STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215024	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Rehabilitation and Nursing Center	6500 Riggs Road Hyattsville, MD 20783

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that the facility staff failed to provide an environment that promotes dignity and respect for a resident (#16) while proving am care. This is evident for 1 of 15 residents reviewed during the survey. The findings include: During observation rounds on 4/16/25 at 8:48 AM Resident #16 was observed lying in bed, with the bed raised to its highest position. The resident was uncovered with a yellow brief exposed; the resident's curtain was only partially drawn. The resident could be seen by his/her roommate and any visitors entering the room. During an interview on 4/16/25 at 9:00am with the Geriatric Nursing Assistant (GNA) staff (#24) she stated, I should have pulled the curtain completely shut. During an interview with the Resident #16 at 10:30am s/he stated, they never close the curtain. The Director of Nursing was made aware of the findings on 4/16/25 at 10:45. She stated the staff would be reeducated on privacy.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on record review and an interview, it was determined that the facility failed to ensure a Resident was offered information for an Advance Directive. This was evident for 4 (Residents #85, #108, #109, #135) out of 6 residents reviewed for Advance Directives. The findings include: According to the Centers for Medicare and Medicaid (CMS) the definition of an Advance Directive is a document that appoints an agent and records a patient's medical treatment wishes based on their values and preferences. Advance Directives can be different from state to state. A record review on 04/17/25 at 07:38am showed there was not an Advance Directive found or documentation that Advance Directive information was offered in the electronic medical record of Residents #85, #108, #109, or #135. On 4/17/25 at 10:02am, while interviewing Staff #23, the surveyor requested assistance locating the Advance Directives for the selected residents in the electronic medical record. Staff #23 explained that she had begun an audit of the residents that needed Advance Directives and started reaching out to residents and their responsible parties. Staff #23 confirmed that this had not been done consistently. This surveyor made Staff #23 aware of the concern that Residents #85, #108, #109, and #135 did not have an Advance Directive in his/her electronic medical record, and did not have documentation that the Resident was offered information for an Advance Directive. On 4/17/25 at 11:17am, Staff #23 confirmed that the 4 residents did not have the required documentation. Documentation was provided at this time of attempts to contact the responsible parties on 4/17/25 for these residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** During observation rounds on 04/16/2025 the following concerns were found: 3. At 8:09 AM room [ROOM NUMBER]: The resident bathroom sink was found to be loosely hanging from the wall and the base of the toilet, where the toilet meets the floor, was brown in color with no seal leaving a hole between the base of the toilet and the floor. 4. At 8:20 AM room [ROOM NUMBER]: The resident bathroom floor was noted to have several areas of a brown in color substance that had a strong foul odor and the base of the toilet, where the toilet meets the floor, was brown in color with no seal. The bathroom wallpaper was ripped from the wall in several places. 5. At 8:28 AM room [ROOM NUMBER]: The door frame of the bathroom and the connected wall were separated, not allowing for the bathroom door to be safely used. 6. At 8:35 AM room [ROOM NUMBER]: The bathroom walls were noted to have brown stains on the upper area of the walls on the wallpaper, the exhaust fan was missing dry wall around it, the wall under the residents TV was noted to have several areas of marring. During an interview on 04/16/2025 at approximately 8:45 AM the Nursing Home Administrator, staff #1, was made aware of concerns found in resident rooms #34, #38, #39 and #40. Staff #1 stated that maintenance will be made aware and will look into the concerns. Based on observation and interviews with facility staff it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable homelike environment. This was observed on the second floor in 1 resident room (room [ROOM NUMBER]) on the east wing unit and 5 resident rooms (Rooom #29, #34, #38, #39, and #40) on the west wing unit during the survey. The findings include: 1. On 4/16/2025 at 8:55AM during a tour of the east wing nursing unit, the Surveyor observed room [ROOM NUMBER]. Resident #110 was in the first bed by the door. The resident was in his/her bed with the right side of the bed along the wall and was facing the door. The chair railing on the wall, next to the bed, was a plastic like cream material. There were strips of gray duct tape like material on the chair railing near the head of Resident #110's bed. On 4/17/2025 at 11:56AM the Surveyor made the Nursing Home Administrator (NHA) aware of the findings at the bedside of Resident #110 in room [ROOM NUMBER]. The NHA stated he would have the maintenance staff look into the concerns. On 4/18/2025 at 8:57AM, the NHA informed the Surveyor that the wall chair railing was repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 4/17/2025 at 11:06 AM, during an interview with Resident #22 in room [ROOM NUMBER], the Surveyor was informed that the resident likes to have his/her window open to get some fresh air and because the resident gets warm at times. The resident was in the bed closest to the window. The Surveyor observed cobwebs, dead insects, and a black like dirt like substance in the window between the screen and the glass. On 4/17/2025 at 11:56AM the Surveyor made the Nursing Home Administrator (NHA) aware of the findings in room [ROOM NUMBER]. The NHA stated he would have the maintenance staff look into the concerns. On 4/18/2025 at 8:57AM, the NHA informed the Surveyor that the window was cleaned between the screen and the glass.

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview with residents and staff, and other pertinent documents it was determined that the facility subjected residents to involuntary seclusion by restricting their ability to move freely. This was evident for 4 (Resident #17, #30, #102, #108) out of 15 residents residing in the locked area of the Med Bridge unit. Additionally, due to the restriction, Resident #108 experienced distress resulting in self-inflicted physical harm in an attempt to exit the locked unit. As a result of the non-compliance an IJ (Immediate Jeopardy) was determined on 4/25/2025 at 3:30 PM. An IJ summary tool was provided to the facility on 4/25/25. The facility submitted a draft of their plan to remove the immediacy on 4/25/25 at 6:40pm, and it was not accepted. The facility submitted a second draft of their plan to remove the immediacy on 4/25/25 at 7:45pm and it was accepted by the State Agency on 4/25/2025 at 8:00pm. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The Immediate Jeopardy was removed on 4/29/25 after on-site confirmation of the completion of the facility's plan of removal. The findings include: During an interview with the NHA (Nursing Home Administrator), the ADON (Assistant Director of Nursing) and Staff #2 on 4/16/25 at 1:11pm, Staff #2 stated that the locked unit was initiated on 10/31/24 following an elopement incident involving a resident. At the time of the interview, the door to the unit was unlocked and opened and remained that way during the rest of the survey. During record review on 4/25/25 at 11:40am, it was revealed that Resident #108 was observed by staff banging on the double doors of the locked portion of the Med Bridge unit on 11/6/24 at 7:00am. At 4:04pm, the resident had an X-ray performed which showed acute fractures of the distal radius and ulnar styloid. The resident was sent to the hospital on [DATE] for immobilization of the fractures. Prior to this incident, there had been no documentation to indicate Resident #108 had demonstrated similar behavior of banging on doors. During observation rounds on 4/16/25 at 7:56am, 15 residents were observed to be behind a locked door when the surveyor conducted an initial tour of the facility. The surveyor questioned the unit manager (Staff #18) regarding the lock unit. Staff #18 stated the locked door was not actually a locked unit and that it was part of a skilled unit. On 4/23/25 at 02:48pm, Staff #2 was interviewed for follow-up information regarding the decision to lock part of the Med Bridge unit. Staff #2 stated that the VPO (Vice President of Operations) initiated the locked portion of the unit as a temporary makeshift unit for the wandering residents. Brief Interview for Mental Status (BIMS) is an assessment tool used to screen and identify resident cognitive status. Scores of 8-12 indicate moderate cognitive impairment, scores of 13 or above indicate cognition is intact. