STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215039	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care Center	415 South Market Street Havre DE Grace, MD 21078

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50457 Based on observations and interviews it was determined that the facility staff failed to get a resident out of bed for four out of five days and failed to dress the resident in his/her own clothing. This deficient practice was evident in 1(#59) of 2 residents observed for dignity during the survey. The findings include: On 04/29/24 at 1:14 pm The surveyor entered Resident #59's room and observed him/her in bed wearing a soiled hospital gown, and tube feed infusing. On 05/01/24 at 10:35am The surveyor observed Resident #59 in bed wearing a hospital gown, and his/her hair was not combed. On 05/02/24 at 10:35am The surveyor observed Resident #59 in bed wearing a hospital gown, uncombed hair, and the blinds closed. During an interview with Geriatric Nursing Assist (GNA)#30 on 05/02/24 at 1:46 pm, the GNA reported being assigned to Resident #59 the previous day (05/01/24) and the resident prefers to wear a hospital gown while in bed. GNA#30 did not get Resident # 59 out of bed (OOB) on 05/01/24 or 05/02/24. Resident #59 did not get out of bed Monday (4/29/24) and had on a gown because they wanted to remain in bed. GNA #30 was unable to confirm whether the assigned nurse was made aware, that Resident #59 was not dressed in his/her clothing and did not get OOB for several days. During an interview with Unit Manager RN #33 on 05/06/24 at 11:44 am, when asked to describe a typical day for residents on Harbor View, he/she stated typically night shift provides breakfast trays to residents and day shift helps with distributing breakfast trays. Afterwards the residents are bathed and get out of bed. Activity comes around and updates the activity calendar. If a resident refuses to get out of bed the nurse should be made aware.

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47200 Based on record review and interview it was determined that the facility failed to issue the bed hold notice. This was evident for 1 out of 1 resident (#109) reviewed for hospitalization during the facility's recertification survey. The findings include: Review of the medical record by the surveyor on 5/3/24 at 11:16AM revealed a nursing progress note dated 9/24/21 that Resident #109 was transferred to the hospital on 9/24/21, however, no documentation could be found in the medical record to indicate the facility issued the bed hold notice. On 5/3/24 at 11:32AM the surveyor made a request to the Director of Nursing (DON) for any documentation of the bed hold notice having been provided to Resident #109 and/or their representative. During an interview on 5/3/24 at 12:15PM the DON informed the surveyor that the facility did not have any documentation that the bed hold policy was issued to the resident.

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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 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. 30440 Based on a review of the medical record and interviews with the facility staff it was determined the facility failed to follow the resident care plan for the management of a resident with a foley catheter. This was found to be evident for 1 (Resident # 18) of 39 residents reviewed during the facility's survey. 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 care. A medical record review was done on 5/2/24 at 10:00 AM and it revealed resident # 18 was admitted to the facility with the following but not limited to diagnosis: Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and Benign Prostatic Hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). Review of the facility resident matrix indicated the resident currently had an indwelling catheter in place. The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents. Review of the care plan revealed the resident has an indwelling suprapubic catheter (urinary catheter inserted into the bladder from a small cut in the belly, just above the pubic bone) related to Neurogenic bladder (several urinary conditions in people who lack bladder control due to brain, spinal cord or nerve problem) that was initiated on 1/26/2017 with a revision date of 8/19/22. One of the interventions listed includes Urology (Genitourinary) consults as ordered. During an interview with the DON on 5/3/24 at 11:30 AM she was asked of the resident care plan intervention that included Urology consults as ordered, and that the resident did not follow-up in six (6) months following the Urology Consultation on 4/11/22 as recommended. The DON acknowledged that the resident care plan was not followed and further added that the physician could not accommodate the resident in a stretcher. She went on to say that arrangements will be made for the resident with Urology for management of the catheter. All concerns were discussed with the Administration team at the time of exit on 5/7/24 at 3:00 PM

