that was given to the surveyor from the Director of Nursing indicated that 97 of the 114 residents in the facility were either totally dependent on nursing staff for toileting or required the assistance of one or two nursing staff for assistance with toilet use. It was also documented that 100 of the 114 residents in the building were dependent on staff for bathing, 97 residents were totally dependent or required assistance of 1 to 2 staff for dressing, 102 residents required assistance for transferring, and 72 of the 114 residents were either totally dependent or required assistance of 1 or 2 staff members for eating. There were 61 residents documented with occasional or frequent incontinence of the bladder and bowel. There were 20 residents with a pressure ulcer greater than stage 1 and 7 of those were acquired in house with 81 residents receiving preventive skin care. There were 19 residents that had behavioral healthcare needs. 3) A review of Resident Council Meeting minutes dated 2/27/25 documented the concerns of GNAs not answering call bells as old news. A review of the 1/16/25 Resident Council Meetings documented old business as, nursing staff being short and the residents not getting proper care. New business for the month included, nursing staff being short, not enough nurses to care properly for the residents, nurses cutting off call bells without addressing the concern of the resident and putting double diapers on residents. A review of the 11/22/24 Resident Council Meeting Minutes documented old business as, call bells being on for extended amounts of time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the 9/26/25 Resident Council Meeting Minutes documented old business as, lack of staff, nurses/aides lack of quality of care, and call bells going unanswered. New business documented, it has been reported and acknowledged by the department heads that on September 26th that there has been a shortage of GNA's and CNA's which led to residents not being got up out of bed as sufficiently as residents would like, soiled linen being left in the resident rooms and trays being left on the cart for extended amounts of time causing food to be cold, when resident eat and when residents ask the aides to warm the food up in the kitchen, the food is not being warmed up. 4) Staff interviews: a) On 3/10/25 at 9:08 AM Staff #4 stated, staffing is not good. Sometimes there is only 1 GNA. There are increased falls and increased fights with residents. b) On 3/10/25 at 9:10 AM an interview with Staff #5 stated, staffing is not great. Sometimes we can't even get started until after 7:30 AM. We have at least 12 to 15 residents. It is a lot. c) On 3/10/25 at 9:12 AM Staff #18 stated, a lot of the time we work short. Most of the time there are just 2 of us. We have 17 to 18 residents each on day shift. We can't do a full bath. It is usually a partial bath and then we have to document. There are a lot of behaviors, and we have to redirect the residents. d) On 3/10/25 at 9:44 AM observation was made of the breakfast cart sitting in the 200 hallway. Resident #8 had complained of not receiving breakfast yet. An interview was conducted with Staff #20. Staff #20 stated, there are only 2 aides, and we have to take residents to dialysis and there is no one else to pass trays to 30 some people. That is the norm. We can't get to everything. e) On 3/10/25 at 3:55 AM Staff #21 stated they work short, and it is a problem when they need 2 people when using the Hoyer lift and need to spot each other. Staff #21 stated they could have 10 to 15 residents depending on the unit. f) On 3/11/25 at 9:35 AM Staff #16 stated that staffing is sometimes good and sometimes bad. Staff #16 stated that on the rehab unit a GNA typically has 15 patients on day shift. Staff #16 stated, last week there was a call out and I was by myself on the floor for 30 patients with an orientee until lunch time. g) On 3/11/25 at 9:40 AM Staff #15 stated, staffing is terrible. We can't give showers and cannot get enough time to get the residents clean. We have between 16 and 17 residents each. The residents don't just have dementia. They have psych issues, behaviors, and it clashes with the dementia residents. When we are short we don't get a break and can't get to some of the people until after lunch. h) On 3/11/25 at 1:00 PM Staff #19 stated they work short staffed. We can't give adequate care. There are just 2 of us for 30 residents during the day so that is 15 residents each. If there are only 2 of us on dialysis days then showers can't get done. i) On 3/17/25 at 8:55 AM Staff #44 stated, staffing, it is horrible. You work short. Normally on Chesapeake 3-11 or 11-7 we have 2 aides or 1 ½ and 1 might have 19 people. I work on Chesapeake and Wye Oak. Realistically, residents do not get turned every 2 hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	j) On 3/17/25 at 12:30 PM, during an interview, Staff #46 stated that there wasn ' t always enough staff to get her work done. Staff #46 reported that today the GNA ' s had 15-16 residents each to care for, they had to get residents ready for therapy and it also was a dialysis day. Staff #46 stated that on dialysis days, there was supposed to be someone to transport the residents back and forth to dialysis, but today, and most of the time they didn ' t have anyone to do this, so the aides had to transport their own residents. Staff #46 stated that when there is not enough staff, she can ' t give her residents showers and can ' t finish documentation. Staff #46 reported she had worked other shifts, and she thought they needed more staff on dayshift. k) On 3/17/25 at 3:40 PM Staff #53 was interviewed and asked about the note of 2/20/25 in Resident #8's medical record where it was documented, b/p (blood pressure) not obtained due to staffing. Staff #53 stated, we didn't have enough GNAs on the floor and [he/she] was not in favor of me. When you make accusations - I'm not going in there. [He/she] tells me I am harassing [him/her]. I brought it up to the administration and they say they will find more staff that can go in there. How my day goes, there was not enough staffing on the floor between GNAs and nurses. It was lunch time when I documented that note. I have 1,000 things going on. l) On 3/17/25 at 3:45 PM Staff #49 was interview and stated, we are short staffed. We can't give showers, do our documentation, rounds, a lot of falls and safety concerns. Staff #24 confirmed what Staff #49 stated. 5) On 3/17/25 at 10:09 AM a review of the facility assessment documented staffing was adequate based off a PPD of 3.0. With staffing, PPD stands for per patient day and refers to the amount of nursing hours allotted per day per resident. Staffing goals were to maintain a 3.0 PPD. Our companies PPD allowed is 3.24. The aides run a 15:1 ratio. Department heads that are licensed GNA's periodically assist w/ADLs. Maryland CO[DATE].07.02.19 states, A nursing home shall employ supervisory personnel and a sufficient number of support personnel to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week. Review of actual worked nursing staffing schedules revealed the facility failed to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week. This was evident for 6 of 8 days reviewed for July 2024, 3 of 5 days reviewed for October 2024, 6 of 8 days reviewed for November 2024, 5 of 26 days reviewed for January 2025, and 10 out of 19 days reviewed for February 2025. On 3/11/25 at 1:47 PM an interview was conducted with Staff #24, the nursing scheduler. She stated she has been in the position for the past 2 weeks. When asked about scheduling she said it has to be 3.0 PPD and can't go over 3.2 PPD, not in this building. The minimum is 2.8 PPD. Cross Reference CO[DATE] 6) On 3/11/25 at 2:22 PM observation was made of an unlocked and unattended medication cart on the dementia unit. The top drawer was opened by the surveyor and observation was made of resident's medications and a pair of scissors. There were residents ambulating in the dementia unit in the hallways and common area while the surveyor stood at the unattended medication cart. