STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observations, and interviews, it was determined that the facility failed to provide an accurate mailing address, email address, and telephone number for the State regulatory agency. This was found in 2 of 2 postings located in the facility corridors. The findings include: On 6/17/24 at 6:19 AM, the surveyor observed a sign located on the wall leading to the resident's rooms stating, General Information with the information to contact OHCQ (Office of Health Care Quality) and the number [PHONE NUMBER]. The surveyor next called the number and verified it was not the direct number to OHCQ rather a direct number to a hospital facility surveyor. On 6/18/24 at 8:43 AM, the surveyor conducted an interview with Staff #34. During the interview the surveyor asked Staff #34 where the information and instruction to contact State agencies was located. Staff #34 walked over to the bulletin board just before the entrance to the Potomac floor. At this time the surveyor observed the board where the number listed was not the direct line to OHCQ, the address was the previous OHCQ office address and the website was not the current website that leads to the email address used to file a complaint. On 6/18/24 at 10:13 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor asked the NHA where the contact information for the State agencies was located. The NHA walked past the first sign located in the front hallway leading to the residents' rooms. The surveyor informed the NHA that the sign stating contacts and OHCQ's number was incorrect. The NHA stated he didn't realize that and would change the sign. He further stated the contact information for State agencies was just down the hallway. The surveyor again observed the same bulletin board, just outside the Potomac floor, with the wrong contact information seen previously. The surveyor informed the NHA that the mailing address, phone number and website to the OHCQ were all incorrect. The nursing NHA stated he would update the board with the correct information.

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42828 Based on observation, survey results book review and interview, it was determined that the facility failed to have survey results available for the most recent surveys and reports of the facility readily available for review. The findings include: On 6/11/24 at 8 AM surveyors entered the facility and located a binder labeled CURRENT FACILITY SURVEY, near the receptionist's desk in the front lobby. Review of the survey results binder on 6/11/24 at 8:45 AM revealed the last survey results were from a Complaint survey conducted in February 26, 2019. The surveyor next reviewed the Certification and Survey Provider Enhanced Reporting (CASPER). The review revealed that the facility had additional complaint surveys completed in January of 2021 and January of 2024. No results from either of these surveys were in the binder. On 6/11/24 at 11:45 AM the surveyor interviewed the Director of Nursing (DON) who confirmed that the survey results from the last survey were not in the binder. The DON confirmed that he would update the binder. On 6/14/24 at 11:05 AM, the DON provided the surveyors with the updated survey results binder. Review of the binder revealed survey results from complaint surveys conducted January 2024 and January 2021. On 6/21/24, surveyors located the CURRENT FACILITY SURVEY near the reception area, which revealed the updated the most recent survey results from complaint surveys conducted January 2024 and January 2021.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50503 Based on medical record review and interviews, it was determined that the facility staff failed to obtain advance directives for residents. This was found evident for 3 (Resident #26, #38, and #122) of 8 Residents reviewed for advanced directives during an annual survey. The findings include: 1a) During record review for Resident #26 on 6/12/24 at 11:14 AM, the surveyor did not find documents related to advance directives in the resident electronic record or hard chart. During an interview with Staff #35 on 6/17/24 at 11:16 AM, the surveyor asked about the process of obtaining advance directives for residents upon admission. She stated that a resident's advance directive gets collected at the time of entry, if they have them, then given to the Social Worker for them to follow up with residents within 72 hours. She also stated that advance directives don't necessarily have to be collected during admission and that after admission she does not follow up with residents. During an interview with Staff #15 on 6/17/24 at 1:36 PM, the surveyor asked about whether there was an advance directive on file for Resident #26. She stated she could not find any documents in the residents ' record. She stated that normally if a resident had an advance directive, they would give it to admissions upon entry to the facility. She then stated, otherwise, it would be obtained from the resident directly and she would offer if they did not have one. 1b) During record review for Resident #38 on 6/12/24 at 11:14 AM, the surveyor did not find documents related to advance directives in the resident electronic record or hard chart. During an interview with Staff #35 on 06/17/24 at 11:16 AM, the surveyor asked about the process of obtaining advance directives for residents upon admission. She stated that a resident's advance directive gets collected at the time of entry, if they have them, then given to the Social Worker for them to follow up with residents within 72 hours. She also stated that advance directives don't necessarily have to be collected during admission and that after admission she does not follow up with residents. During an interview with Staff #15 on 06/17/24 at 1:36 PM, the surveyor asked about whether there was an advance directive on file for Resident #38. She stated she could not find any documents in the resident's record. She stated that normally if a resident had an advance directive, they would give it to admissions upon entry to the facility. She then stated, otherwise, it would be obtained from the resident directly and she would offer one if they did not have one. 1c) During record review for Resident #122 on 6/12/24 at 11:14 AM, the surveyor did not find documents related to advance directives in the resident electronic record or hard chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff #35 on 06/17/24 at 11:16 AM, the surveyor asked about the process of obtaining advance directives for residents upon admission. She stated that a resident's advance directive gets collected at the time of entry, if they have them, then given to the Social Worker for them to follow up with residents within 72 hours. She also stated that advance directives don't necessarily have to be collected during admission and that after admission she does not follow up with residents. During an interview with Staff #15 on 06/17/24 at 1:36 PM, the surveyor asked about whether there was an advance directive on file for Resident #122. She stated she could not find any documents in the resident's record. She stated that normally if a resident had an advance directive, they would give it to admissions upon entry to the facility. She then stated, otherwise, it would be obtained from the resident directly and she would offer one if they did not have one.