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	BIMS scores were reviewed for all the residents residing in the locked area on 4/16/25. Three residents (#17, #30, #102) were identified to have BIMS scores above 11 indicating they would be interviewable. On 4/24/25 at 12:20 pm, interviews were conducted with the alert and oriented residents residing on the unit on 4/16/25 when the unit was found to be locked by the State Agency surveyors. Residents #17, #30, and #102 all stated they did not have the code to open the door and that when they needed to go off the unit that staff had to open the door for them. There was no evidence or documentation to indicate these residents needed to reside on a secure locked unit. The other 11 residents on the unit were determined to be not interviewable by review of their BIMS scores and had no documentation in their medical records indicating that they needed a locked unit for their safety. An immediate jeopardy was declared on 4/25/2025. The provision of the plan to remove the immediacy had a completion date of 4/25/25 and included the following: 1. The keypad on the doors was immediately disabled/deactivated and has remained open since 4/16/25 2. All residents in the facility, especially those who wander, have the potential to be affected. No doors in the facility except the door in question has a keypad. The keypad was deactivated on 4/16/25. 3. All double doors in resident care areas do not have keypad/unable to be locked except the doors referenced in this citation, which has been deactivated since 4/16/25. Residents who are noted to be wanderers are being monitored/redirected to their floors/units by the facility staff. All staff to be educated on resident's rights related to freedom from unnecessary restraint and seclusion. Training/in- service to be completed by 4/25/25 4. The facility administrator conducted an audit of all double doors in the resident care areas and no deficiency noted. This audit will continue daily x 4 weeks, weekly x 4 weeks and monthly x 3 months. Results of these audits will be submitted to the QA/QAPI committee for further recommendation(s)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 3. During an interview on 04/16/2025 at 12:00 PM Resident #50 stated that he/she reported to the facility that $20.00 was stolen from his/her room last year and no one had followed up with him/her as to what happened. During an interview on 04/16/2025 at 1:00 PM staff #1 was made aware, by surveyor, that Resident #50 reported that there was money stolen from his/her room. During an interview and review of facility documentation on 04/16/25 at 3:00 PM staff #1 submitted the Facility Reported Incident Initial Report Form (FRI) regarding Resident #50's missing money to surveyor. The (FRI) revealed that the facility documented having been aware of Resident #50 money missing on 10/03/24 but did not report it to the Office of Health Care Quality or other appropriate agencies within 24 hours of the time the money was reported missing. During an interview on 04/22/2025 at 9:14 AM staff #12 stated that Resident #50 reported money missing from his/her room on 10/03/2024 to him/her and it was not reported to the Office of Health Care Quality or any other agencies by the facility. Based on record review and interview with residents and facility staff, it was determined that the facility failed to timely report allegations of abuse within the required two-hour timeframe and failed to report an alleged violation of misappropriation of resident property/funds immediately or not later than 24 hours to the Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 3 resident's facility reported incidents (Resident #139, #353, and #50) out of 19 facility related incident reports reviewed during the survey. The findings include: 1. On 4/21/25 at 12:43pm, the surveyor reviewed a facility reported incident which was related to possible abuse of Resident #139. According to the incident report filed with the State Agency, the Assistant Director of Nursing (ADON) was notified at 12:00am on 4/16/25, the NHA (Nursing Home Administrator) was made aware at 7am, and the initial report was submitted to the State Agency at 3:15pm. 2. On 4/22/25 at 8:11am, a record review of MD00212051 revealed that the DON (Director of Nursing) was made aware of the allegation of abuse involving Resident #353 on 11/21/24 at 11am, the administrator was notified at 11:30am, and the report was submitted to the State Agency on11/21/24 at 4pm. The reporting to the State Agency of both allegations of abuse was outside the two-hour window. On 4/22/25 at 12:54pm, during an interview with Staff #2 she reiterated that the expectation for abuse reporting is within 2 hours of being notified of the occurrence.

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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. Based on observation, record review and interviews with staff, it was determined that the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #105) out of 33 residents reviewed during the investigative portion of the survey. The findings include: On 4/16/2025 at 12:11PM, the Surveyor observed Resident #105 in his/her room sitting in a chair. The resident had a wander guard on the right wrist. The resident had been observed walking around the hallways of the East Wing and [NAME] Wing units on 4/16/2025, 4/17/2025, and 4/22/2025 with a wander guard bracelet on the right wrist. Elopement or exit seeking risk are those who are at risk of leaving a place unnoticed and unsupervised. On 4/22/2025 at 10:45AM, a review of a facility reported incident (FRI) investigative file for Resident #105 revealed that on 1/10/2024 the facility substantiated the resident's elopement from the facility at approximately 9:24PM. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. On 4/22/2025 11:01AM, a review of Resident #105's electric medical record revealed an Elopement Risk Tool assessment on 1/11/2024 with a score of 11, which indicated that the resident was at high risk for elopement/exit seeking. A continued review revealed a care plan focus stating that [Resident #105] had a risk for elopement resident wanders related to impaired safety awareness secondary to dementia. [Resident #105] has a wander guard monitor on right wrist for placement /skin alteration created on 4/25/2023 with revisions on 1/12/2024 and interventions to include for elopement risk assessment, monitor wander guard for placement, and monitoring in progress. The Treatment Administration Record (TAR) for January 2024 confirmed that Resident #105's wander guard was checked for placement and function by nursing staff as ordered. The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 4/22/2025 at 11:46AM, during a review of the MDS quarterly assessment completed on 1/29/2024, the Surveyor discovered that Section E Behaviors revealed that there was no wandering behavior exhibited, and Section P Restraints revealed that the wander guard/alarm was not used. During an interview with the Regional Director of Clinical #2 on 4/22/2025 at 12:44PM, the Surveyor was informed that if a resident was at risk or at high risk for elopement, then a wander guard will be placed on that resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MDS Coordinator #19 on 4/23/2025 at 10:00AM, the Surveyor expressed the concern that the facility failed to ensure accuracy of an MDS assessment for a wandering resident after a substantiated elopement on 1/10/2024 and who was at the time a high elopement risk and had a wander guard bracelet. MDS Coordinator #19 confirmed that Resident #105 was not coded accurately for the use of a wander guard bracelet and wandering in their quarterly MDS assessment on 1/29/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 2. On 4/16/25 at 9am while speaking with Resident #39, s/he stated, I was seen by the dentist and would like these teeth pulled. I can only eat soft foods. On 4/16/25 at 9:30am the unit manager (staff #18) was made aware of the resident request. She stated the resident was seen by the dentist and she would follow up on it. Review of Resident #39's medical record on 4/22/25 at 11am revealed a dental consult dated 4/2/25 from a Prosthodontist, which read please evaluate and treat for full mouth rehabilitation; resident strongly wants implants. A Prosthodontist is a dental specialist who focuses on tooth restoration and replacement, including the design and fitting of prosthetics. They are trained in areas like dental implants, crowns bridges and dentures. The referral indicated Resident #39 needed several teeth surgically extracted. Further review of the medical record on 4/22/25 at 11:15am, failed to