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the observation, Resident #16, who had a history of a fall out of Geri-chair on 8/1/24 at 4:30 PM, that resulted in an acute mildly displaced fracture of the tip of the nasal bones, was observed trying to get out of the Geri-chair that was located in the back of the common area of the unit. There were no nursing staff visible on the unit. Housekeeper (HK) #25 was the only staff member visible on the unit. Surveyor and Housekeeper intervention prevented Resident #16 from getting out of the Geri chair without assistance and prevented the other cognitively impaired residents on the dementia unit from accessing the unlocked medication cart until nursing staff could be found. This resulted in an Immediate Jeopardy situation. On 3/13/25 from 4:00 PM to 4:30 PM the surveyors had an extensive conversation with the Chief Operating Officer (COO) of the facility. A discussion occurred concerning issues related to staffing, food, lack of resident showers, resident dissatisfaction related to cold food and staffing. The COO stated understanding. On 3/18/25 at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the concern.7) On 3/13/25 at 8:30 AM, a review of complaint #MD00209282 alleged Resident #36 did not receive adequate care at the facility On 3/13/25 at 8:48 AM, during an Interview, when asked if there was enough staff available to get the care s/he needed without having to wait a long time, Resident #36 indicated that there wasn't always enough staff and sometimes it took 20 to 25 minutes for them to answer the call light. When asked what staff could not get done for him/her, Resident #36 stated that they never make his/her bed and only strip it about once a month. Resident #36 also stated that s/he did not always get a shower on his/her shower days, and staff had told him/her it was because they did not have enough help. The concerns with staffing were discussed with the Nursing Home Administrator (NHA) and Director of Nurses (DON) on 3/18/25 at 6:40 PM. The NHA and DON acknowledged the that concerns with inadequate staffing had been identified. Cross Reference F689

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined the facility failed to conduct yearly performance reviews at least every 12 months for 5 out of 5 personnel files (GNA #49, #52, #50, #51, #47) reviewed during a complaint survey. The findings include: A review was conducted of GNA personnel files on 3/17/25. A review of GNA #49's personnel file revealed GNA #49 was hired on 2/8/23. A review of GNA #52's personnel file revealed GNA #52 was hired on 7/12/22. A review of GNA #50's personnel file revealed GNA #50 was hired on 9/5/23. A review of GNA #51's personnel file revealed GNA #51 was hired on 2/3/23. A review of GNA #47's personnel file revealed GNA #47 was hirted on 8/23/20. There were no yearly performance reviews found in any of the personnel files. On 3/17/25 at 5:23 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA confirmed that they were behind on yearly reviews and education. The NHA stated that the new Director of Nursing had just started 2 weeks prior and would be putting processes in place for the yearly reviews.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 2) On 3/10/25 at 8:10 AM observation was made in the lobby of the posted nursing schedule for the day. The schedule on the table to the right of the door entrance documented the Staffing projected hours for 3/6/25. The form documented the census was 113 and the projected HPPD was 2.9. The posting had documented all 3 shifts. The staffing sheet had not been updated for 4 days. The Nursing Home Administrator and Director of Nursing were informed on 3/18/25 at 5:15 PM. Based on review of facility documentation, interview, and observation, it was determined the facility staff failed to maintain nursing staffing data. This was evident during a complaint survey. The findings include: 1) During review of complaints and facility reported incidents from January 2023 until January 2025 the Survey team asked the Administrator and Director of Nursing for daily nursing staffing sheets that include staff assignments, census and actual hours worked. Interview with the Administrator on 3/12/25 at 10:44 AM, the Administrator stated we do not have daily nursing staffing sheets until February 2025. The Administrator stated that is when we started to maintain the data.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of complaints, interview, and medical record review, it was determined the facility failed to provide timely medication to meet the needs of the residents. This was evident for 3 (#18, #8, #5) of 44 residents reviewed during a complaint survey. The findings include: 1) On 3/10/25 at 8:16 PM a review of Resident #18's medical record revealed Resident #18 did not receive the medication Escitalopram 20 mg. on 3/9/25 and 3/10/25 for depression due to the medication being on order. On 11/27/24, 11/28/24, 11/29/24, and 11/30/24, Resident #18 did not receive the transdermal patch Nicotine for smoking cessation and the patch was on order. On 3/13/25 at 8:28 AM an interview was conducted with Licensed Practical Nurse (LPN) #36. LPN #36 was asked what she did if a medication was not available. LPN #36 stated she would call the provider and let them know that the medication was not available or to see if they wanted to order an alternative. First I check the cubex. If it is a medication that requires prior authorization the DON (Director of Nursing) will handle and fax over to pharmacy. On 3/13/25 at 8:30 AM an interview was conducted with Certified Medicine Aide (CMA) #37. CMA #37 stated she would let the nurse know and she would see if she could get the medicine out of PIXUS system and put it in for a reorder. CMA #37 stated, I normally do re-orders 5 days prior to running out. Some do 8 days, 5 days, or 2 days prior to running out. Depends on the medicine aide. On 3/13/25 at 8:35 AM an interview was conducted with CMA #38 who stated, I check the bottom of the cart, tell the nurse, call the pharmacy, and then put in a 9 and document. We have had issues with the pharmacy. I usually reorder 2 weeks out. 2) On 3/17/25 at 11:15 AM a review of complaints received from Resident #8 alleged that in February 2025 the resident's Naproxen (2) 250 mg. tablets for pain were not available. Review of emar (electronic medication administration record) notes documented the Naproxen was on order 2/7/25 at 10:00 PM and not available. A 2/8/25, 2/9/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, and 2/15/25 documented awaiting delivery. Further review of Resident #8's medical record revealed in April 2024, Zinc 50 mg. was not available on 4/17/24 as awaiting delivery from pharmacy along with Garlic 0.5 mg. On 4/19/24 Vitamin D3 and Garlic 0.5 mg were not available, and the nurse was following up with the medication. On 4/20/24 Vitamin D3 and Garlic 0.5 mg were being followed up by the nurse and not available. On 4/22/24, 4/23/24, and 4/25/24 the medication was on order and awaiting pharmacy. The 4/25/24 note documented, this medication will be in on 4/26/24 per the pharmacy. On 3/18/25 at 6:30 PM the concern was discussed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) who stated they were working on the issue. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 3/12/25 at 5:30 PM a review of complaint MD00213409 alleged that Resident #5 was having a hard time receiving medications that were prescribed. Review of Resident #5's medical record revealed a medication administration note dated 10/4/24 that documented the medication Gilenya 0.5 mg for multiple sclerosis was on order and not available. The pharmacy was called to confirm reorder. On 10/6/24 a note documented Oxycontin 10 mg. was not given as it was not available and awaiting pharmacy. A 10/7/24 documented Oxycontin 10 mg, medication not yet received by pharmacy. A 12/19, 12/20, 12/21, 12/22, 12/23, and 12/25/24 notes documented the medication Gilenya 0.5 mg was on order and the pharmacy was awaiting for prior authorization form from the facility. A 12/26/24 and 12/27/24 note documented, medication is currently not available. Confirmed with pharmacy that medication is on order but pending a prior authorization form from the facility. The situation has been communicated to the ADON and Unit Manager for further follow-up and resolution. A second note dated 12/27/24 documented, prior auth faxed for Fingolimod (Gilenya) sent today. A 12/29/24 note documented, medication on order. Pharmacy contacted; delay due to pending prior authorization form from the facility. A 12/31/24 note documented, Medication on order. Pharmacy contacted; delay due to pending prior authorization from the facility. ADON and NP made aware. The facility failed to have a process in place to ensure that medications that required preauthorization forms were followed up on timely. On 3/18/25 at 6:30 PM the concern was discussed with the DON and NHA.