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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. 50385 Based on observations, staff interviews, and record review, it was determined that the nursing staff failed to meet professional standards of care by not ensuring that medication was consumed prior to leaving the resident room. This was evident for 1 (Resident #89) of 4 residents observed for professional standards. The findings include: On 04/30/24 at 11:39 AM, the surveyor observed Licensed Practical Nurse (LPN) #22 administer medications to Resident #89. LPN #22 placed a dark amber colored liquid in a small cup at the resident's bedside table. The LPN left the room. The cup was untouched, and no directions were given to the resident on what to do with the cup. On 04/30/24 at 11:41 AM, the surveyor interviewed Geriatric Nursing Assistant (GNA) #25 and LPN #22. GNA #25 stated that's the protein when asked about what was in the cup on Resident #89's bedside table. When the surveyor asked LPN #22 about what the standard of practice is when administering medications, the LPN confirmed it is the standard of practice to ensure the resident completes the medication before leaving the resident ' s room. On 5/2/24 at 1:02 PM, a review of the Medical Administration Record (MAR) audit for Resident #89 was conducted. The MAR audit showed the following medications ordered for 9am: Tylenol 650 mg tablet (a pain relief medication), 1 Potassium Chloride 10 mEq tablet (a potassium supplement), Lasix 40 mg tablet (a diuretic) , and Prostat 30 ml (a protein supplement) scheduled to be administered at 10am on 4/30/24. Review of the MAR audit revealed that the Lasix was documented at 11:29 AM. The Potassium, the Tylenol, and the Prostat were documented at 11:34 AM. The standard of practice when giving medications is to administer medications an hour before and an hour after the due time of the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30440 Based on medical record review and interviews with facility staff it was determined the facility failed to: (1) to ensure that a resident followed up with the Urologist for management of the foley catheter; (2) transcribe physician pain scale orders for resident #1. (3) follow a treatment order as ordered by the physician for resident #59. (4) follow physician orders as evidenced by a resident not being properly positioned to receive enteral nutrition, enteral nutrition not being administered during the ordered times, medications were not administered the times ordered, and the ordered amount of oxygen was not delivered for several days. This deficient practice was evident in 5, (Resident #1 # 18, #33, #59, #100) of 38 resident records reviewed during the Survey Findings include: 1. The facility failed to ensure that resident #18 followed up with the Urologist for management of the foley catheter. A medical record review was done on 5/2/24 at 10:00 AM and it revealed resident # 18 was admitted to the facility with the following but not limited to diagnosis: Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and Benign Prostatic Hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). Review of the facility resident matrix indicates the resident currently has an indwelling catheter in place. The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents. On 5/2/24 at 11:00 AM the DON provided the survey team with a copy of the resident's most recent Urology Consultation that was dated 4/11/22. Upon review of the Consultation Report it revealed the following recommendation: follow-up in six (6) months and continue current management. During an interview with the DON on 5/3/24 at 11:30 AM she was asked if the resident followed up with Urology Consultation appointment as recommended within six (6) months and she stated, no. The DON went on to say that the resident was scheduled for an appointment in 2023, however, the resident did not go to that appointment because the physician could not accommodate the resident via a stretcher. The DON acknowledged that arrangements needed to be made for resident # 18 regarding a follow up with Urology and that the facility will work on scheduling this. 50385 2. During observation rounds on 4/29/24 at 8:13am, resident #59 was observed lying in bed with his/her head turned to the right. The resident was observed with a dark red dried substance on the left side of the earlobe, neck, and pillow. The Licensed Practical Nurse (LPN) (staff #32) was immediately made aware. Staff #32 stated, it is not my resident, but I will look at it. During a follow-up observation on 4/29/24 8:30 am Staff #32 was observed cleansing and applying lotion to the left earlobe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with staff #32 on 4/29/24 at 10am, when asked by the surveyor if she knew how long the resident left earlobe had contained the dark red dried substance she stated, I don ' t know but we do walk report for on-coming and off-going shifts and someone should have seen it. Review of the medical record on 5/2/24 at 1pm, revealed a physician order dated 3/20/24 to apply bacitracin to the left ear every morning and evening shift until healed. 