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50503 Based on observation and interview, it was determined that the facility staff failed to provide privacy for resident's protected health information. This was evident for 1 (Resident #239) of 67 residents reviewed during an annual survey. The findings include: During observation on 6/24/24 at 11:41 AM, the surveyor found a medication cart laptop open with Resident #239's medical information visible to anyone in the hallway. It was noted that no residents or facility staff were in the hallway. During an interview with Staff #33 on 6/24/24 at 11:50 AM, the surveyor identified the open laptop and resident record with Staff #33. She stated that she did not recall leaving the laptop open because there was a black screen present. During the interview, it was also revealed that Staff #33 was able to pull up Resident #239's record on the laptop by simply clicking the mouse without entering a secure password. During observation on 6/24/24 at 11:53 AM, the surveyor observed Staff #33 walk away from the laptop with the open browser tab that visibly stated on a white background, THIS SCREEN IS HIDDEN, at which the surveyor was still able to access resident protected health information from a secondary open browser tab.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49815 Based on interviews and medical record review it was determined the facility failed to provide notification to the Ombudsman of the Resident that transferred to the hospital. This was evident in 1 Resident #123 out of 4 Residents reviewed for hospitalization notification. The findings include: On 6/12/2024 at 11:30 AM the surveyor reviewed Resident #123's medical record. The review of the medical record revealed that Resident #123 was transferred to the hospital on 1/30/2024. At 11:15 AM on 6/20/2024 the surveyor requested from the Director of Nursing the documentation of the Ombudsman notification of Resident #123's transfer to the hospital on 1/30/2024. During an interview with the Director of Nursing on 6/21/2024 at 11:00 AM he stated that he requested from the Ombudsman a copy of the email and transfer log that the facility Social Services Department sent to the Ombudsman for January 2024, because the facility was unable to locate documentation of notification to the Ombudsman for Resident #123's transfer on 1/30/2024. The Director of Nursing further stated in the interview that the Social Services Department had the responsibility of notification to the Ombudsman of residents that transfer to the hospital, and that the Admission/Discharge To/From Report is emailed to the Ombudsman monthly by the Social Services Department. The Director of Nursing at 11:15 AM on 6/21/2024 stated to the surveyor that the Ombudsman was unable to locate an email from the facility Social Services Department of residents that were transferred to the hospital during the month of January 2024. The surveyor confirmed with the Ombudsman on 6/24/2024 at 1:25 PM that she had not received notification via email from the Social Services Department that Resident #123 was transferred to the hospital on 1/30/2024.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #65) of 67 residents selected for review during the recertification survey. The findings include: Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. On 06/13/24 at 12:40 PM a review of Resident's #65 medical record revealed that the resident was admitted to the facility on [DATE] with multiple diagnoses including Dementia, ETOH (alcohol) abuse and Hypertension (high blood pressure). On 4/16/24 Resident #65 sustained a fall and was hospitalized for Hip Fracture. Upon readmission to the facility on [DATE], the resident was prescribed and received Lovenox (Enoxaparin-a blood thinner or anticoagulant) injections for Deep Vein Thrombosis prophylaxis for the period 4/22/24 -5/5/24. Resident# 65's MDS dated [DATE] (5 day assessment) revealed that the resident received 6 injections for the assessment period. The Drug Classification, Anticoagulant, was not documented on the MDS for the Lovenox (Enoxaparin) injections. On 06/20/24 at 09:40 AM the surveyor interviewed the MDS Coordinator regarding the omission of the drug classification. The MDS Coordinator stated that she would look into the matter. Later at about 10:20 AM on 6/20/24, the MDS Coordinator informed the surveyor that she had corrected the inaccuracy and gave the surveyor a copy of the MDS document showing the correction.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on record review, and staff interview, it was determined that the facility staff failed to develop and initiate comprehensive person-centered care plans for residents. This was evident for 3 (Resident #65, #36 and #80) of 10 residents reviewed for comprehensive care plannig. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The Minimum Data Set is a standardized assessment tool that measures health status in nursing home residents. MDS assessments are completed every 3 months on all residents of nursing homes. 1a) On 06/13/24 at 12:40 PM a review of Resident's #65 medical record revealed that the resident was admitted to the facility on [DATE] with multiple diagnoses which included Dementia, ETOH (alcohol) abuse and Hypertension (high blood pressure). On 4/16/24 Resident #65 sustained a fall and was hospitalized for hip fracture. The resident was readmitted to the facility on [DATE]. Resident #65 had active physician's orders dated 4/22/24 for Tramadol and Tylenol Extra Strength for pain. The resident's medication record confirmed that the resident was receiving the pain medications. Further review of Resident's #65 medical records on 6/14/24 01:06 PM revealed that a care plan was developed for pain on 3/19/24 and discontinued the same day. There was no active care plan for pain for Resident #65 in the medical record. On 6/17/24 at 09:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident # 65. Staff #5 confirmed the findings and stated that they would take care of them. A care plan was initiated by the facility on 6/17/ 24 with interventions for Resident #65's pain. On 6/20/24 at 10:30 AM The surveyor also informed the Assistant Director of Nursing (ADON) of the care plan findings for Resident #65 and enquired about the process to ensure care plan initiation. The ADON stated that they use a triple check system in which licensed nurses would make changes and update the clinical record as events occur. The events are recorded on the 24 hour report and it is the responsibility of the supervisors and managers to further review. 