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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 medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to follow physician ordered blood pressure parameters for administering a blood pressure medication. This was evident for 1 (#3) of 44 residents reviewed during a complaint survey. The findings include: On 3/14/25, at 9:00 AM, a review of complaint # MD00214414 alleged that Resident #3's representative was not notified when a new medication was prescribed for the resident or prior to the resident receiving the new medication. On 3/14/25 at 10:00 AM, a review Resident #3's electronic medical record) (EMR) revealed Resident #3 was admitted to the facility in late December 2024 following an acute hospitalization and discharged from the facility in late February 2025. The medical record documented that Resident #3 had multiple diagnoses including hypertension (high blood pressure (BP), cirrhosis of liver (scarring of liver), hepatic encephalopathy (brain disorder caused by liver dysfunction), kidney failure, and received hemodialysis (procedure to remove waste products and excess fluid from the body). 1) Review of Resident #3's January 2025's medication administration record (MAR) revealed a 1/25/25 order for Amlodipine (Norvasc) (treats high BP) by mouth 1 time a day for hypertension, hold for systolic (top number of a BP reading) less than 110, that was discontinued on 1/27/25. The January MAR documented that Resident #3 was given Amlodipine when the resident's systolic blood pressure was outside of parameters on 2 (1/25, 1/26) of 3 administrations days in January. The MAR documented on 1/25/25, at the hour of Day, Resident #3's BP was 101/66 and the medication was given and not held when the resident's systolic bp was outside of parameters, and the MAR documented on 1/26/25, at the hour of Day, Resident #3's BP was 102/76 and the medication was given and not held when the resident's systolic bp was outside of parameters. The facility failed to follow the physician's order by administering the medication when the resident's BP was outside of the ordered parameters 2) Review of Resident #3's February 2025 MAR revealed a 1/31/25 order for Midodrine (treats low BP) by mouth one time a day every day, Monday, Wednesday, Friday, for hypotension (low BP). Hold for systolic BP greater than 140, that was discontinued on 2/27/25. The February MAR documented that Resident #3 was given Midodrine on 11 (2/3, 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, 2/28) of 11 administration times in February, with no documentation found in the MAR to indicate the resident's blood pressure (BP) was monitored prior to the administration of Midodrine. 3) Further review of Resident #3's February 2025 MAR revealed a 1/31/25 order for Propranolol (Inderal) (treats high blood pressure) by mouth two times a day for hypertension, hold for systolic BP less than 110, that was discontinued on 2/27/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The February MAR documented that Resident #3 was given Propranolol at 8:00 AM on 25 (2/1, 2/3, 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22, 2/23, 2/24, 2/25, 2/26) of 26 administrations in February, with no documentation to indicate the resident's BP was monitored prior to the administration to Propranolol. The February MAR documented Resident #3 was given Propranolol at 5:30 PM on 22 (2/1, 2/2, , 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/22, 2/23, 2/24, 2/25, 2/26) of 25 administrations in February with no documentation to indicate the resident's BP was monitored prior to the administration to Propranolol. The facility failed to follow the physician's order by failing to monitor Resident 3's BP prior to administering the medication, then potentially holding the medication if the BP was outside of the ordered parameters. On 3/18/25 at 4:44 PM, the above concerns were discussed with the Director of Nurses (DON). The DON acknowledged the concerns and offered no further comments at that time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary psychotropic medication. This was evident for 1 (#12) of 44 residents reviewed during a complaint survey. The findings include: Schedule II (C2) controlled drugs refer to drugs with a high potential for abuse and addiction that are regulated by the government and include anxiolytic (anti-anxiety) benzodiazepine medication and opioid (analgesic) (narcotic) medication. A psychotropic describes any drug that affects behavior, mood, thoughts, or perception On [DATE] at 9:00 AM, a review of complaint #MD00209003 alleged Resident #12, who was terminally ill, but not on hospice or receiving palliative care, was prescribed and administered Ativan (anxiolytic) and Morphine (Opioid) for end of life , without notifying the resident's representative, and obtaining consent. The complaint alleged that giving the medications together contributed to Resident #12's respiratory failure, and lead to the death of the resident. The complaint also alleged the facility staff failed to notify Resident #12's representative timely when the resident was transferred to the hospital. A review of Resident #12's electronic medical record (EMR) revealed Resident #12 was admitted to the facility in mid-[DATE] following a transfer from a sister facility and had multiple diagnoses, including hepatocellular carcinoma (liver cancer) and hepatic encephalopathy (brain disorder caused by liver dysfunction), and a history of blood transfusions. The resident was discharged from the facility following his/her transfer to the hospital 3 days after admission. Resident #12 had a MOLST (Maryland Orders for Life Sustaining Treatment) form that was signed and dated [DATE] and documented Resident #12 elected to Attempt CPR, indicating the resident was a full code. In a Nurse Practitioner (NP) Progress Note on [DATE] at 12:30 PM, Staff #64 NP documented Resident #12 was being transferred from another facility to the current facility on that day, and the NP was very familiar with Resident #12 because the NP provided care to him/her at the other facility. The NP wrote that Resident #12 was currently full code, that resident's declining condition was discussed with the Director of Nurses (DON) (Staff #78) and the DON would discuss end-of-life (EOL) care, which they believed was appropriate, with the resident's representative. The NP further wrote that s/he left C2 (controlled drugs) prescriptions for EOL medications with the DON because an NP on site [in the facility] tomorrow, with the stipulation that Resident #12's code status was changed to reflect this. On [DATE] at 6:41 PM, a review of Resident #12's [DATE] Medication Administration Record (MAR) revealed orders for 2 psychotropic medications to be administered as needed for symptoms related to end of life symptoms. Resident #12's [DATE] MAR documented: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An [DATE] order for Lorazepam (Ativan) (Anxiolytic) by mouth every 2 hours as needed for restlessness; agitation related to end of life for 14 days that was documented as given on [DATE] at 11:41 PM, and [DATE] at 1:00 AM - An [DATE] order for Morphine Sulfate (Opioid) (narcotic) oral solution by mouth every 2 hours as needed for dyspnea (shortness of breath) and end of life care with a start date of [DATE] at 12:15 PM was documented as given on [DATE] at 1:00 AM. Both the Lorazepam and Morphine orders had been entered into the EMR by the NP, Staff #64 Continued review of Resident #12's medical record failed to reveal documentation to that prior to initiating psychotropic medication, the resident and/or resident representative was informed of the risks and benefits of the medication and consent obtained, and no documentation was found in the medical record to indicate end of life care for Resident #12 discussed with the resident's representative prior to initiating the medications. In addition, there was no further documentation in the medical record to indicate the NP, Staff #64, followed up with the resident, the resident's responsible party or the DON following the implementation of the orders. On [DATE] at 12:47 PM, during an interview, Staff #64, NP stated s/he had not seen Resident #12 after s/he arrived to the current facility, however s/he knew him from the previous facility. Staff #64 stated Resident #12 was very sick, and the NP had numerous discussions with the family about the residents health. Staff #64 stated that the resident was nearing the end of life, that his/her MOLST was full code, and the NP had attempted to talk to the family. The NP stated s/he spoke with the DON who said s/he would talk family about changing Resident #12's code status and the NP wanted prescriptions available if the resident's MOLST was changed to palliative care and was concerned a provider would not be available to write the prescriptions. The NP stated s/he wrote the prescriptions for morphine and lorazepam for Resident #12 for palliative care and EOL and gave the physical prescriptions to the DON with the stipulation they would be available if the MOLST was changed, the resident was in a lot of pain, or something changed. The NP indicated s/he didn't think the prescriptions would be sent to the pharmacy until the resident's MOLST was changed and confirmed that s/he entered the orders for the in the EMR as active orders. On [DATE] at 2:45 PM, the above concerns were discussed with the Medical Director, Staff #9, Physician, who stated s/he remembered the resident very well. At that time, Staff #9 expressed concerns with Resident #12 being administered the lorazepam and morphine for end of life care while s/he was a full code, and indicated the EMT's should have given the resident Narcan (medication that reverses Opioid overdose). On [DATE] at approximately 4:50 PM, the attending physician, Staff #66, was made aware of the above findings. Staff #66 stated that s/he became aware Resident #12 had been put on Ativan and Morphine when he saw the resident following his/her transfer to the facility, The physician stated s/he thought the NP wanted something more for the resident's pain and it never entered his/her head that the medications were for end-of-life, and Resident #12's family didn't want that. The physician stated that it was the providers job to talk to the families and s/he would never have left signed prescription for end-of-life care without first talking to the family. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above concerns were discussed with the Director of Nurses (DON) and Nursing Home Administrator (NHA) on [DATE] at 6:00 PM. The DON acknowledged the concerns at that time and offered no further comments. Cross Reference F550, F658