reveal a care plan to address the resident dental issues. Based on medical record review and staff interview, it was determined the facility failed to develop and implement a person-centered care plan to meet a resident's medical, nursing, mental, and psychosocial needs. This was evident for 4 out of 66 residents (Resident #74, #39, #141, #51, #108) reviewed during the survey. The findings include: 1. Review of Resident #74's medical record on 04/21/2025 at 11:38 AM revealed that Resident #74 was admitted to Hospice care on 02/13/2025 and Resident #74's care plan dated 03/06/2025 was not updated documenting that he/she was receiving Hospice care. During an interview on 04/21/2025 at 3:30 PM staff #11 stated and verified that Resident #74 was receiving Hospice care and that Resident #74's care plan dated 03/06/2025 was not updated that resident was receiving Hospice care. 3. A Wander Guard bracelet is a device that residents at risk for wandering or elopement wear to trigger alarms where the system is activated and can lock monitored doors to prevent the resident from leaving unattended. On 4/22/2025 at 12:09PM, during an interview conducted with the Regional Director of Clinical #2, the Surveyors were informed that every resident who is assessed as at risk or at high risk for elopement/exit seeking, will wear a wander guard bracelet for safety. On 4/25/2025 at 8:10AM, during a review of Resident #141's electronic medical record, the Surveyor discovered an elopement risk assessment dated [DATE] with a score of 14 which indicated that the resident was a high risk for elopement/exit seeking. An additional review revealed physician orders that the resident had a Wander Guard on the right lower leg, to check function weekly every Wednesday, and to check placement every shift. Further review failed to reveal a care plan focus for wandering and exit seeking behaviors with interventions to implement for the resident monitoring and safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/2025 at 9:30AM, during an interview conducted with the Nursing Home Administrator (NHA), the Surveyor requested Resident #141's care plan for wandering and exit seeking. On 4/25/2025 at 9:49AM, the NHA confirmed that Resident #141 did not have a care plan implemented for wandering and exit seeking and that the nursing staff would create one. 4. Ataxia is a neurological disorder characterized by a lack of coordination and control over muscle movement. On 04/25/25 at 01:12 PM, during observation rounds on 4/16/25 and 4/17/25, Resident #51 was noted smoking without supervision. On 04/25/25 at 01:12 PM, during observation rounds on 4/18/25, 4/21/25, 4/22/25, 4/23/25 and 4/24/25 Resident #51 was observed smoking without supervision and not wearing a smoking apron/blanket. On 04/25/25 at 01:41 PM, review of resident records revealed that Resident #51's Smoking Safety Screen, dated 4/18/25, indicated that Resident #51 was a smoker, had dexterity problems, unable to use a lighter independently, required a smoking apron/blanket while smoking, and required supervision while smoking. On 04/25/2025 at 1:43 PM, review of resident records revealed that Resident #51 had a medical diagnosis of ataxia and muscle weakness. On 04/25/25 at 01:47 PM, review of resident records revealed that Resident #51's care plan indicates that Resident #51 required supervision while smoking. Resident #51's care plan did not indicate that Resident #51 required a smoking apron/blanket while smoking as stated in the Smoking Safety Screen. On 04/25/25 at 2:18 PM, Activity Director staff #12 was interviewed. During the interview, staff #12 stated that many dependent smoking residents and independent smoking residents are non-compliant with following the smoking policy. Dependent smoking residents have been told several times that they must smoke in the downstairs courtyard where they can be supervised by staff as well as wear a smoking apron/blanket. Staff #12 also stated that they have told independent smokers not to light cigarettes for dependent smokers. On 04/25/25 at 2:49 PM, Resident #51 was interviewed. During the interview, Resident #51 indicated that he/she was aware that they must be supervised by staff and must wear a smoking apron/blanket while smoking. 5. On 04/25/2025 at 1:32 PM, review of resident records revealed that Resident #108's care plan indicated that, on 4/24/23, Resident #108 was care planned as being an elopement risk/wanderer and had behavior of removing his/her elopement band. Also, the care plan's intervention mentioned to check Resident #108's elopement band's function weekly and replace the elopement band as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2025 at 1:44 PM, Review of resident records revealed that Resident #108's Medication Administration and Treatment Administration Records, from 1/1/24 until 4/25/25, indicate that Resident #108 was monitored for the following behaviors: itching; picking at the skin; restlessness (agitation); hitting; increase in complaints; biting; kicking; spitting; cussing; racial slurs; elopement; stealing; delusions; hallucinations; psychosis; aggression and refusing care. On 04/25/2025 at 1:47 PM, Review of resident records revealed that Resident #108's Medication Administration and Treatment Administration Records indicate that during the evening shift on 11/7/24, it was documented that Resident #108 displayed at least one of the following behaviors: itching; picking at the skin; restlessness (agitation); hitting; increase in complaints; biting; kicking; spitting; cussing; racial slurs; elopement; stealing; delusions; hallucinations; psychosis; aggression and refusing care. On 04/25/2025 at 1:51 PM, Review of resident records revealed that Resident #108's Medication Administration and Treatment Administration Records, for January 2024, indicate that there was an order to check Resident's 108's wander prevention band every shift for monitoring, which started on 1/31/24 and discontinued on 2/7/24. Also, it was documented on the Medication Administration and Treatment Administration Records, for January 2024 and February 2024, that Resident #108's wander prevention band was checked on: the evening and night shifts on 1/31/24; the day, evening and night shifts from 2/1/24 through 2/6/24; and the day shift of 2/7/24. However the care plan was not updated to reflect the discontinuation of testing the wanderguard band weekly. On 04/25/2025 at 1:56 PM, Review of resident records revealed that Resident #108's Medication Administration and Treatment Administration Records, for April 2025, indicate that there was an new order to check the function of Resident's 108's left leg Wanderguard weekly, every dayshift on Wednesdays for elopement prevention, which started on 4/14/25. Also, it was documented on the Medication Administration and Treatment Administration Records, for April 2025, that Resident #108's left leg Wanderguard was checked at 11:00 AM on the dayshifts of 4/16/25 and 4/23/25 and evening and night shifts of 4/14/25 and the dayshift on 4/25/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview with staff, it was determined that the facility failed to ensure residents were offered the opportunity to participate in their care planning process by holding timely care plan meetings. This was evident for 1 (Resident #8) out of 4 residents reviewed for care planning during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. On 4/18/2025 at 12:10PM, an interview with Social Worker (SW) #23 revealed that care plan meetings are held quarterly after a quarterly or annual MDS assessments and as requested by family or residents. Since starting approximately 6 months ago, SW #23 identified an issue with timely care plan meetings for residents and was currently in the process of completing past due care plan meetings with residents and/or resident representatives. On 4/21/2025 at 8:22AM, during a review of Resident #8's electronic medical record, the Surveyor discovered that that the resident had a quarterly MDS assessment on 8/22/2024 and 11/22/2024 and an annual MDS assessment on 1/19/2025. Further review failed to reveal care plan meetings including the resident and resident representative following the quarterly and annual MDS assessments for 8/6/2024, 11/22/2024, and 1/19/2025. On 4/21/2025 at 9:30AM during an interview with SW #23, the Surveyor expressed the concern that Resident #8 did not have care plan meetings after their MDS assessment on 8/6/2024, 11/22/2024, and 1/19/2025. The Surveyor requested documentation to verify that Resident #8 had care plan meetings on those dated MDS assessments. On 4/21/2025 at 10:00AM, the Surveyor and SW #23 confirmed that Resident #8 did not have care plan meetings after MDS assessment on 8/6/2024, 11/22/2024, and 1/19/2025. SW #23 provided documentation of a care plan meeting for Resident #8 scheduled on 5/1/2025 at 11:00AM.