1b) A review on 6/17/24 at 08:12 AM of Resident #36's medical record revealed the following. The resident was admitted to the facility on [DATE] with multiple diagnoses including Hypertension (high blood pressure), Atrial Fibrillation (abnormal heart rhythm), Diabetes Mellitus. Resident #36 had an active physician's order dated 2/22/24 for Xarelto for Atrial Fibrillation. Xarelto belongs to a category of blood thinners commonly called Direct Oral Anticoagulant. Resident #36's medication record confirmed resident was receiving the medication Xarelto. There was no care plan for Resident #36 relating to the anticoagulant medication, Xarelto. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24 at 09:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident #36. Staff #5 confirmed the findings and stated that they would take care of them. A care plan was initiated by the facility on 6/17/ 24 with interventions for Resident #36's relating to the medication, Xarelto. On 6/20/24 at 10:30 AM The surveyor also informed the Assistant Director of Nursing (ADON) of the care plan findings for Resident #36 and enquired about the process to ensure care plan initiation. The ADON stated that they use a triple check system in which licensed nurses would make changes and update the clinical record as events occur. The events are recorded on the 24 hour report and it is the responsibility of the supervisors and managers to further review. 45733 1c) During a unit rounding, on 6/11/24 at 1:09 PM, Resident #80 stated he/she had a fall a few months ago. This resident was admitted on [DATE] to this facility with diagnoses of radiculopathy of cervical region, dementia, diabetes, malignant neuroendocrine tumors and diverticulosis of small intestine. An observation, on 6/12/24 at 10:00 AM, found that Resident #80 was in bed and the staff were providing complete morning care because this resident was unable to assist. Later Resident #80 was a total transferred to a wheelchair. Record review, on 6/17/24 at 01:40 PM, of Resident #80's record revealed that on 1/5/24 at 1:58 PM, the resident had lost his/her balance and sustained a fall while trying to use the bathroom by him/herself. The Resident was found in a supine position and stated that his/her head hit the floor. Further review of Resident #80's Minimum Data Set assessment, on 5/13/24, revealed that the resident's functional pattern was coded 02, which meant that the resident needed maximal assistance. Also coded 01 as the dependent in daily living transfers and toilet transfers. However, no care plan had been developed to address the resident's fall risk and safety level of functional assistant. During interview, on 6/23/24 at 02:27 PM, Unit Manager Staff #17 stated that staff were checking Resident #80 often and assisting his/her dependent level of needs. He admitted that there was no care plan developed for the fall prevention at this time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on interviews and medical record review it was determined that the facility failed to: 1) revise a Resident's care plan and 2) provide an invitation and/or invite a resident for a care plan meeting . This was evident in 4 Residents (#65, #36 #143, & #57) and 2 Residents (#63 and #38) out of 10 residents reviewed for care planning. The findings include: 1a) On 6/13/24 at 12:40 PM a review of Resident's #65 medical record revealed that the resident was admitted to the facility on [DATE] with multiple diagnoses which included Dementia, ETOH (alcohol) abuse and Hypertension (high blood pressure). On 4/16/24 Resident #65 sustained a fall and was hospitalized for Hip Fracture. Resident #65 was readmitted to the facility on [DATE]. A review of Resident #65 medical record on 6/14/24 01:06 PM revealed that the resident was administered Lovenox (Enoxaparin) injections for the period 4/22/24 to 5/5/24 for Deep Vein Thrombosis prophylaxis and a care plan was initiated on 4/22/24. The resident's care plan for Lovenox remained active even though the medication was discontinued on 5/5/24. On 6/17/24 at 09:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident # 65. Staff #5 confirmed the findings and stated that they would take care of them. Further review of the residents' medical record on 6/28/24 at 12:55 PM revealed that the care plans for Resident #65 for Lovenox discontinued on 6/17/24. On 6/20/24 10:30 AM The Assistant Director of Nursing (ADON) was made aware of the findings. 1b) A review on 6/17/24 at 8:12 AM of Resident #36's medical record revealed the following. The resident was admitted to the facility on [DATE] with multiple diagnoses including Hypertension (high blood pressure), Atrial Fibrillation (irregular heart rhythm), Diabetes Mellitus. Resident #36 was administered Vancomycin (an antibiotic) for the period 5/9/24 -5/19/24 for C-diff (a bacteria that causes infection in the colon). The resident's care plan for Vancomycin remained active even though the medication was discontinued on 5/19/24. On 6/17/24 at 9:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident #36. Staff #5 confirmed the findings and stated that they would take care of them. Further review of the residents' medical record on 6/28/24 at 12:55 PM revealed that the care plans for Resident #36 for Vancomycin were discontinued on 6/17/24. On 6/20/24 10:30 AM the Assistant Director of Nursing (ADON) was made aware of the findings. 