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, interviews and review of pertinent documentation, it was determined the facility failed to keep residents free from a significant medication error by failing to ensure medication was available in a timely manner for the facility to administer, and failing to accurately document when medications were not given or not available. This was evident for 1 (#3) of 44 residents reviewed during a complaint survey. The findings include: On 3/14/25, at 9:00 AM, a review of complaint # MD00214414 alleged the facility failed to inform and acquire consent from Resident #3 and his/her responsible party, when a medication was ordered for the resident, and prior to Resident #3 being given the medication. At 3/14/25 at 10:00 AM, a review Resident #3's electronic medical record) (EMR) revealed Resident #3 was admitted to the facility in late December 2024 following an acute hospitalization and discharged from the facility in late February 2025. The medical record documented that Resident #3 had multiple diagnoses including hypertension (high blood pressure (BP), cirrhosis of liver (scarring of liver), hepatic encephalopathy (brain disorder caused by liver dysfunction), kidney failure, and received hemodialysis (procedure to remove waste products and excess fluid from the body). Review of Resident #3's January 205 electronic Medication Administration Record (eMAR) revealed a 12/27/24 order for Rifaximin 500 MG tablet by mouth two times a day, at 8:00 AM and 8:00 PM for encephalopathy. The MAR was signed off with the code 9 (other/see nurses notes) 12 (1/3, 1/12, 1/13, 1/19, 1/21, 1/22, 1/23, 1/25, 1/28, 1/29, 1/20 1/31/25) of 31 administrations scheduled at 8:00 AM, and 7 (1/12, 1/23, 1/24, 1/27, 1/28, 1/20, 1/31/25) of 31 administration times scheduled at 8:00 PM in January, indicating 19 of 62 scheduled administration times in January, Resident #3 was not given Rifaximin as ordered. Resident #3's February 2025 MAR documented the Rifaximin 500 MG tablet by mouth two times a day, at 8:00 AM and 8:00 PM for encephalopathy that was signed with the code 9 on 4 (2/1, 2/3, 2/4, 2/5/25) of 5 administration times scheduled at 8:00 AM, and on 1 (2/3/25) of 5 administration times scheduled at 8:00 PM. When the medication administration is coded 9, the medication order populates in an administration note in the EMR for the practitioner to document pertinent information when medication was not given. Review of the Resident #3's order administration notes for when the Rifaximin order was signed 9, revealed Rifaximin was not available in the facility for the staff to administer to the resident. The Rifaximin order administration notes documented the following - on 1/3/25 at 8:04 AM, awaiting delivery, nurse made aware. - on 1/12/25 at 8:51 AM, reorder, nurse aware. - on 1/12/25 at 7:35 PM, medication on order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 1/13/25 at 9:05 AM not on hand, not in back up, med reordered from pharmacy. - on 1/19/25 at 9:12 AM, pending pharmacy delivery, nurse aware. - on 1/21/25 at 8:45 AM, medication has been ordered. waiting on pharmacy. - on 1/22/25 at 8:47 AM, reorder, nurse aware. - on 1/23/25 at 8:31 AM, waiting for approve, on 1/23/25 at 5:38 PM, the note documented, on order. - on 1/24/25 at 7:22 PM, medication on order - on 1/25/25 at 7:47 AM, medication on order, nurse aware. - on 1/27/25 at 7:42 PM, on order. - on 1/28/25 at 11:24 AM, not on hand, not in backup, waiting on payment authorization. - on 1/28/25 at 9:29 PM, medication has been ordered; waiting on pharmacy. - on 1/29/25 at 9:19 AM, waiting on payment authorization. - on 1/30/25 at 10:43 AM pharmacy is waiting on payment authorization. - on 1/31/25 at 2:29 AM, there was no provider documentation. - on 1/31/25 at 9:02 AM, on order. - on 2/1/25 at 12:51 PM, the medication was not given, the pharmacy was notified and stated they need a authorization form signed by our facility. The nurse is aware. - on 2/3/25 at 1:37 PM, not on hold, not in back up, awaiting authorization. - n 2/3/25 at 7:30 PM on order. - on 2/4/25 at 8:27 AM, med on order, and - on 2/5/25 at 8:31 AM, awaiting delivery, nurse aware. Continued review of Resident #3's EMR revealed, on 1/31/25 at 8:03 PM, in a Nurse Practitioner (NP) follow-up note, Staff #77, NP, wrote that Resident #3 was seen that day, the resident continued with lethargy and low blood pressure, the resident should be taking Rifaximin every day for hepatic encephalopathy. The NP wrote that, per the staff, the resident had not received Rifaximin, that authorization was needed because of the expense. The NP wrote s/he spoke with management and was told the medication was approved and the resident would receive it. The NP further wrote the resident's lethargy could be from not getting his/her prescribed Rifaximin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a NP follow-up note on 2/3/25 at 11:17 PM, Staff #77, NP, wrote that Resident #3 was seen that day, the resident appeared lethargic, and his/her lethargy could be hepatic encephalopathy. The NP wrote that s/he spoke with the nurse, and the resident was not getting Rifaximin because the medication was not available, however staff had signed [in the MAR] that Rifaximin had been given to the resident. On 3/18/25 at 4:44 PM, during an interview, the above concerns were discussed with Staff #66, Attending Physician. At that time, Staff #66 stated he/she had not been aware that Resident #3 was not given Rifaximin as ordered, that s/he assumed the resident was taking the medication. Staff #66 also stated that the physician should be called any time a resident was out of medication, On 3/18/25 at 6:35 PM, the Director of Nurses (DON) and Nursing Home Administrator (NHA) were made aware of the concern that the facility failed to ensure prescribed medication was available to be administered, resulting in Resident #3 not receiving Rifaximin as prescribe. The DON & NHA acknowledged the concerns at that time, with no other comments offered. The surveyor then requested pharmacy documentation of when Rifaximin was dispensed and became available in the facility to give to Resident #3. On 3/19/25, the surveyor reviewed a pharmacy invoice that listed the medications the pharmacy dispensed to the facility for Resident #3 from 2/27/24 to 2/25/25. The pharmacy invoice documented the date Rifaximin 550 MG tablets were dispensed to the facility, the number of tablets dispensed on that date and the days the doses would cover as follows: - 6 tablets dispensed, for 3 days on 12/27/24. - 6 tablets dispensed for 3 days on12/30/24. - 6 tablets dispensed for 3 days on 1/3/25. - 8 tablets dispensed for 4 days on 1/7/25. - 8 tablets dispensed for 4 days on 1/13/25. - 28 tablets dispensed for 14 days on 2/5/25. - 28 tablets dispensed for 14 days on 2/20/25. The pharmacy invoice documented a total of 22 doses of Rifaximin were dispensed in January 2025, and Resident #3's January 2025 MAR, documented Rifaximin was given to the resident on 43 of 62 administration times scheduled in January. A concurrent review of the Rifaximin dispensing record and the resident's January MAR revealed staff documented Rifaximin was administered to the resident when the medication was unavailable in the facility on 18 of 43 scheduled administration times in January. Rifaximin was inacurately documented as given on 6 (1/7, 1/18, 1/20,1/24, 1/26, 1/27/25) administration times scheduled at 8:00 AM, and 12 (1/2, 1/6, 1/11, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/25, 1/26, 1/29/25) administration times scheduled at 8:00 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at approximately 1:00 PM, the DON was made aware of the concern with Resident #3 not being given Rifaximin as prescribed, and the concern with staff documenting the medication had been administered when there was no evidence the medication had been available to give. The DON acknowledged the concerns, and indicated she was aware of staff who may have falsely documented the medication administration in the MAR.