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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 record review and interview with staff, it was determined that the facility failed to meet professional standards of care by ensuring a resident's cardiology follow up appointment was scheduled as ordered by physician. This was evident for 1 (Resident #303) out of 33 facility residents reviewed during the investigative phase of the survey. The findings include: On 4/18/2025 at 10:21, a review of Resident #303's electronic medical record revealed a physician order, dated 2/15/2025, for the resident to follow up with his/her cardiologist in 12 weeks. During further review, the Surveyor discovered that the resident was admitted to the facility on [DATE] after being hospitalized for a stroke. On 4/22/2025 at 9:50AM, the Surveyor requested documentation of Resident #303's follow up appointment with his/her cardiologist as ordered on 2/15/2025. During an interview conducted with the Assistant Director of Nursing (ADON) #11 on 4/23/2025 at 9:30AM, the Surveyor was informed that when a resident is admitted to the facility, the nurses reconcile all orders from the discharge summary. If the resident has a doctor's appointment ordered on the discharge summary and was placed in the electronic health record, the unit manager reviews the order and will inform the unit clerk to schedule the appointment for the resident. The Surveyor requested documentation to verify that the unit clerk tried to schedule an appointment prior to this day. On 4/23/2025 at 9:50AM, an interview with Unit Clerk #26 confirmed that Resident #303 had a cardiology appointment scheduled for 6/3/2025. The Surveyor discovered that Unit Clerk #26 cannot access the electronic health record to see orders for appointments, so the unit managers inform her when a resident has an appointment that needs to be scheduled. Unit Clerk #26 informed the Surveyor that she just found out about Resident #303's need for a cardiologist appointment on 4/22/2025 and scheduled the appointment that day for 6/3/2025. On 4/23/2025 at 9:55AM, the ADON provided the Surveyor with a copy of the new physician order dated 4/22/2025 at 11:09AM for Resident #303's cardiology appointment scheduled for 6/3/2025 at 11:30AM.

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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. Based on medical record review, observation, and staff interview it was determined the facility failed to administer medication to a resident as ordered by the physician. This was evident for 1 resident #106 out of 7 residents reviewed for orders during the survey. The findings include: Review of Resident #106's medical record on 04/18/2025 at 6:30 AM revealed a physician's order stating that Resident #106 was to receive a controlled substance medication Lacosamide 150mg 1 tablet by mouth twice daily. During observation rounds and review of Resident #106's medical records on 04/18/2025 at 6:32 AM on the [NAME] wing medication cart #1 with staff #5, a controlled substance count of Resident #106's medication Lacosamide 150mg tablet blister pack was counted to have a total of 8 tablets. A review of the facility medication-controlled substance count sheet revealed that on 04/17/2025 at 9:00 PM staff #6 signed that Resident #106 received 1 tablet of medication Lacosamide 150mg and there was a total of 7 tablets left. During an interview on 04/18/2025 at 6:35 AM staff #5 stated that Resident #106 had not received medication Lacosamide 150mg during his/her shift yet and confirmed that the controlled substance blister pack count for medication Lacosamide was incorrect compared to the controlled substance medication Lacosamide count sheet.

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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** 4a. Record review of Resident #23's medical record on 4/16/25 at 10:15 AM revealed a smoking care plan was initiated on 7/27/22 and revised on 2/5/25. It indicated the resident was a dependent smoker with the goal to monitor any issues or complications and assist the resident during smoking times. Additionally, on 5/22/23 a focus area was added to the care plan that the resident was non-compliant with wearing the recommended smoking vest and following the facility smoking policy; however, the goals and/or interventions did not address the resident's noncompliance. During observation rounds 4/16/25 at 9am resident #23 was observed reclining back in the wheelchair in the courtyard located on the first floor. The resident was observed with a lit cigarette hanging from his/her mouth and was unsupervised. On 4/17/25 at 8am Resident #23 was again observed by this surveyor in the upper level courtyard with his/her wheelchair reclined back. Resident #36 walked over to Resident #23 and put a lit cigarette in his/her mouth. At that time the Administrator was walking in the hall and verified the findings. The Administrator stated Resident #36 should not be giving Resident #23 or any other resident a cigarette. Review of Resident #36's record revealed s/he was assessed as being an independent smoker with a BIMs of 9 (moderately cognitive impaired). 4b. Review of Resident #125's medical record on 4/16/25 at 11am revealed the resident has a BIMs (brief interview of mental status) score of 7, (0-7 indicates severe cognitive impairment) as of 4/15/25. Continued review of the medical record revealed a Smoking-Safety Screen dated 2/4/25 assessing the resident as being an independent smoker. Resident #125 was observed ambulating back and forth in the upper level (1st floor) courtyard with a lit cigarette in his/her hand and was unsupervised. During an interview on 4/16/25 at 9:15am the Administrator and the Acting Director of Nursing were made aware of the observation. Both stated that dependent smoking residents should be monitored and should be going downstairs to the courtyard to smoke. It was verified by Both the Administrator and the ADON that resident #125 had been assessed as being a dependent smoker. During an interview with the Activities Director on 4/16/25 at 9:30am, she stated that she has spoken to residents on several occasions about lighting dependent resident cigarettes. She stated Resident #23 was non-compliant with the smoking policy and has been told several times that the dependent residents are to smoke in the downstairs courtyard where they can be supervised. Based on record reviews, observations, and interviews with staff and residents, it was determined that the facility failed to:1) ensure a system was in place to prevent exit seeking residents from leaving the facility unsupervised. This was evident for 2 (Resident #105 and Resident #154) out of 22 residents reviewed for exit seeking; 2) Assess, Supervise and monitor residents while smoking. This was evident for 4 (Resident #106, #23, #125, and #51) out of 22 residents reviewed for smoking; 3) Assess and monitor residents with known wandering behaviors. This was evident for 1 (Resident # 108) out of 25 residents reviewed for wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of this deficient practice, an Immediate Jeopardy was identified on 4/25/2025 at 9:10 PM. An IJ summary tool was provided to the facility on 4/25/2025. The facility submitted the first plan to remove the Immediacy on 4/25/2025 at 11:18PM. The first plan was not accepted. The facility submitted a 2nd plan to remove the Immediacy on 4/26/2025 at 2:01AM. The 2nd plan was not accepted. The facility submitted a 3rd plan to remove the Immediacy on 4/26/2025 at 3:21AM. The 3rd plan was not accepted. The facility submitted a 4th plan to remove the immediacy on 4/26/2025 at 3:55AM which was accepted at 4:22AM. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The Immediate Jeopardy was removed on 4/29/25 at 3:15 PM after on-site confirmation of the completion of the facility's plan of removal. The Findings Include: Wandering is a pattern of aimless and often repetitive walking that significantly increases the risk of injury to the individual. Elopement or exit seeking risk are those who are at risk for leaving a place unnoticed and unsupervised. 1. On 04/18/25 at 9:20 AM, a review of resident #154's medical record and facility investigation revealed a care plan focus area, created on 07/29/2022, stated that resident #154 has a risk for elopement and patient wanders related to Impaired Safety Awareness. The resident had a Brief Interview for Mental Status (BIMS) score of 02/15 on 10/21/2024, which indicated the resident was severely cognitively impaired. Further review of an Elopement Risk Tool assessment dated [DATE] revealed resident #154 was a high risk for elopement and exit seeking. A care plan focus area, created on 10/22/2024, stated the resident was at risk for elopement related to dementia and the patient wears a wander guard. On 04/18/2025 at 10:00 AM a review of the facility investigation revealed that on 10/30/2024 approximately. 4:34 PM the facility was first made aware when a phone call from hospital alerting them that resident #154 was found and brought to the emergency room by Emergency Medical Services (EMS). EMS received a call from someone in the community that resident #154 was on their property, EMS responded and took the resident to the Emergency Room. Per facility investigation on 10/30/2024 the resident was last seen by Nurse staff #20 at 2:00 PM standing in the hallway of the unit. Staff #20 said he heard the back door alarm go off and responded immediately with other staff members and they went outside the door but did not see anyone, the alarm was deactivated and staff returned to the unit. The investigation revealed that the staff did not take any additional steps to validate that Resident #154 was still on the unit and in the facility. Further review of resident #154's medical record and facility investigation revealed that on 10/30/2024 at 7:30 PM Resident #154 returned to the facility from the emergency room and the Nurse Supervisor verified that the resident was wearing a wander guard, staff completed an assessment on resident and determined that resident had no injuries, facility placed a one on one caregiver with resident upon return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/22/2025 at 12:09 PM during an interview - Regional Consult for Clinical staff #2 stated on 10/30/2024, day of the elopement, it was on the downstairs unit, 2-3 staff members went through the first door on the unit leading to the stairwell to go to a training on another unit upstairs. The door closed