44440 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) On 6/25/24 at 12:02 PM, the surveyor reviewed Resident #143's medical record. The review revealed that Resident #143 was first admitted to the facility in early 2018 and had a past medical history, which included but not limited to, bipolar disorder, dementia with behavioral disturbances and schizoaffective disorder. On further review the surveyor noted a care plan for Resident #143 initiated on 8/26/20 that stated, Resident #143 is to be on one-on-one monitoring. The goal stated Resident #143 will remain calm without hurting someone through the next review date. This goal was revised on 6/3/21 however, the intervention of, to monitor the resident as ordered that were initiated on 8/26/20 were not revised. An additional care plan stated, Resident #143 has the potential to be physically aggressive related to dementia and was initiated on 10/21/20. The goal for this care plan stated Resident #143 will not harm self or others through the review date and was last revised on 6/3/21. One intervention listed was for one on one and supervision ongoing for the resident's safety and the safety of others. This intervention was initiated on 8/25/20. This intervention was initiated before the care plan date and both the care plans and intervention were not revised and not updated when the goals were reviewed on 6/3/21. The surveyor noted a psychiatric progress note written on 9/10/20 that stated that Resident #143 was seen, and no behavior disturbance was reported or noted. If further recommended, discontinuing the one to one monitoring. Additionally, a progress note written by the Director of Nursing (DON) on 9/11/20 that stated, the Facility will continue One on One at this time as a plan of care not physician orders. On 7/2/24 at 12:16 PM, the surveyor conducted an interview with the DON and Nursing Home Administrator. During this interview the DON confirmed that the care plan was not up to date, that the resident did not need one to one monitoring, and the care plan was inaccurate. 49815 1d) On 6/21/2024 at 8:36 AM the surveyor reviewed Resident #57's medical record. There was a current care plan for Seroquel which is an antipsychotic medication. Further review of the medical record revealed that there was not a current physician order for the medication and that the Seroquel was discontinued by the physician on 5/23/2024. The surveyor interviewed the Director of Nursing on 6/24/2024 at 12:25 PM and reviewed Resident #57's current care plan for Seroquel and the physician orders for the discontinuation of Seroquel on 5/23/2024. The Director of Nursing stated that he would have to investigate this. No additional information was provided to the surveyor by the Director of Nursing at the time of exit. 2a) During an interview on 6/12/2024 at 9:14 AM Resident #63 stated to the surveyor that he/she does not get invited to care plan meetings. The surveyor reviewed Resident #63's medical record on 6/17/2024 at 8:00 AM. There was no documentation that a care plan invitation was provided to Resident #63 for the December 2023 care plan meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 6/17/24 at 1:30 PM, the Social Services Director #15 conveyed that the facility was unable to locate the care plan invitation letter for Resident #63 for the December 2023 care plan meeting. The Social Services Director #15 was able to provide to the surveyor a copy of the September 2023 Care Conference Invitation letter that was provided to Resident #63 and the Responsible Party which is the expectation of the facility. 45733 2b) During a floor rounding, on 6/12/24 at 2:43 PM, Resident #38 stated, No one had talked to me about what program that I was in since I got here. Record review, on 6/13/24 at 1:28 PM, revealed that Resident #38 was admitted to the facility, on 2/21/24, with diagnoses of percutaneous pinning of pelvis on 2/12/24, impaired vision, cardiac arrhythmia and dementia. The resident was authorized for skilled level nursing care upon admission. The resident was able to answer questions appropriately, making his/her own decisions about his/her care and making his/her needs known. Further review of the Social Worker Staff #16's notes, dated 2/28/24 at 16:18 PM and 5/24/24 at 9:40 AM, revealed that the interdisciplinary team had conducted care plan meetings telephonically with this resident's surrogate without inviting the resident. During the second care plan meeting on 5/24/24, the discharge plan was changed from going home to becoming a long-term care resident. Per facility staff that the surrogate had not visited this resident since 2/21/24 nor to explain the long-term care's decision. During interview, on 6/14/24 at 10:09 AM, Social Worker Staff #15 stated that the care plan meetings were conducted telephonically and because the surrogate had only very limited for each care plan meeting, Staff #16 excluded Resident #38 from the meeting. During interview, on 6/14/24 at 11:50 AM, the Director of Nursing (DON) stated he could not remember why this resident was not in his/hers care plan meetings. The surveyor informed the DON that this resident was excluded from his/her own care plan meetings which it was a concern.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50503 Based on medical record review and interviews, it was determined that the facility failed to turn and reposition residents at risk for pressure ulcers. This was evident for 2 (Resident #26 and #158) of 4 residents reviewed for positioning during an annual survey. The findings include: During an interview with Resident #26 on 6/12/24 at 8:49 AM, the surveyor asked if staff repositioned them due to limited range of motion. The resident stated he/she was only repositioned when they asked the staff to do so and not done by a schedule. The resident confirmed that he/she could not reposition himself/herself and would need help. During an interview with Resident #26 on 6/18/24 at 1:08 PM, the surveyor asked if they had been repositioned during the night shift. The resident stated he/she was not repositioned the night before. During record review for Resident #26 on 6/18/24 at 9:46 AM, the records revealed documented care for turn and reposition was not done on 14 days for the night shift during the month of June. The record also revealed the night shift documented the resident as Substantial/maximal assist on 7 days and Dependent for 16 days in the month of June. During an interview with Staff #5 on 6/20/24 at 1:27 PM, she was asked about how do residents get turned and repositioned. Staff #5 stated the standard is that residents should be turned and repositioned on every shift. She also indicated that the aides are supposed to perform this task every two hours or as needed. Staff #5 was asked if Resident #26 should be turned and repositioned. She stated if he/she is able to reposition him/herself the staff would educate if they are not able to, or the aides would have to do it. Staff #5 stated that she was not sure why it was not done but would have to check. During an interview with Staff #2 on 6/28/24 at 2:04 PM, he was asked about insufficient documentation for residents who should be turned and repositioned. He stated he was not sure about why it was not done, but confirmed the task for turn and reposition was not done on the night shift. 