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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. Based on observation and staff interview, it was determined that facility staff failed to keep medication carts locked when unattended. This was evident on 1 of 3 nursing units observed during a complaint survey. The findings include: On 3/11/25 at 2:22 PM observation was made of an unlocked and unattended medication cart on the Homestead Unit, which is a locked memory care unit. The unattended medication cart was sitting next to the nurse's station which was adjacent to the dining/activity room. The top drawer of the medication cart was opened by the surveyor and observation was made of resident's medications and a pair of scissors on the left-hand side of the drawer. Subsequent drawers were opened by the surveyor and observation was made of anti-hypertensive, anti-psychotic, anti-depressants, and other varieties of medications. There were residents ambulating in the unit in the hallways and the dining/activity area. There was no nursing staff available in the unit. The surveyor stood at the medication cart until 2:29 PM when the AIT (Administrator in Training) came back to the unit and walked up and saw the medication cart and attempted to lock it while the surveyor stood there. At that time the surveyor asked where the nurse on the unit was. The AIT said he would get the unit manager (UM). He was asked again where the nurse on the unit was, and he said I'll get the unit manager. On 3/11/25 at 2:30 PM the unit manager walked up to the surveyor and the surveyor asked where the nurse on the unit was. UM #28 stated the nurse on the unit left early and the UM was responsible for 2 units. It was revealed that UM #28 was doing patient care on another nursing unit at the time. The surveyor informed UM #28 that the medication cart was left unlocked and unattended and the surveyor was able to open all the drawers. At that time UM #28 locked the medication cart. The Nursing Home Administrator and the Director of Nursing were informed on 3/11/25 at 4:45 PM.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of resident council minutes, observations and interviews, the facility staff failed to prepare and serve food that was palatable, attractive and at a safe and appetizing temperature. This was evident for 5 (#9, #41, #42, #43, #36) of 44 residents interviewed and during a test tray observation during a complaint survey. The findings include: 1) During interview with Resident #9 on 3/11/25 at 7:00 AM, Resident #9 complained the food was bad and not getting what is on the menu. The Surveyor noted the menu posted on the Chesapeake Unit stated lunch was salisbury steak, parsley potatoes, butter carrots, dinner roll and vanilla pudding. Observation of Resident #9's lunch meat tray ticket on 3/11/25 at 12:20 PM said diet: bite sized, double portion. Observation of Resident #9's lunch tray at that time revealed it contained ground up meat with gravy, diced hash browns and vanilla pudding. The tray did not contain carrots or any vegetable or a dinner roll. The Dietary Manger was brought to the Chesapeake Unit to observe Resident #9's lunch tray on 3/11/25 at 12:40 PM and confirmed the meat was ground and it did not contain a vegetable or roll. 2) Interview with Resident #42 on 3/11/25 at 12:30 PM, Resident #42 stated he/she does not get what he/she orders. The Surveyor returned on 3/11/25 for dinner service and the Resident stated he/she ordered Kielbassa and mashed potatoes but instead the Surveyor observed Resident #42 was served what appeared to be a piece of Salisbury steak with gravy and cabbage on the side. The Surveyor observed Resident #9 (Resident #42's roommate) was served Kielbassa and mashed potatoes. Interview with Resident #42 on 3/11/25 at 6:15 PM, Resident #42 stated when you are in a place like this you look forward to getting your meals but not here since I never get what I asked for. 3) Interview with Resident #43 on 3/14/25 at 11:25 AM, the Resident stated he/she is unhappy with the taste of the food and that is cold when it is supposed to be hot. 4) Interview with Resident #41 on 3/17/25 at 11:00 AM, the Resident stated he/she is tired of not getting what he/she orders and that the food is cold. 5) The Surveyor reviewed 4 recent Resident Council Meeting minutes provided by the Administrator. Review of the Resident Council Meeting minutes on 9/26/24 the residents complained the trays were brought out late, cold and sometimes the wrong food on trays. In the 11/22/24 Resident Council meeting residents discussed food being served cold and frozen on the weekends and that is not on the resident's menus. In the 1/16/25 Resident Council Meeting minutes the residents discussed proper food is not being put on the trays and they are not getting what they ask for on the menus. In the 2/27/25 Resident Council Meeting minutes the residents discussed cold food being served at meals and residents not getting the food they filled out on the menus. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 3/17/25 at 12:58 PM the Surveyor did a temperature reading of a test tray with the Dietary Manager present. The Surveyor waited on the Chesapeake Unit and when the dining cart arrived the Surveyor immediately pulled a regular tray and checked the temperatures. Noodles with a beef gravy had a temperature of 119 degrees and mixed vegetables had a temperature of 104 degrees. Hot foods are to be served at 135 degrees. The Surveyor reviewed the findings with the Administrator on 3/17/25 at 2:00 PM. 7) On 3/13/25 at 8:48 AM, during an Interview, when asked if s/he had any concerns with the meals provided by the facility, Resident #36 stated the food provided by the facility tasted good, however what is on the tray is not always what you wanted, and the food was usually cold. Resident #36 stated that residents fill out daily menu papers and select the food they would like at each meal, and stated that most of the time, the food was what you ordered. Resident #36 stated that the food tasted good, however it was usually cold and it's not what you wanted. The above concerns were discussed with the Director of Nurses (DON) on 3/18/25 at approximately 6:45 PM. The DON acknowledged the concerns at that time with no further comments offered.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on resident complaint, record review, and staff interview, it was determined that the facility staff failed to provide a resident with a bedtime snack and 3 meals daily. This was evident for 2 (#8, #10) of 44 residents reviewed for complaints during a complaint survey. The findings include: 1) On 3/10/25 at 9:30 AM an interview was conducted with Resident #8 who complained he/she was not always getting an evening snack. On 3/17/25 at 11:15 AM a review of complaint MD00204843 alleged Resident #8 had not been given any food the day before. Review of Resident #8's medical record revealed a physician's order for peanut butter crackers 3 times daily and as needed. On 3/18/25 at 11:06 AM Staff #30, the Dietary Director was interviewed and stated the resident received beer battered fish for breakfast, lunch, and dinner per his/her request along with peanut butter crackers. Staff #30 stated that there were a lot of times the resident would tell her that he/she didn't get fish, however the food cart would come back and the fish was in there. Staff #30 stated she would go back and warm it up and the resident would tell her that they don't give it to him/her but she couldn't prove that. Staff #30 stated there were a lot of times Resident #8 would call and ask for peanut butter crackers because the resident takes medication with the crackers. Staff #30 stated that the staff go down around 7 PM and take his/her snacks down. Staff #30 stated that she does hear that the snacks don't make it there and she will check the refrigerator and the snacks are still in the pantry on the floor. She stated, I am assuming they aren't passing them. My staff will bring back trays of nourishments. I have voiced my concerns about that to the administrator. She said this was happening in December 2024 and January 2025. On 3/18/25 at 5:15 PM the Nursing Home Administrator and Director of Nursing were informed of the issue with snacks being passed at night.2) On 3/11/25 at 2:14 PM, a review of complaint #MD00212207 alleged that on 2 days (11/24/23, 11/25/23) following Resident #10 admission to the facility, the resident was not provided with a meal. Following review of the complaint, a review of Resident #10's medical record revealed Resident #10 was admitted to the facility for rehab in November 2023 following an acute hospitalization for right knee patellar fracture and patellar tendon repair. The medical record documented Resident #10 had multiple diagnoses including hypertension, diabetes, COPD (chronic obstructive pulmonary disease). (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's November 2023 Documentation Survey Report revealed the intervention, Nutrition - amount Eaten which was followed by the times, 9:00 AM, Day (7-3), 1:00 PM, Day, (7-3) and 6:00 PM, Evening, (3-11) then followed by a space to document the percentage of the meal eaten by the resident during those times for each day of the month. The report documented that on 11/24/23 at 6:00 PM (evening, 3-11) Resident #10 consumed 75% of a meal. However, on 11/25/23, during 7 AM to 3:00 PM, there was no documentation to indicate the resident had eaten anything. On 11/25/24 at 9:00 AM Day, (7-3) and on 11/25/23. Day (7-3) the spaces to document the percentage of the meal eaten were blank, with no documentation to indicate Resident #10 consumed any portion of a meal, or beverage, with no documentation to indicate the resident had eaten a meal at those times. On 3/19/25 at approximately 8:30 AM, the surveyor asked Staff #30, Dietary manager for a copy of the meal tickets for any meals provided to Resident #10 on 11/24/23 and 11/24/23. On 3/19/25 at 9:00 AM, Staff #30 reported meal tickets for Resident #10 were not able to be printed for the resident for dates requested because the resident had been discharged from the facility. Staff #30 was made aware of the allegation that meals were not provided to Resident #10 on 11/25/23, and the concerns with no documentation to indicate the resident been provided breakfast or lunch on that day. Staff #30 acknowledged the concerns and indicated there was no evidence to indicate a meal had been provided to the resident on that date.