and shortly after Resident # 154 went through the first door entering the stairwell, then Resident #154 went to the left and went through the second door that leads to the outside and staff responded to the alarm, they looked around outside and did not see anyone and came back into the center. On 04/22/2025 at 1:45 PM during observation rounds of facility and interview with Maintenance Director staff #13, Assistant Director of Nursing staff #11 and Regional Consult for Clinical staff #2, the Maintenance Director stated the doors that Resident #154 eloped from were located on the lower level of the facility near room [ROOM NUMBER]. After the elopement of Resident #154 the keypad, release button on the inside of stairwell door and wander guard system leading out the first door into the stairwell was noted to be broken. The wander guard system only works if the resident is wearing a wander guard and presses the door handle. The second door that the resident went through leading to the outside of the building had not been connected to the fire alarm system but will now open and alarm only when the fire alarm is alarming. At the time of rounds the first door leading to the stairwell did alarm when the door was pressed while holding a wander guard device near the door and the second door was noted to be locked and able to be opened only by using the keypad with a code. On 04/23/2025 at 9:48 AM during observation rounds with Maintenance Director staff #13 and Nursing Home Administrator staff # 1 revealed the wander guard systems did not alarm when a wander guard device was placed next to the doors which demonstrated that the wander guard system was not working for the following doors: a. the upper East Wing door, b. the lower level East Terrace door next to the physical therapy room, c. the lower level East Terrace door between physical therapy room and DON office, d. the upper level Main Dining Room door and the upper level door next to the Dietician office 2. On 4/22/2025 at 11:00AM, a review of Resident #105's electronic medical record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of but not limited to dementia and anxiety. The resident had a Brief Interview for Mental Status (BIMS) score was 13/15, which indicated the resident was cognitively intact. There was a care plan focus created on 4/25/2023, which stated that the resident wanders related to impaired safety awareness secondary to Dementia. Further review revealed an admission Elopement Risk Assessment on 4/24/2023 which indicated the resident was at a high risk for elopement/exit seeking. The resident had physician orders dated 10/5/2023 for a wander guard on the right wrist, to check function weekly every day shift on Wednesdays, and to check placement every day, every shift and a quarterly Elopement Risk Assessment on 10/27/2023 which indicated the resident was at risk for elopement/exit seeking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/22/2025 at 10:45AM, a review of a facility reported incident (FRI) investigative file revealed that on 1/10/2024 at approximately 9PM, Resident #105 and a visitor were allowed out of the building by a Geriatric Nursing Assistant (GNA) staff member. The GNA staff member assumed the resident was going on a leave of absence with a family member. The GNA turned off the wander guard alarm at the main entrance door after the resident's wander guard triggered the alarm. Further review of the FRI revealed that on 1/10/2024 at approximately 9:24PM, Resident #105 was returned to the facility accompanied by two police officers who saw the resident walking along the sidewalk down the street from the facility. The resident informed the officers that he/she resided at the facility and did not go out and wanted to take a walk. The resident sustained no injuries. 3. On 4/18/2025 at 7:37AM a review of the facility's current smokers list as of 4/7/2025, revealed Resident #106 was an independent smoker, indicating the resident did not need to be supervised while smoking. During review of Resident #106's electronic medical record, the Surveyor discovered a quarterly smoking safety screen assessments with scores. Scores of 0-4 mean the resident may smoke unsupervised and scores 5 or greater means the resident requires supervision with smoking. Resident #106 was assessed as a smoker and had a smoking safety screen score of 0 on 4/17/2024, score of 7 on 7/17/2024, and a score of 2 on 10/18/2024. On a 1/20/2025 smoking safety screen assessment it documented the resident did not smoke and had a score of zero. Further review of the electronic medical record revealed a care plan created on 4/14/2023 and updated on 3/26/2025 with a focus which stated the resident prefers to smoke with interventions for nursing staff to complete a smoking assessment as needed and all staff to supervise with smoking. On 4/18/2025 at 7:00AM, the Surveyor observed Resident #23 and Resident #125 in the upper-level courtyard smoking unsupervised. On 4/18/2025 at 7:50AM during an interview with Activity Director #12, the Surveyors were informed that she does the smoking assessments and that the nursing staff should follow up with them. 6. On 4/22/25 at 11:11 AM, during review of the medical record for Resident #108, the resident's care plan from 5/4/24 read as follows [Resident 108] is an elopement risk/wanderer related to impaired safety awareness. The following interventions were in place Monitor the resident while on the unit as indicated, Redirect the resident as needed. These interventions were in place to prevent Resident #108 from wandering into areas that could lead to an unsafe situation. Review of the previous care plans for Resident #108 showed that he/she was identified as a wanderer since being admitted in April 2023. The prior care plans were dated 5/9/23, 8/8/23 and 11/6/23 and all identified Resident #108 as a wanderer. On 4/24/25 at 2:19pm, review of the progress notes for Resident #108 revealed that on 5/21/24 the resident had wandered into Resident #154's room and when asked to leave, Resident #108 took his/her shoe and threatened to hit Resident #154. Staff separated the residents and took Resident #108 back to his/her room. The resident care plan was not updated with any additional interventions after this incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's investigation related to facility-reported incident MD00206662 was reviewed on 4/22/25 at 10:17 AM. In the investigation, the facility substantiated there was an altercation on 6/13/24 between Resident #108 and Resident #19. The investigation revealed that Resident #108 wandered into Resident #19's room. Resident #19, unable to call for help due to their medical condition, attempted to go into the hall for assistance and used an emergency whistle to get attention from staff. When no one came to assist, Resident #19 felt he/she was in danger and pepper sprayed Resident #108. Resident #108 had a BIMS (Brief Interview for Mental Status) score of 0 on the most recent assessment dated [DATE] prior to this incident. BIMS scores of 0-7 indicate severe cognitive impairment. Resident #108 was found by staff screaming and holding his/her hands over his/her eyes. The resident was evaluated by the physician at the facility and was ordered to be sent for further evaluation at the hospital. The resident was diagnosed with chemical burns of the eyes at the hospital and was prescribed eye drops for 5 days. On 4/23/25 at 01:40pm, an interview with Resident #19 was conducted. He/she stated that the incident with Resident #108 was not the first time that a wandering resident had entered his/her room and that he/she had alerted administration and staff that it was a recurrent problem. He/She also said that he/she was pushed to the floor in the past by another resident who wandered into his/her room. On 4/23/25 at 8:46am, the facility provided 2 more incident reports which involved Resident #108 wandering into other resident rooms. On 10/27/24 Resident #108 wandered into a resident's room and hit the resident with a plastic hanger, which was substantiated by a witness. The corrective actions related to this incident were to conduct staff in-service on close monitoring and redirection of wandering residents. On 12/2/24, Resident #108 was involved in another incident where Resident #108 wandered into a different resident's room and allegedly kicked his/her leg but there were no other witnesses, and the altercation could not be substantiated. The facility's investigation found that staff did not see Resident #108 enter the other resident's room that night and no witnesses could confirm the event occurred. The corrective action for this incident was as follows, [Resident #108] is being monitored by staff. There were no modifications to the interventions in Resident #108's care plan following the incident on 6/13/24. Further review of the progress notes showed that Resident #108 continued to wander into other residents' rooms with documented examples from the dates 11/21/24, 11/27/24, 12/5/24, 12/12/24, 1/2/25, 2/3/25, 2/20/25, 2/23/25, 3/23/25, and 4/19/25. On 4/24/25 at 09:35am, an interview was conducted with the NHA (Nursing Home Administrator) who stated that the expectations for standard practice at this facility were to monitor the wandering residents anytime they are in the hallways. An Immediate Jeopardy was identified on 4/25/2025. The provision of the plan to remove the Immediate Jeopardy immediacy had a completion date of 4/29/2025 and included the following: 1. Resident #154 no longer resides in the facility; Resident #105 still resides in the facility with a wander guard in place, functioning checked and the wander guard functioning properly. 2. Resident #23, #36, #125, and #51 still reside in the facility and will be supervised during smoking activity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Resident # 23 will be provided reeducation on the designated smoke areas and times and was provided with the smoking acknowledgment form for compliance. b. Resident #125 will be provided supervision during smoking activity. A designated staff member will be stationed at the upper-level courtyard door. 3. Wander guards are in place and working properly for Resident #141, 121, and #108. Facility staff will supervise both smoking areas located in the upper and lower level of the facility throughout all scheduled smoke times whether dependent or independent. 4. All individuals identified as a smoker, wanderer, or at risk for elopement have the potential to be affected. A facility wide audit was conducted to verify accuracy of assessments for all residents completed by 4/29/2025. 