1b) During record review for Resident #158 on 7/01/24 at 1:09 PM, records revealed the resident was not turned and repositioned according to physician orders and care plan. During an interview with Staff #5 on 6/20/24 at 1:27 PM, she was asked about how do residents get turned and repositioned. Staff #5 stated the standard is that residents should be turned and repositioned on every shift. She also indicated that the aides are supposed to perform this task every two hours or as needed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on interview and record review it was determined that the facility staff failed to promptly make appointments for the proper diagnosis and treatment of vision impairment conditions. This was found to be evident for 1 (Resident #38) out of 2 residents reviewed for vision services during an annual survey. The findings include: During a floor rounding, on 6/12/24 at 2:53 PM, Resident #38 stated I only could see vague shadows, my eyesight was getting poor. I had not had an eye appointment since I got here which I was worried about and I feel helpless. Record review, on 6/13/24 at 1:27 PM, of Resident #38's record revealed that he/she was admitted on [DATE] with diagnoses of percutaneous pinning of pelvis on 2/12/24, vision impaired, cardiac arrhythmia and dementia. This resident was able to answer questions appropriately, making his/her own decisions about his/her care and made his/her needs known. Further record review found that the Medical Director Staff #32 had entered the order that the resident may be seen and treated by an Ophthalmologist dated on 2/21/24 at 5:44 PM. Additionally, the Minimum Data Set assessment dated on 2/29/23 under section B10000 vision section documented the resident as highly impaired. In terms of this resident's care plan on file the vision impaired was identified, however, the only intervention was to arrange consultation with eye care and the facility staff did not secure an eye appointment after 4 months later. During the interview, on 6/17/24 at 11:10 AM, Unit Manager Staff #17 confirmed that this resident did not have any eye examination since he/she was admitted to this facility on 2/21/24. He stated that he had just completed an eye referral to the provider system so the scheduling of a visit date was pending. Staff #17 was informed that the facility staff had identified that this resident's vision was highly impaired upon admission, but then failed to promptly make an eye appointment for finding the accurate diagnosis and effective treatments which it was a concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50503 Based on observation and interviews, it was determined that the facility staff failed to ensure residents are not exposed to hazards. This was evident for 1 (Resident #26) of 67 residents reviewed during an annual survey. The findings include: During observation on 6/18/24 at 1:12 PM, the surveyor observed Resident #26's call light with wires exposed. During observation on 6/20/24 at 1:50 PM, the surveyor observed Resident #26's call light with wires exposed. Staff #5 was asked to identify if the resident's call light was faulty and who should report and where. She identified the exposed wires, and stated anyone who sees a faulty call bell can report it. She also stated she will put it in the maintenance log book. During an interview with Staff #2 on 6/28/24 at 2:04 PM, he was asked about who should report faulty call lights. He said anyone should be able to identify and the nurses should have seen that and put it in the book.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on record review and interviews it was determined that the facility staff failed to track the pharmacy's irregularity monthly recommendation, assure the review by the medical staff and have timely action by the medical staff in response to the recommendation. This was found evident of 1 (#26) of 5 residents reviewed for medication regimen review during an annual survey. The findings include: Record Review, on 6/13/24 at 12:05 PM, of Resident #26's record revealed that he/she was admitted on [DATE] with diagnoses of chronic heart failure, arthritis, diabetes, fibromyalgia, hypertension, chronic renal failure, obesity and migraine. Further record review of a Monthly Pharmacy Report, dated on 5/15/24 at 5:42 PM, revealed that the report identified an irregularity that was marked recommendation written for the medical staff to respond. However, there was no record of a medical staff response on 5/15/24. During interview, on 6/13/24 at 12:58 PM, the Director of Nursing (DON) was aware that on 5/15/2024 at 5:42 PM the Pharmacy Consultant, Staff #42, made a recommendation to reduce the dosage, but no hard copy was found. The DON stated he was going to provide the document with the medical staff 's response. During the interview, on 6/14/24 at 12:06 PM, the DON stated that the Pharmacist Staff #42 failed to send the written recommendation to the facility. The report of the recommendations indicated as the following: 1) the standing order Diphenhydramine 50 mg for allergies; consider reducing the dosage. 2) the as needed order Diphenhydramine should be limited to before sleep since it may cause sedation. The DON presented a medical staff 's Prescriber Response to the recommendation after the surveyor's intervention. The response was a box checked off that indicated; agreed as above the recommendations, by Nurse Practitioner (NP) Staff #7, dated 6/13/2024. The facility failed to track the pharmacy's irregular monthly recommendation, review by the medical staff and to act upon the recommendation timely. The DON was informed that this was a concern due to being 28 days later.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on interview, observation and record review it was determined that the facility staff failed to promptly provide or obtain visit/appointments for routine dental care or treatment for Medicaid Residents. This was found to be evident for 1 (Resident #33) out of 3 residents reviewed for dental services during an annual survey. The findings include: During a floor rounding, on 6/12/24 at 11:50 AM, Resident #33 stated that several months ago he/she had requested the facility staff to arrange a dentist appointment for his/her a few broken teeth. Record review, on 6/12/24 at 1:40 PM, revealed that Resident #33 was admitted on [DATE] to this facility for a short stay then readmitted on [DATE] as a long-term care resident. This resident had a medical history with diagnoses of hypotension, chronic heart failure and asthma. The resident was able to answer questions appropriately, making his/her own decisions about his/her care and making his/her needs known. Further