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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 and interviews with staff it was determined that the facility failed to store food and monitor temperatures in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared in the facility's kitchen. The findings include: Due to multiple complaints of food quality, the Surveyor began a kitchen tour with the Dietary Manager on 3/17/25 at 9:20 AM. At that time the Surveyor observed the following concerns and the Dietary Manager confirmed: In the dry storage area was a large bag of cornmeal on the bottom shelf. The bag had a ripped open area that was not sealed. 4 large containers of dry goods located on the floor labeled thick it, flour, panko and sugar. None of the 4 large containers were dated to be able to determine how long the dry goods had been in the bins. A plastic container of walnuts had a crack in it, not allowing it to be sealed. In the freezer was a tray of 16 individual plastic containers of sherbert that were not dated. The sink next to the food prep area did not contain soap. Review of the temperature logs revealed no daily temperatures recorded for the reach in refrigerator, walk in refrigerator and freezer daily from 3/1 through 3/17/25. During interview with the Dietary Manager at that time, the Dietary Manager stated I told staff they need to record the temperatures here daily. Follow up interview with the Dietary Manager on 3/17/25 at 9:35 AM, the Dietary Manager stated the cook recorded the temperatures in a notebook and accidentally took the notebook home yesterday. The findings were reviewed with the Administrator on 3/17/25 at 10:20 AM.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with the administrator, the facility failed to make an appointment for a resident to have a sleep study done so a CPAP can be ordered for a diagnosis of sleep apnea. This is evident for 1 (#29) of 44 residents reviewed during a complaint survey. The findings include: On 3/10/25 at 11:18 AM a medical chart was reviewed for Resident #28. Resident was admitted [DATE] and discharged on 2/23/24. On 1/20/24 Doctor ordered a sleep study to be scheduled to rule out sleep apnea. The order was taken off by the former Director of Nursing, however the appt. was never made. I spoke to the current administrator who was not here during that time and has no information regarding Resident #28. The former DON is no longer here to discuss Resident #28 to see why apt. was not made. Resident was discharged to another facility on 2/23/24.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) On [DATE] at 11:15 AM a review of Resident #8's medical record revealed geriatric nursing assistant (GNA) tasks for bathing. Review of bathing records for Resident #8 documented that Resident #8 received a bed bath for 12 of 30 days in [DATE]. Review of the geriatric nursing assistant (GNA) bathing task for [DATE] revealed blank spaces for the 7-3 shift on 9/1, 9/4, 9/5, 9/6, 9/8, 9/9, 9/11, 9/16, 9/18, 9/19, 9/21, 9/22, 9/23, 9/24, 9/25, 9/27, and [DATE]. There were blank spaces for the 3-11 shift on 9/2, 9/8, 9/9, 9/11, 9/13, 9/17, 9/18, 9/20, 9/23, 9/26, and [DATE]. There were blank spaces for the 11-7 shift on 9/2, 9/11, 9/14, and [DATE]. Review of bathing records for Resident #8 documented that Resident #8 received a bed bath for 13 of 31 days in [DATE]. Review of the GNA bathing task for [DATE] revealed blank spaces for the 7-3 shift and there were 7 days of documented refusals. There were no bed baths documetned on 10/1, 10/3, 10/4, 10/5, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/18, 10/19, 10/21, 10/22, 10/29, 10/30, and [DATE]. There were blank spaces for the 3-11 shift for 10/1, 10/4, 10/10, 10/14, 10/15, 10/18, 10/19, 10/21, 10/26, and [DATE]. There were blank spaces for the 11-7 shift for 10/3, 10/4, 10/5, 10/9, 10/10, 10/14, 10/16, 10/18, 10/23, and [DATE]. Review of bathing records for Resident #8 documented that Resident #8 received a bed bath for 14 of 30 days in [DATE]. Review of the geriatric nursing assistant (GNA) bathing task for [DATE], there were blank spaces for the 7-3 shift on 11/3, 11/8, 11/16, 11/17, 11/21, 11/22, 11/24, and [DATE]. There were blank spaces for the 3-11 shift for 11/1, 11/2 11/,3 11/6, 11/13, 11/14, 11/15, 11/16, 11/20, 11/21, 11/29, and [DATE]. There were blank spaces for the 11-7 shift for 11/16, 11/25, 11/26, 11/27, 11/28, 11/29, and [DATE]. Review of bathing records for Resident #8 documented that Resident #8 received a bed bath for 12 of 31 days in [DATE]. Review of the geriatric nursing assistant (GNA) bathing task for [DATE], there were blank spaces for the 7-3 shift on 12/4, 12/6, 12/12, 12/15, 12/24, 12/25, 12/26, 12/27, 12/29, and [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were blank spaces for the 3-11 shift for 12/2, 12/4, 12/8, 12/10, 12/14, 12/15, 12/19, 12/21, 12/24, 12/25, 12/28, 12/29, 12/30, and [DATE]. There were blank spaces for the 11-7 shift for 12/1, 12/2, 12/4, 12/9, 12/11, 12/12, 12/13, 12/16, 12/19, 12/20, 12/21, 12/24, 12/27, 12/28, 12/29, 12/30, and [DATE]. On [DATE] at 1:55 PM an interview was conducted with LPN #28. LPN stated that GNAs document if they give a shower or bed bath or if the resident refuses. LPN #28 stated that if a resident refuses a bed bath or shower then the GNAs were to tell the nurse, and the nurse was to document. On [DATE] at 7:05 AM an interview was conducted with the Director of Nursing (DON). The DON was asked if a resident was bedridden should a bed bath be offered or given every day. The DON stated that a bed bath should be given every day with AM care. If it is refused it should be documented. There should not be any blank spaces on the GNA documentation. 4) On [DATE] at 9:52 PM a review of facility reported incident MD00208337 was conducted and revealed Resident #17 was found to have a right hip fracture on [DATE]. Resident #17 was sent to the hospital on [DATE] and according to the facility and the census tab of the electronic medical record, Resident #17 never returned to the facility. Review of Resident #17's progress note section of the medical record revealed a [DATE] at 6:43 AM administration note documented, sent to ER. Review of a [DATE] at 16:01 (4:01 PM) physician's progress note doumented the resident was seen on [DATE] and documented, chief complaint and documented that the resident was sent to the ER from the facility on [DATE] s/p fall and had a mildly displaced femoral neck fracture. The family preferred conservative management. The patient was without complaints. The note had a history, medications, review of systems, and assessment and plan. The document was signed by Physician #66. Review of a [DATE] at 9:24 AM physician's progress note documented a date of service [DATE] as a discharge note and that Resident #17 had expired at 2:26 PM. Death certificate completed. On [DATE] at 8:37 AM an interview was conducted with the MDS Coordinator and she was asked why she did not do a reentry on Resident #17 when the resident came back from the hospital. The MDS Coordinator reviewed Resident #17's medical record with the surveyor and confirmed the physician's note of [DATE] was not for the resident seen at the facility as the resident never returned from the hospital. The physician then wrote a note for [DATE] that said the resident had expired. The MDS Coordinator stated it was the wrong resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:10 PM an interview was conducted with Physician #66 and he was asked how he saw Resident #17 on [DATE] at the facility when the resident was never readmitted to the facility from the hospital. Physician #66 looked extensively in his phone and at first kept insisting that he saw the resident. Physician #66 continued to look at the electronic medical record system and said there must have been 2 people with a similar last name. Physician #66 was adamant that when he did the death certificate that he took that very seriously and put the note in the resident's chart. The surveyor asked Physician #66 if Resident #17 was admitted to the sister facility and he just documented in the wrong system. Physician #66 looked at the sister facility's electronic system from his phone and stated Resident #17 was not admitted there. There were no other facility's that Physician #66 went to. Physician #66 stated, the only explanation is that I put it in about another patient. It was an innocent mistake. It is not something I take lightly. The software we use there are names that are similar. I must have mixed up with another patient. On [DATE] at 4:48 PM the Nursing Home Administrator stated she found out Resident #17 was re-admitted to their sister facility and passed away there. Physician #66 was informed and stated he must have clicked on the wrong facility when he wrote the notes. Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 4 (#30, #4, #8, #17) of 44 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) Review of Resident #30's medical record on [DATE] revealed the Resident was admitted to the facility in [DATE] and left the faciity on [DATE]. Further review of the Resident's medical record revealed no note or assessment at discharge to include where the Resident was discharged to and Resident's status at discharge. Interview with the Director of Nursing on [DATE] at 5:28 PM confirmed the facility staff failed to document the discharge of Resident #30 on [DATE]. 2) Review of Resident #4's medical record on [DATE] revealed the Resident was admitted to the facility in [DATE] and left the faciity on [DATE]. Further review of the Resident's medical record revealed no note or assessment at discharge to include where the Resident was discharged to and Resident's status at discharge. Interview with the Director of Nursing on [DATE] at 2:45 PM confirmed the facility staff failed to document the discharge of Resident #4 on [DATE].

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on review of resident council meeting minutes and interview, it was determined the facility failed to employ a qualified social worker on a full time basis. Failure to have a qualified social worker has the potential to affect all the residents of the facility. This was evident during a complaint survey. The findings include: Review of Resident Council Meeting minutes from January and February 2025 provided by the Administrator revealed the residents discussed not being able to see social workers to address concerns about their case. Interview with the Social Work Assistant (SWA) on 3/12/25 at 11:06 AM, the SWA stated she works at the facility part time 3 days a week and the other 2 days the Regional Social Worker comes to the facility. The SWA stated she is currently pursing her Associate's degree in nursing and does not have a Bachelor's degree in social work or a human services field. The SWA stated she was unable to hold any care plan meetings in January because she was by herself until the 3rd week or so in January 2025 when the Regional Social Worker starting coming to the building 2 days per week. Interview with the Administrator on 3/12/25 at 4:30 PM confirmed the facility does not have a qualified social worker on a full-time basis.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 2) On 3/10/25 at 11:00 AM a review of complaint MD00213615 and complaint MD00210751 revealed an allegation that the facility had been having issues with the water being cold at night when it was time for showers. Review of complaint MD00208729 alleged that there was no hot water in August 2024 and residents had to get a bath with cold water. On 3/10/25 at 2:00 PM an interview was conducted with Resident #5 who stated that there have been on and off issues with the hot water for a couple of months and the problem has not been fixed. On 3/10/25 at 2:31 PM an interview was conducted with the Director of Maintenance, Staff #7. Staff #7 stated, it was going on and off which started in mid-January (2025) when it got real cold outside. The switch on the boiler clicks off and back on. I went over to the unit, and I looked at the boiler and it was reading the code, and we got someone to service it. They are here today. They came last Thursday. It has been going on since January. First it happened in the Chesapeake area and then it happened in the Wye Oak area. It went out and I would reset the boiler, and it was fine. In February it was just the Wye Oak unit. Staff #7 was asked by the surveyor, so it happened in January. Did it every happen prior to January? Staff #7 stated, no. At that time the surveyor asked if he had informed anyone about having someone come to fix the unit. Staff #7 said he didn't because he would flip the switch, and the hot water would come back on. On 3/10/25 at 2:43 PM an interview was conducted with the Regional Director of Maintenance, Staff #34. Staff #34 was asked when he became aware of this issue. Staff #34 stated, this morning about the boiler issue. Staff #34 was asked why he was just made aware of the issue. Staff #34 stated, because you guys walked in the door. Staff #34 stated that he needs to be kept in the loop. I would have had someone come out right away and verify the patient care areas had hot water and would have contacted the vendor as it seemed to be some kind of issue. On 3/10/25 at 3:25 PM a review of the work order report for 8/1/24 to 8/30/24 revealed on 8/15/24 there was no hot water on the Chesapeake unit. The timeline was created on 8/15/24 by the previous Assistant Director of Nursing (ADON) and closed out by Staff #34. The comments stated, staff complaining there is no hot water on the unit. Duplicated w/o (without) removing this one. Waiting on parts to come in. A second work order was created on 8/19/24 with the notes, we push the button to reset the hot water, and it doesn't get hot anymore. The work order was set to completed on 8/21/24. On 3/18/25 at 5:15 PM the issue was discussed with the Nursing Home Administrator and the Director of Nursing. 2) On 3/18/25 at 7:00 AM a review of complaint MD00208729 alleged that in July and August 2024 there were no washcloths, and the staff were tearing up bed sheets to use as washcloths. On 3/18/25 at 9:15 AM an interview GNA #57 revealed, linen is a struggle. In the morning there is none left. They are only working with 1 dryer and 1 washer. We run out a lot. We have to go down to laundry and get the linen. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/18/25 at 9:18 AM an interview with GNA #18 and GNA #15 was conducted. They stated, some days are better than others and then some days we barely get any linen. We are short washcloths, towels, and fitted sheets. We barely get 1 washcloth per person. We may get 6 washcloths each and then we have to use a towel, half as a washcloth and the other half to dry. This has been going on for the past 6 months to a year. On 3/18/25 at 9:45 AM an interview was conducted with Staff #58. Staff #58 stated, we only have 1 working washing machine and 1 working dryer. It is off and on. There are 4 washers and 4 dryers. Someone is here today working on them. This has been going on for at least 2 months. There are supposed to be 2 to 3 washcloths per patient. On 3/18/25 at 9:47 AM an interview was conducted with Staff #59. Staff #59 stated that the issue with linen, has been going on for a while now, greater than 6 months. There currently is 1 working washing machine and 1 working dryer. Someone came last week, when surveyors entered the building, and ordered a part and are back today to fix it. Staff does complain about being short on linen. It is a problem between short linen and only 1 machine working at a time. The residents complaint that their personal clothes are taking longer to get back. The turnover is supposed to be 72 hours, but it may take longer. We have to take turns using the machines. We have to have the linen carts ready by 3 for the next shift. The 11-7 shift is out of luck. Trying to get linen out but there is not enough for the 11-7 shift. On 3/18/25 at 9:48 AM observation was made of the washing machines in the laundry room. There was only 1 machine that was in use. There were repair men in the room working on other machines. On 3/18/25 at 9:50 AM the surveyor asked Staff #7 and Staff #34 how long the problem with the washing machines and dryer had been going on and they both looked at the surveyor. The surveyor asked, a while and they both shook their heads yes. The Surveyor said, budget issues and both looked and shook their heads, yes, in agreement. On 3/18/25 at 5:15 PM the Nursing Home Administrator and the Director of Nursing were informed of the concern. Cross Reference F584 Based on observation and interview, the facility failed to ensure the kitchen's dishwasher, boiler, laundry washer and dryer were in working order. This had the potential to affect all residents. This was evident during a complaint survey. The findings include: 1) During observation of the facility's kitchen on 3/17/25 at 9:45 AM with the Dietary Manager, the Surveyor noted the gauges on the dishwasher rinse temperature and wash temperature were not rising and both noted on 110 degrees. At the time 3 staff (Staff #61, #62 and #63) were manually cleaning dishes of debri and running dishes through the dishwasher. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At that time the Surveyor asked Staff #61 if the gauges were moving this morning above 120 degrees. Staff #61 stated no and staff continued to run dishes through the dishwasher. The Dietary Manager stated she worked last night and at that time the dishwasher was working properly. The Surveyor asked the Dietary Manager if the dishwasher was hot water sanitizing or chemical sanitizing. The Dietary Manager stated chemical and showed the Surveyor the chemicals feeding into the dishwasher. On the dishwasher is posted for chemical sanitizing dishwasher the final rinse and wash tank minimum temperature is 120 degrees. The Dietary Manager confirmed the dishwasher was currently running at 110 degrees and stated she would contact Maintenance and the manufacturer. On 3/17/25 at 10:05 AM, the Surveyor was informed the dishwasher was working, the Surveyor returned to the kitchen and was met by Corporate Director of Maintenance. At that time the dishwasher's rinse temperature and wash temperature was again observed to be 110 degrees. The Corporate Director stated he saw the temperatures go to 115 degrees and confirmed the temperature did not meet the dishwasher's manufactures guidelines. The Corporate Director of Maintenance stated a contractor has been contacted. The findings were shared with the Administrator on 3/17/25 at 11:05 AM who stated the facility has converted to using paper products until the dishwasher is in working order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 - Some	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 observation and interview, the facility failed to maintain the resident call bell system in working order. This was evident for 1 of 4 nursing units during a complaint survey. The findings include: During investigation of a complaint of non-working call bells on the Homestead Unit, the Surveyor began a tour with Staff #11 on 3/10/25 at 1:15 PM of the Homestead Unit. The following occupied rooms were observed to not have a functioning call bell: 300A, 300B, 301A, 301B, 302A, 302B, 303A, 303B, 304A, 305A, 305B, 306B, 307A, 307B, 310A, 310B, 312A, 312B, 313B, 315A, 315B, 316A, 316B, 317A, 317B, 318A, 318B, 319A, 319B, 320A, 320B, 321A, 321B, 322A and 322B. room [ROOM NUMBER]B had a manual call bell on top of a dresser but was not in reach of the Resident. No other rooms had manual bells at the residents' bedside. Interview with the Administrator on 3/10/25 at 1:30 PM confirmed the call bell system is not in working order on the Homestead Unit and no contractor is currently in the building working on the call bell system.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and documentation review, it was determined the facility failed to have an effective pest control program as evidenced by numerous flies and gnats seen in the kitchen and parts of the facility along with ants. This was evident on 2 of 2 days observed during a complaint survey. The findings include: On 6/16/25 at 9:30 AM observation was made of several gnats and a fly in the conference room. On 6/16/25 at 9:27 AM observation of the laundry room in the washer area and dryer area with Staff #9 present revealed multiple flies and gnats. At that time there was standing water on the ground between and behind the washing machines. On 6/16/25 at 1:25 PM observation was made of flies in the kitchen over the food preparation area. The flies were hanging on 2 black electric cords that were hanging down from the ceiling over the food serving station and there were flies flying over the food. There was a minimum of 12 flies seen at that time. The surveyor then went into the kitchen general storage area and the dry storage area where gnats were observed. Staff #26 stated the flies were bad and had been in the kitchen for a while and hoped that something would be done about it. On 6/16/25 at 1:30 PM the Dietary Manager was interviewed and said pest control was just out on 6/10/25 and treated. The Dietary Manager showed the surveyor a copy of the pest control log which documented the pest control company came out, however there were no reports of pests, so they treated the baseboards. According to the pest control log, the previous time the pest control company was in the kitchen was 5/13/25. On 6/16/25 at 2:07 PM observation was made of an ant in the hallway outside of the conference room door adjacent to the staffing office. The Nursing Home Administrator was shown the ant at that time. On 6/17/25 at 11:15 AM observation was made in the soiled section of the laundry room of an open trash can with a used yogurt container with at least 12 gnats and flies that were swarming around the container and the laundry area. At that time the Nursing Home Administrator (NHA) was present and said, why is a trash can in the middle of the laundry room? On 6/17/25 at 11:25 AM an interview was conducted with Staff #7 the Regional Maintenance Director. Staff #7 stated that there were pest control logs at the receptionist desk and at nurse's stations. Review of pest control log revealed the pest control company was coming to the facility every 2 weeks. Staff #7 confirmed that there was a pest control problem and that the pest control company should have been coming to the facility more frequently.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on documentation review and interview, it was determined the facility failed to ensure nurse aide competency training occurred no less than 12 hours per year. This was evident for 1 (GNA #52) of 5 geriatric nursing assistant files reviewed and had the potential to affect all residents during the extended survey of a complaint survey. The findings include: On 3/17/25 a review was conducted of geriatric nursing assistant (GNA) personnel files. A review of GNA #52's personnel file revealed GNA #52 was hired on 7/12/22. There was no formal way to validate the yearly training and number of hours GNA #52 received by reviewing the personnel file. Review of a binder that contained in-service signature sheets for various topics throughout the year was reviewed to validate education and give credit for education received. The binder contained 9 in-service sheets that GNA #52 had signed as attended throughout the year. It was not known the amount of time credited for each in-service. On 3/17/25 at 5:13 PM an interview was conducted with Staff #67, staff educator, who had just started on 2/24/25. Staff #67 stated she just started and was just putting a training program together. Staff #67 stated, I am getting my binder together and getting my stuff together for it. All of what is currently in the binder is prior to when I started. We do not have anything formal as far as keeping track of the number of hours of education. On 3/17/25 at 5:23 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated, we cannot validate the number of hours of GNA training. There are signatures next to topics only. The NHA stated, we are a little behind with our education. As of this June we are starting yearly competencies and reviews for the GNAs.