5. All doors with the wander guard system were checked for proper functioning by the vendor on 4/24/2025 and the following was corrected: a. Checked all secure units, lobby, east wing, exit to kitchen, stairwell by lounge, west by central supply, east terrace by smoking area, east terrace by rehab, main dining room, and exit by maintenance shop. Replaced strobe alarm at terrace smoking door. Disconnect door switch to allow alarm to activate. Verify alarms at all remaining doors while approaching the door. 6. All doors with a wander guard system were checked for proper functioning by the Maintenance Director on 4/26/2025 at 12:45AM and confirmed to be functioning properly. 7. All residents with the wander guard bracelets were checked for placement and function on 4/26/25 at 12:45AM. 8. All residents with wandering behavior will be provided monitoring to ensure safety and wellbeing with the use of an individual hourly monitoring log daily to be completed by nursing and care plan reviewed and revised accordingly. 9. To ensure the accuracy and use of appropriate safety devices, the facility will conduct a new assessment on all current wandering and elopement risk residents by 4/29/2025. 10. To accurately determine the level of assistance needed, all smoking residents will receive a new assessment for 4/29/2025. 11. To safeguard residents, staff will be trained on alarm response and thorough search procedures, followed by a headcount to ensure all are present and accounted for by 4/29/2025. 12. For resident safety, a designated staff member will always provide supervision for all residents during scheduled smoking times. Training will be provided to all staff on facility smoke policy by 4/29/2025. 13. All residents identified for wandering, elopement risk, and smoking will have behavior monitoring implemented as needed by 4/29/2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Wander guard device functioning will be checked weekly by central supply b. Wander guard device placement will be checked every shift by the charge nurse and/or the supervisor. 14. 100% audit was conducted of the wander guard door a;arm system and bracelets completed. The Maintenance Director will complete a daily audit on exit doors x4 weeks, weekly audits x4, and monthly audits x3; daily monitoring of the smokers supported with an audit tool will be completed daily by the nursing staff daily x4 weeks, weekly x4 weeks, and monthly x3; Nursing will monitor all wandering residents Q hourly utilizing a monitoring log to ensure safety daily x4 weeks, weekly x4 weeks, and monthly x3; wander guard device placement audit will be conducted daily x4, weekly x4 and monthly x3 by central supply. 15. All results of the audits will be submitted to the QA/QAPI committee for further recommendation (s) monthly and as needed. 5. On 04/25/25 at 01:41 PM, review of resident records revealed that Resident #51's Smoking Safety Screen, dated 4/18/25, indicated that Resident #51 was a smoker, has dexterity problems, cannot use a lighter independently, requires a smoking apron/blanket while smoking, and must be supervised while smoking. On 04/25/2025 at 1:43 PM, review of resident records revealed that Resident #51 has a medical diagnosis of ataxia and muscle weakness. On 04/25/25 at 01:47 PM, review of resident records revealed that Resident #51's care plan indicated that Resident #51 must be supervised while smoking. Resident #51's care plan did not indicate that Resident #51 must use a smoking apron/blanket while smoking. On 04/25/25 at 01:12 PM, during observation rounds on 4/16/25 and 4/17/25, Resident #51 was noted smoking unsupervised. On 04/25/25 at 01:12 PM, during observation rounds on 4/18/25, 4/21/25, 4/22/25, 4/23/25 and 4/24/25 Resident #51 was observed smoking unsupervised without wearing a smoking apron/blanket. On 04/25/25 at 2:18 PM, Activity Director staff #12 was interviewed. During the interview, staff #12 stated that many dependent smoking residents and independent smoking residents are non-compliant with following the smoking policy. Dependent smoking residents have been told several times that they must smoke in the downstairs courtyard where they can be supervised by staff as well as wear a smoking apron/blanket. Staff #12 also stated that they have told independent smokers not to light cigarettes for dependent smokers. On 04/25/25 at 2:49 PM, Resident #51 was interviewed. During the interview, Resident #51 indicated that he/she was aware that they must be supervised by staff and must wear a smoking apron/blanket while smoking.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interviews, it was determined that the facility failed to post the required staffing information in a prominent and readily accessible location for all residents and visitors. This was evident for 17 out of 32 residents on the Med Bridge unit. The findings include: During observation rounds on 4/16/25 at 7:56am, 15 residents were observed to be behind a locked door on the Med Bridge unit when the surveyor conducted an initial tour of the facility. The Med Bridge unit had 32 residents in total with 17 of them residing on the unlocked portion of the unit. The white dry erase board with the daily staffing schedule was not posted so that visitors and residents could easily visualize the information from the unlocked side. It was on the wall inside the locked side of the unit and could only be seen through a slim rectangular window on the side of the door. The surveyor found the sign was only visible from a difficult angle, making it inaccessible to most ambulatory residents. The surveyor questioned the unit manager (Staff #18) regarding the ability of all residents to see the posted staffing information. Staff #18 confirmed that the staffing information was posted on the locked side and explained that staff are expected to inform residents of their assigned caregivers at shift start. On 4/16/25 at 1:11pm, the NHA (Nursing Home Administrator), ADON (Assistant Director of Nursing) and Staff #2 were informed of the concerns regarding 17 residents on Med Bridge unit not having nurse staffing information posted in a prominent place readily accessible to residents and visitors. At this time the unit was unlocked, and all residents and visitors were able to view the signage.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, observation and staff interview, it was determined that the facility failed to perform accurate reconciliation of resident controlled substance medications. This was evident for 1 resident (#106) out of 7 residents reviewed for medications during survey. The findings include the following: Review of Resident #106 medical's record on 04/18/2025 at 6:30 AM revealed a physician's order stating that Resident #106 was to receive controlled substance medication Lacosamide 150mg 1 tablet by mouth twice daily. During observation rounds, review Resident #106's medical records and facility medical records on 04/18/2025 at 6:32 AM on the [NAME] wing medication cart #1 with staff #5, revealed a controlled substance count of Resident #106's medication Lacosamide 150mg tablet blister pack was counted to have a total of 8 tablets. A review of the facility medication controlled substance count sheet revealed that on 04/17/2025 at 9:00 PM staff #6 signed that Resident #106 received 1 tablet of medication Lacosamide 150mg and there was a total of 7 tablets left. The facility shift count for all controlled substances reveled that on 4/17/25 on the 11:00 PM - 7:00 AM shift staff #5 and #6 signed that the status of the controlled substances count was exact. On further review staff #5 had already signed the shift count sheet on 4/18/25 for 7:00 AM - 3:00 PM shift as completed but the count sheet was not completed with another nurse. During an interview on 04/18/2025 at 6:35 AM staff #5 stated and confirmed that the controlled substance medication Lacosamide blister pack count for Resident #106 was incorrect compared to the controlled substance medication Lacosamide count sheet and the medication was not administered 04/17/2025 on the 11:00 PM to 7:00 AM shift. Staff #5 further stated that the shift count sheet on 04/18/2025 7:00 AM - 3:00 PM should not have been signed off by him/her without doing the count with another nurse at the time of change of shift.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation and interviews it was determined that the facility staff failed to ensure a resident received dental care. This deficient practice was evidenced in 1 (#39) of 2 residents assessed for dental care during the survey. The findings include: On 4/16/25 at 9am while speaking with Resident #39, s/he stated, I was seen by the dentist and would like these teeth pulled. I can only eat soft foods. On 4/16/25 at 9:30am the unit manager (staff #18) was made aware of the resident request. She stated the resident was seen by the dentist and she would follow up on it. Review of Resident #39's medical record on 4/22/25 at 11am revealed a dental consult dated 4/2/25 from a Prosthodontist which read please evaluate and treat for full mouth rehabilitation; resident strongly wants implants. A Prosthodontist is a dental specialist who focuses on tooth restoration and replacement, including the design and fitting of prosthetics. They are trained in areas like dental implants, crowns bridges and dentures. The referral indicated resident #39 needed several surgical extractions. During an interview with the Administrator on 4/22/25 at 11:30am, he stated that the amount for the dental work the resident was requiring was thousands of dollars and the resident was not insured for the procedure. During an interview on 4/22/25 at 12pm with the ADON she stated that the resident was seen by the Prosthodontist for possible dental work and she would investigate it. During an interview with the Business Office Manager on 4/22/25 at 1pm, he stated there was a program that the resident can apply for and he would speak to the resident regarding the cost. On 4/24/25 at 11am the surveyor received a copy of a National Preventive Solutions Corp Senior Dental Plan Application dated 4/24/25; which applied for dental insurance and an email that stated, could you please process this as soon as possible and request a visit for this resident. The form and email were completed and sent by the Business Office Manager. When asked why this referral was not done sooner, he stated he was not aware of the dental issue until this surveyor spoke to him about it.