review record review found that the Medical Director Staff #32 had entered an active order on 3/3/24 that the resident may be seen and treated by a dentist. Additionally, Resident #33's Minimum Data Set assessment (MDS), on 3/12/24, revealed that the resident's dental assessment under section L0200 identified broken (chipped, cracked) teeth, which meant that the resident needed prompt dental treatments. The Minimum Data Set is a standardized assessment tool that measures health status in nursing home residents. MDS assessments are completed every 3 months on all residents of nursing homes. Observation, on 6/14/24 at 12:34 PM, revealed that Resident #33 was eating his/her lunch slowly and stated, I had mild pain sometimes when I bit on my broken tooth. Record review, on 6/14/24 at 2:16 PM, revealed that this resident had no dental visits by this time. During interview, on 6/17/24 at 11:10 AM, Unit Manager Staff #17 confirmed that this resident did not have any dental care since he/she was admitted to this facility on 3/3/24. Staff #17 was informed that the facility MDS assessment had identified broken teeth on 3/12/24, but then failed to promptly make an appointment for the proper diagnosis and treatment, which was a concern.

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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. 50504 Based on observations, interviews and record review, it was determined that the facility failed to ensure sanitary and safe food handling practices were followed to reduce the risk of foodborne illness. This deficient practice has the potential to affect all residents. The findings include: On 6/11/24 at 9:01 AM during an initial tour of the kitchen, the surveyor observed two large white (approximately 4 gallon) containers quarter filled with yellow liquid in Refrigerator #2. The containers were unlabeled and undated. Staff #10 immediately removed the containers and stated that they contained leftover lemonade. On 6/25/24 at 08:08 AM the surveyor observed the following during a follow-up tour of the kitchen: - Six stacks of white saucers (approximately 20 saucers per stack), wet nesting (occurs when wet dishes or pots and pans are stacked together before they are completely dry, which can lead to bacterial growth) with surface up on the countertop next to the dishwasher. Air drying dishes is required to ensure adequate sanitization. Staff #29 stated that she would rewash them and proceeded to put them into the dishwashing basket. - Surveyors inspected a room at the back of the kitchen housing the ice machine. Surveyors observed one 32-ounce (oz) beige colored tumbler, half filled with a tan colored liquid along with a soiled paper towel sitting on the second shelf. - Sticky floors noted when the surveyors inspected a room used for storing chemicals and several types of kitchen equipment. Staff # 10 stated that some of the kitchen equipment were out of service. There were no signs posted identifying which equipment was out of service. - Two bags of cake mix powder with a labeled date showing stored 5/21/24 observed with no expiration or 'use by date. - On the floor next to door of the walk-in freezer, there was a build-up of ice in the size and shape of a doorstop. There was wetness and ice build-up on top of a cardboard box sitting on a shelf under the fan in the freezer. The surveyor observed the staff remove the ice and the cardboard box from the freezer and discard it. At the time of the observation Staff #10 informed the surveyor that the freezer was serviced the week before. The surveyor asked Staff #10 for a copy of the record verifying the maintenance service. The surveyors reviewed the record which did not verify service to the freezer. On 6/26/24 at 1:07 PM the surveyor conducted observations of the nourishment room on the Potomac Unit. The findings include: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One opened half-filled cranberry apple 64 oz bottle with no dates on bottle - One zip lock bag with half of a head of a withered green, leafy vegetable, no dates or name on the bag - One 32 oz cup with a tan colored liquid, half filled, no name or date on cup - One covered container with cooked food- one fried chicken drumstick, some short ribs, and loose corn kernels. Container was dated 6/10/24 - One banana in a cup in the overhead cupboard - One opened 8 oz vanilla boost carton, no name or date on the carton On 6/26/24 at 1:20 PM the surveyor interviewed Staff #17 who stated that it was the facility's policy to label and date food stored in the refrigerator and also to have food thrown out after two days. The surveyor observed Staff #17 trash the non-compliant items. The surveyors reviewed a facility policy titled, Food: Safe Handling for Foods from Visitors, last revised on July 2019, which stated: Section 4- Label food with resident name and the current date; Section 5- Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for 7 or more days. On 6/26/24 at 1:22 PM the surveyor observed a soiled mobile steam table in the large dining room on the first floor. The top shelf contained 4 open trays with white residue at the bottom of each tray along with one empty plastic container, a used napkin, a white poster and deflated balloons. On the bottom shelf there were rust-like brown spots and a white powdered substance scattered along the length of the shelf. The DON was in the area, and he approached the surveyors while they were observing the steam table. He stated that steam table was used during the COVID-19 epidemic to give residents a homelike dining experience and it was no longer in service. He confirmed the findings of the surveyors and stated that he would arrange for the table to be removed. He was also made aware of findings relating to the refrigerator in the 1st Floor nourishment room. On 6/28/24 at 8:25 AM the surveyor observed the steam table had been removed

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44440 Based on interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 5 (Resident #154, #143 #121 #26 and #158) of 67 residents reviewed during the survey. The findings include: 1a) On 6/12/24 at 10:55 AM, the surveyor reviewed Resident #154's medical record. The review revealed that Resident #154 had a past medical history that included, but was not limited to, below the knee amputation, and osteomyelitis (infection of the bone). On further review Resident #154 had a Peripherally Inserted Central Catheter (PICC) (a catheter inserted into a vein in the upper arm and guided into a large vein above the right side of the heart, used to give intravenous fluid, medications and blood products) on 10/11/22. Orders were also written on the same day for measuring external length of catheter each week, changing dressing every Friday, and measuring arm circumference every Friday. On 6/13/24 at 11:15 AM, the surveyor reviewed the October 2022 Treatment Administration Record (TAR). On 10/14/22, 10/21/22 and 10/29/22 the dressing changes for the PICC were documented as completed. On further review, on the same days of the dressing changes, the external length of the catheter was documented at 5 cm and the arm circumference was documented as 6 cm. On 6/13/24 at 11:15 AM, the surveyor conducted an interview with the Regional Nurse. During the interview the Regional Nurse stated the facility uses an outside agency to place PICC lines. The surveyor asked for documentation from the PICC line placement. On 6/17/24 at 8:05 AM, the surveyor reviewed the documentation from the company that placed Resident #154's PICC line. The review revealed that the PICC was placed on 10/11/22 and the arm circumference was documented at 28 cm on the day of insertion. On 6/17/24 at 9:37 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked why there was a 22 cm discrepancy from the placement of the PICC to the facility's documentation. The DON stated he would look into the concern and follow up. On 6/17/24 at 1:27 PM, the surveyor conducted a follow up interview with the DON. He further stated that the documentation was done in error and an in-service education was started on appropriate PICC line documentation. 1b) On 6/25/24 at 12:02 PM the surveyor reviewed Resident #143's medical record. The review revealed that Resident #143 was first admitted to the facility in early 2018 and had a past medical history, which included but not limited to, bipolar disorder, dementia with behavioral disturbances and schizoaffective disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 11:02 AM, the surveyor reviewed the Task flow documentation that the Geriatric Nursing Assistance (GNA) used to document interventions/cares. Review of the May 2021 behavior monitoring for Resident #143 had no documentation on; 5/3/21 11PM-7AM shift, 5/8/21 7AM-3PM shift, 5/9/21 on 7AM-3PM shift 5/10/21 11PM-7AM shift, 5/14/21 7AM-3PM shift, 5/15/21 11PM-7AM shift, 5/21/21 11PM-7AM shift, 5/22/21 11PM-7AM shift, and 5/29/21 11PM-7AM shift. Further review revealed behaviors documented on 5/22/21 at rejecting care, push/grabbing/kicking hitting, on 5/23/21 rejecting cares, pushing/grabbing, kicking hitting, and biting and on 5/31/23 behaviors noted of pinching scratching and kicking hitting. On 7/2/24 the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that documentation of behaviors was missing on the May 2021 GNA Task form. He further stated it is the expectation the behaviors be monitored and documented by the GNAs. He further stated that the nurses also monitor and document behaviors. The DON provided the May 2021 Treatment Administration Record (TAR) for Resident #143 to the surveyor. The monitoring stated, nursing to monitor behavior and mood and redirect patient every shift for being combative. On 5/4/21 there was no documentation that the behavior was monitored on the 11PM-7AM shift. 49815 1c) During medical record review by the surveyor on 6/17/2024 at 8:15 AM it was revealed that there were multiple dates that initials were not documented on the enteral orders - medication and treatment administration record that Resident #121 had received prescribed enteral tube feedings. The following dates did not have documented initials that the prescribed enteral tube feedings were administered: January 6, 8 and 30; February 5, 8, 9, 13, 21, 22, and 23; March 6, 18, 25 and 31; April 23; May 14, 24 and 27; and June 15, 2024. During review of the nursing progress notes on these dates there was no documentation that the enteral tube feedings were held or any adverse effects on Resident #121. At 10:25 AM on 6/17/2024 the surveyor reviewed the facility's enteral tube feeding policy and procedure dated 12/12/2022. The policy on page 2 - #9 stated that Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. The surveyor conducted an interview with the Director of Nursing at 11:25 AM on 6/20/2024 and reviewed the enteral orders - medication and treatment administration record for January through June 2024 for Resident #121. The surveyor informed the Director of Nursing of the missing initials of the nursing staff for those dates. The Director of Nursing stated to the surveyor, I will look into that, there must be a reason. During follow-up interview with the Director of Nursing on 6/21/2024 at 1:07 PM the Director of Nursing confirmed with the surveyor that there were missing initials of the nursing staff on the enteral orders - medication and treatment administration records for Resident #121 for these dates. In addition, there was no documentation in the progress notes as to why the enteral tube feedings were not administered by the nursing staff as ordered by the physician for Resident #121. The Director of Nursing conveyed to the surveyor that the nursing staff was already being in-serviced on the enteral orders - medication and treatment administration record documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50503 1d) During an interview with Resident #26 on 6/12/24 at 8:34 AM, he/she was asked about whether he/she received showers since admission to the facility. He/she stated they tried to get a shower but staff told him/her to ask the next AM or PM shift and they wouldn't give them to him/her and knew nothing about shower preferences. During record review on 6/25/24 at 11:07 AM, the surveyor received hard copy shower records from Staff #2 for Resident #26. The hardcopy shower record was documented that a shower was given to the resident on 6/12/24 and 6/19/24. Under the tasks section in the electronic health record on 6/12/24 and 6/19/24 it was documented that a bath was given to the resident. Both methods used for the documented care specifically require a selection of whether a bath or shower was given. The records revealed the indicated dates of care did not accurately depict what type of care had been provided for the resident. During an interview with Staff #2 on 6/28/24 at 2:04 PM he was asked about the inaccuracy of documentation for resident records pertaining to baths and showers. He stated that this may be a Point Click Care system error and would have to check into that issue. He also mentioned that perhaps the staff who documented the resident records may have thought that both baths and showers coincided with one another. 