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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, interviews and facility policy review, it was determined that the facility failed to store food in accordance with professional standards for food service safety. The findings include: During observation rounds with Dietary Aide staff #7 on 04/16/25 at 08:04 AM, the kitchen's dry goods storage room was observed to have sealed bins of white flour, white rice, brown rice, and sugar with expired use-by dates labeled on them. The white flour had an expired use-by date of 3/1/25. The white rice had an expired use-by date of 2/5/25. The brown rice had an expired use-by date of 3/5/25. The sugar had an expired use-by date of 3/5/25. During observation rounds with Dietary Aide staff #7 on 04/16/25 at 08:11 AM, the kitchen's freezer was observed to have an have opened, frozen bag of pepperoni that was not labeled when it was opened and when it would expire. On 04/16/2025 at 10:22 AM, the Dietary Director staff #8 and Regional Food Service Director staff #9 were interviewed. During the interview, the surveyor informed staff #8 and #9 that the kitchen's dry goods storage room was observed to have sealed bins of white flour, white rice, brown rice, and sugar with expired use-by dates labeled on them. Also, the surveyor informed staff #8 and #9 that the kitchen's freezer was observed to have an opened, frozen bag of pepperoni that was not labeled when it was opened and when it would expire. On 04/16/2025 at 01:25 PM, the Nursing Home Administrator staff #1 was interviewed. During the interview, the surveyor informed staff #1 that the kitchen's dry goods storage room was observed to have sealed bins of white flour, white rice, brown rice, and sugar with expired use-by dates labeled on them. Also, the surveyor informed staff #1 that the kitchen's freezer was observed to have an opened, frozen bag of pepperoni that was not labeled when it was opened and when it would expire. On 04/16/25 at 10:49 AM, the facility's Food Storage Chart policy was reviewed. The facility's Food Storage Chart policy states that the expiration dates printed by the manufacturer apply until the food product is opened. Rice, flour and sugar have an expiration date of 6 months once opened, unless the manufacturer's date is sooner. All frozen food items have an expiration date of 3 months once opened, unless the manufacturer's date is sooner. Also, the opened food item must be labeled with the date it was opened to determine the expiration date.

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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. 3. A Brief Interview for Mental Status (BIMS) is a standardized cognitive screening tool used in long-term care facilities to quickly assess a resident's cognitive function. The score ranges from 0 to 15, and different ranges suggest varying levels of cognitive impairment. A score of 13-15 generally indicates intact cognition, 8-12 suggests moderate impairment, and 0-7 indicates severe impairment. A smoking screen and/or assessments in long-term care facilities focus on evaluating residents' ability to safely smoke without posing a risk to themselves or others. These assessments typically consider cognitive ability, judgement, manual dexterity, mobility, and physical diagnoses that could impact smoking safety. During review of Resident #54's medical record on 04/17/2025 at 1:30 PM revealed on 03/03/2025 Resident (#54) had a Brief Interview for Mental Status (BIMS) assessment score of (99). A score of (99) is entered when a resident is unable to complete the interview, but the assessment revealed answers that a resident was able to complete the interview with answers that showed the resident had severe impairment. Further review of Resident #54's record revealed a Smoking Safety Screen V2-V4 dated 2/11/2025 question A. COGNITIVE - Does resident have cognitive loss; the answer is documented No. During an interview on 04/23/2025 at 2:00 PM staff (#19) stated that residents #54 Minimum Data Set Assessment BIMS for 03/03/2025 score was not filled out correctly. During review of Resident #54's medical record on 04/25/2025 at 3:10 PM revealed that after surveyor intervention the facility completed a Brief Interview and Staff assessment on 04/25/2025 at 14:50 PM on Resident #54 and resident scored a 14 out of 15. 4. During review of Resident #27's medical record on 04/17/2025 at 2:30 PM revealed on 01/19/2025 Resident #27 had a Brief Interview for Mental Status (BIMS) assessment score of (99). A score of (99) is entered when a resident is unable to complete the interview, but the assessment reveals answers that a resident was able to complete the interview with answers that showed the resident had severe impairment. Further review of Resident #19's record revealed a Smoking Safety Screen V2-V4 dated 2/13/2025 question A. COGNITIVE - Does resident have cognitive loss; the question was not answered and was blank. Question C. Dexterity - Does the resident have any dexterity problems; the question was not answered and was blank. During an interview on 04/23/2025 at 2:30 PM staff #19 stated Resident #27's Minimum Data Set Assessment BIMS for 03/03/2025 score was not filled out correctly. During review of Resident #27's medical record on 04/25/2025 at 3:10 PM revealed that after surveyor intervention the facility completed a Brief Interview and Staff assessment on 04/18/2025 on Resident #27 and resident scored 15 out of 15. 5. Review of Resident #74's medical record on 04/21/25 at 11:40 AM revealed a care plan dated 03/06/2025 that documented Resident #74 was a Full Code and Do Not Resuscitate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/2025 at 3:35 PM with staff #11 verified and stated that Residents #74 care plan dated 03/06/2025 did have that resident was a Full Code and Do Not Resuscitate and this would be corrected. Based on record review and interviews with the residents and staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards of practice. This was evident for 5 (Resident #8, #22, #54, #27 and #74) residents out of 66 resident records reviewed during the survey. The findings include: 1. On 4/21/2025 at 10:51AM during a review of Resident #8's electronic medical record, the Surveyor discovered that the resident was dependent on staff for showering and shower transfers. On 4/21/2025 at 11:00AM, the Surveyor reviewed a complaint from January 2025 which stated that the resident had not had a shower in 3 years. On 4/22/2025 at 11:30AM, the Surveyor requested shower sheets for Resident #8 from the Assistance Director of Nursing (ADON). The Surveyor was informed that shower sheets are filled out on the days the residents are to receive a shower. If they refuse, the GNA's would document on the sheet and document if the resident received a bed bath instead. The GNA's also document in the electronic medical record under the point of care tab when they give a shower on the designated shower days. On 4/22/2025 at 12:09PM, a review of Resident #8's Geriatric Nursing Assistant (GNA) point of care documentation for January 2025 revealed that the resident had a shower on 1/9/2025 with the assistance of GNA #36. A review of a shower sheet for Resident #8 dated 1/9/2025, revealed that the resident did not have a shower and was given a bed bath by GNA #36. 2. On 4/16/2025 at 12:54PM, an interview with Resident #22 revealed that he/she has been having issues with receiving her medications on time or even at all for several months. The resident stated that he/she was supposed to get certain supplements and a muscle relaxer 4 times a day and that he/she has been missing doses. On 4/16/2025 at 1:00PM, during an interview, the Surveyor asked LPN #15 the process for documenting the administration of a medication. LPN #15 stated that the resident's medication administration record is pulled up in electronic health record. The medication is then pulled from the medication cart and the right medication, dose, time, and resident are confirmed. The medication is first signed that it was pulled (administration time) and then signed again (doc'd time) to say that it was taken by the resident. It is signed twice to confirm that the resident received the medication. During an interview with the Nursing Home Administrator (NHA) conducted on 4/18/2025 at approximately 1:00PM, the Surveyor expressed the concerns that Resident #22 stated that he/she receives his/her medications late or sometimes not at all. The NHA stated that he would have a conversation with the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the electronic medical record on 4/21/2025 at 12:00PM for Resident #22, the Surveyor discovered that the resident has an order for D5 Mucuna (supplement) 4 times a day to be given at 9AM, 1PM, 5PM, and 9PM and Baclofen (muscle relaxer) 4 times a day to be given at 9AM, 1PM, 5PM, and 9PM. Further review of the electronic medical record on 4/21/2025 at 12:10PM revealed documentation of a check mark (which equals administered according to the key) in the resident's medication administration record for Baclofen on 4/1/2025 at 9AM, 1PM, 5PM, and 9PM; 4/2/2025 at 9AM, 1PM, 5PM, and 9PM; 4/3/2025 at 9AM, 1PM, 5PM, and 9PM; 4/12/2025 at 9AM, 1PM, 5PM, and 9PM; 4/13/2025 at 9AM, 1PM, and 5PM; 4/15/2025 at 5PM, and 9PM; 4/16/2025 at 9AM, 1PM, 5PM, and 9PM; 4/18/2025 at 9AM, 1PM, 5PM, and 9PM; and 4/21/2025 at 9AM, 1PM, 5PM, and 9PM. On 4/23/2025 at 1:50PM, the Surveyor reviewed Resident #22's Medication Administration Audit report for April 2025. The report showed that on 4/1/2025, the 9AM dose of D5 Mucuna and Baclofen had an administration time and Doc'd time of 3:33PM and the 1PM dose of D5 Mucuna and Baclofen had an administration time and Doc'd time of 3:33PM; on 4/2/2025 the 5PM dose of D5 Mucuna and Baclofen had an administration time 10:06PM and a Doc'd time of 12:07AM on 4/3/2025 and the 9PM dose had an administration time of 10:07PM and a Doc'd time of 12:07AM on 4/3/2025; on 4/3/2025 the 5PM dose of D5 Mucuna and Baclofen had an administration time and Doc'd time of 8:36PM and the 9PM dose had an administration time and Doc'd time of 8:36PM; on 4/12/2025 the 9AM dose of D5 Mucuna and Baclofen had an administration time of 12:15PM and a Doc'd time of 12:57PM and the 1PM dose had an administration time of 12:21PM and a Doc'd time of 12:57PM; on 4/13/2025 the 9AM dose of D5 Mucuna and Baclofen had an administration time of 2:30PM and a Doc'd time of 2:31PM and the 1PM dose had an administration and a Doc'd time of 2:31PM; on 4/15/2025 the 5PM dose of D5 Mucuna and Baclofen had an administration and Doc'd time of 8:22PM and the 9PM had an administration and Doc'd time of of 8:22PM; on 4/16/2025 the 5PM dose of D5 Mucuna and Baclofen had a administration and Doc'd time of 8:49PM and the 9PM dose had an administration and Doc'd time of 8:49PM; on 4/18/2025 the 5PM dose of D5 Mucuna and Baclofen had an administration and Doc'd time of 10:38PM and the 9PM dose had an administration and Doc'd time of 10:38PM; and on 4/21/2025 the 5PM dose of D5 Mucuna and Baclofen had an administration and Doc'd time of 10:38PM and the 9PM dose had an administration and Doc'd time of 10:38PM. On 4/23/2025 at 2:00PM the Surveyor reviewed Resident #22's grievance form, completed by the NHA and reviewed with the resident on 4/23/2025, which included the resident's concern that he/she does not get the medication sometimes. The facility staff signed off in-service education related to resident's rights, abuse prevention, and customer service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215024	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Rehabilitation and Nursing Center	6500 Riggs Road Hyattsville, MD 20783

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. Based on observation and interview with staff, it was determined that the facility failed to ensure a resident's tracheostomy extension tubing and drainage bag were not touching the floor. This was evident for 1 (Resident #88) out of 2 residents observed with tracheostomy's during the survey. The findings include: On 4/16/2025 at 8:38AM during a tour of the east wing nursing unit, the Surveyor observed Resident #88 in his/her room. The Surveyor observed the oxygen delivery system located along the wall to the right of the door. The tracheostomy extension tubing, with drainage bag, stretched across the floor and connected to the resident's trach collar. On 4/17/2025 at 9:00AM, the Surveyor observed Resident #88 's tracheostomy extension tubing and drainage bag stretched across the floor and connected to the resident's trach collar. On 4/24/2025 at 12:00PM, during an interview with Unit Manager #25 of the west wing nursing unit in Resident #88's room, the Surveyor was informed that the tracheostomy extension tubing and drainage bag should not be touching the floor, however, the east wing nursing unit was not the his unit, and he was just covering for the actual unit manager. On 4/28/2025 at 11:35AM, the Surveyor observed Resident #88's tracheostomy extension tubing and drainage bag stretched across the floor and was connected to the resident's trach collar. On 4/28/2025 at approximately 12:30PM during an interview with the Infection Preventionist (IP) #3, the Surveyor expressed the concern that the tracheostomy tubing was observed stretched across the floor and connected to the resident's trach collar on 4/16/2025, 4/17/2025, and 4/28/2025 even after mentioning it to Unit Manager #25 on 4/24/2025. IP #3 confirmed the tracheostomy extension tubing and drainage bag should not be touching the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215024	A. Building B. Wing	04/29/2025

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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 - Few	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** Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, comfortable environment for residents. This was evident for 2 resident bathrooms observed during the survey. The findings include: On 04/16/25 at 08:33 AM during observation rounds, room [ROOM NUMBER]'s bathroom was observed to have a missing cove base at the bottom of the wall. On 04/16/25 at 08:47 AM during observation rounds, room [ROOM NUMBER]'s bathroom was observed to have peeling paint on the floor. On 04/16/2025 at 01:25 PM, the Nursing Home Administrator staff #1 and the Assistant Director of Nursing staff #11 were interviewed. During the interview, the surveyor informed staff #1 and staff #11 about the missing cove base on the wall in room [ROOM NUMBER]'s bathroom and the peeling paint on the floor in room [ROOM NUMBER]'s bathroom.