1e) During record review on 7/01/24 at 11:30 AM, it was revealed the Notification of Change for Resident #158 by the facility on 9/23/23 was incomplete. The hospital information, to include phone number, was left blank. During record review on 7/01/24 at 11:30 AM, it was revealed the Bed Hold authorization for Resident #158 by the facility on 9/24/23 was incomplete. The resident signature or responsible party signature was left blank.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation and interviews it was determined that the facility failed to follow appropriate infection prevention and control practices to prevent the development and transmission of disease and infection. This was found to be evident on 5 random observation during the annual recertification survey. The findings include: 1a) During the initial tour of the laundry department on 6/18/2024 at 9:15 AM the two surveyors observed an employee's purse and personal items in the inside corner of a clean linen bin that was half full of clean folded linens. On tour of the laundry department at 9:30 AM on 6/18/2024 with the facility Nursing Home Administrator (NHA) the two surveyors observed an employee's purse on the clean laundry folding table. Adjacent and connected to the clean area of the laundry room was an open storage area that had four dirty file cabinets (one was empty and three contained unsecured medical records), several cardboard boxes rested directly on the floor filled with clothes, clothes laid on top of these cardboard boxes, clothes were directly on the floor, and there were at least five mattresses stacked against the wall. During an interview conducted on 6/18/2024 at 9:35 AM the Nursing Home Administrator acknowledged the areas of inappropriate infection control practices in the laundry room and in the adjacent storage area connected to the laundry clean area. The Nursing Home Administrator further stated that the facility will get it corrected. 50504 1b) On 6/17/24 at 10:31 AM during rounds the surveyors observed Transmission Based Precautions signs posted on the wall outside of Resident's #188's room. The surveyors entered the resident 's room wearing Personal Protective Equipment (PPE) (disposable gloves, gowns and masks). In the room, the surveyor observed a trash can filled to capacity with an overflow of yellow gowns, one pressure relieving boot on the floor, one empty 10 millimeter needleless syringe on the window sill next to the resident 's bed. On 6/17/24 at 10:33 AM, the Assistant Director of Nursing (ADON) joined the surveyors in the resident's room and addressed the concerns. The ADON put the boot and syringe in the trash and stated that the trash would be cleared out. On 6/17/24 at 11:43 AM a record review revealed that Resident #188 was admitted to the facility on [DATE] with multiple diagnoses including Sepsis , Hypertension and Acute Respiratory Failure with Hypoxia and was placed on droplet precautions. A resident is placed on droplet precautions when he/she has an infection with germs that can spread to others by speaking, sneezing, or coughing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c) On 6/21/24 at 9:24 AM during rounds the surveyor observed all handrails on the Gateway Unit were marred and scratched. A gritty, grime-like sticky brown substance was evident on surveyor's fingers when the bottom of the handrails was touched. The findings were brought to the attention of the Director of Housekeeping. 6/25/24 at 11:08 AM the Director of Housekeeping reported to surveyors that he checked the handrails and the substance was identified as residual from the use of sanitizing solutions used to prevent the spread of the Covid-19 virus. He reported that the handrails were cleaned by the housekeeping staff. On 6/28/24 at 9:35 AM the surveyor observed all handrails in the halls of the Gateway unit were visibly clean on all sides. 50503 1d) During observation of medication administration on 6/26/24 at 8:42 AM the surveyor observed Staff #34 enter Resident #115's room without washing or sanitizing her hands. The surveyor observed this room to be in use of Enhanced Barrier Precautions. During an interview with Staff #2 on 6/28/24 at 2:04 PM, he stated he was not sure why Staff #34 did not sanitize her hands, they are supposed to sanitize before entering the room because every cart has sanitizer. Staff #2 also stated that maybe Staff #34 sanitized before the entire process of medication administration began. 1e) During observation of medication administration on 6/26/24 at 8:42 AM the surveyor observed Staff #34 enter Resident #18's room without washing or sanitizing her hands. The surveyor observed this room to be in use of Enhanced Barrier Precautions. During an interview with Staff #2 on 6/28/24 at 2:04 PM, he stated he was not sure why Staff #34 did not sanitize her hands, they are supposed to sanitize before entering the room because every cart has sanitizer. Staff #2 also stated that maybe Staff #34 sanitized before the entire process of medication administration began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on observations and interview, it was determined that the facility failed to ensure a process was in place to address preventative maintenance of hallway handrails, residents' closets, sofas and wheelchairs. This was evident during multiple tours on the Gateway Unit during the recertification survey. The findings include: On 6/21/24 at 9:24 AM during rounds on the Gateway Unit, the surveyor observed the following: -The left side closet door was off its hinges, and propped up in front of the closet. The right side closet door was in place with its handle missing. The first drawer at the bottom of the closet was missing its handle and the second drawer had a loose hanging handle, -The handrail in the short hallway was loose with 3 screws missing, - All handrails on the unit were marred and scratched, - An empty blue manual wheelchair observed on the long hallway with the back support, seat and armrests tattered, exposing padding material underneath, -A large dark brown single seat sofa chair in residents' dining area with both armrests torn exposing padding underneath. On 6/21/24 at 11:50 AM the surveyor interviewed Director of Maintenance regarding issues with broken closet, loose and marred handrails, tattered wheelchair and sofa chair. The Director of Maintenance stated that he was unaware of the issues but would look into them. On 6/28/24 at 9:35 AM The surveyor observed the following: -All handrails in the halls of the Gateway Unit were visibly clean on all sides. The handrail at the end of the Short Hall was sturdy and all screws were in place. - room [ROOM NUMBER]D's closet was repaired and with all closet/drawer parts operable. - Dark [NAME] single seat sofa chair was removed from dining area on Gateway Unit.