50457 3. On 4/29/24 at 9:32 am upon entering Resident #59 room, the surveyor observed the resident in bed with the foot of the bed elevated and the head of the bed about 15 degrees with the tube feed infusing at 80 milliliter/hour (ml/hr) . An interview with License Practical Nurse (LPN) #23 on 04/30/24 at 9:37 am at Resident #59 bedside, the surveyor asked how the staff adjusts the head of the bed for residents who are receiving tube feeding. LPN #23 verbalized not knowing how to adjust the settings on the bed to determine the elevation of the head and he/she just eyeball the bed. LPN #23 also verbalized that the resident adjusts the bed themselves. On 05/01/24 at 10:38 am during an assessment of Resident #59 ability to change the settings on the bed, the surveyor asked the resident to adjust the controls on the bed. Resident #59 attempted to press the controls to adjust the head of the bed. The surveyor observed the resident being unable to reposition themselves to reach the controls on the bed to make adjustments. On 05/02/24 at 11:02 am review of the facility's tube feeding policy revealed during gastrostomy feedings the resident's head should be elevated to at least a 35-degree angle to prevent aspiration and to promote digestion. Review of Resident #59 treatment and medication administration records (TAR/MAR) revealed an order was written on 02/08/24 for aspiration precautions and for the resident to sit upright during all meals. On 05/02/24 at 9:06 am the surveyor observed Resident #59 slouched down in bed while the enteral nutrition Jevity 1.5 at 80 ml/hr was infusing. Review of Resident #59 orders on 05/02/24 at 10:57 am, revealed the resident was scheduled to receive Jevity 1.5 at 80 ml/hr for 20 hours per day for a total of 1600ml. Administration should have begun at 1pm and ended at 9am. On 05/02/24 at 9:50 am while in Resident #59 room, the surveyor observed Jevity 1.5 infusing at 80 ml/hr when the feeding was scheduled to end at 9:00 am. On 05/02/24 at 1:32 pm during an interview with LPN #17 when asked to tell the surveyor about Resident #33 gastrostomy feeding they verbalized the feeding is Jevity 1.5 at 80 ml/hr for a total of 1600 ml daily. The feeding is scheduled to start at 1 pm and end the next day at 9am. The nurse verbalized stopping the feeding around 9:15 am that day and starting the feeding a little after 1 pm. The surveyor made LPN #17 aware the feeding was observed infusing at 9:50 am. The nurse denied the feeding was still infusing at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/02/24 at 12:51 pm a review of the facility's Medication Administration Audit Report that was received from Assistant Director of Nursing (ADON) #3 revealed Resident #59 did not receive medications as scheduled by LPN #17 on 04/29/24 and LPN #23 on 05/01/24. The resident was scheduled to receive these medications through a gastrostomy tube on 04/29/24 at 9 am. Famotidine tab 40mg Cholecalciferol tab 10 microgram (mcg) Amiodarone tab 200 milligram (mg) Apixaban tab 5 mg Ascorbic Acid Tab 500mg Ferrous Sulfate solution LPN #17 documented the above-mentioned medications were administered on 04/29/24 at 11:21 am. On 5/01/24 at 10:00 am the resident was scheduled to receive these medications through gastrostomy tube: Metoclopramide tab 5mg Thera-M Tablet LPN #23 documented the above-mentioned medications were administered on 5/01/24 at 11:25 am. On 05/06/24 at 11:44 am during an interview with RN Unit Manager #33, the surveyor asked what the expectations are for medication administration of the nurses. Unit Manager #33 verbalized their understanding that the medications can be given 1 hour before and 1 hour after the prescribed time. If the medication was not given during the required time frame, it turns red in PointClickCare (PCC). He/she is still learning how to run the reports to check if the medications are given on time. The surveyor provided RN Unit Manager #33 with the medication administration audit report with the listed medications that were given past the allotted time. He/she verified the medications were given late and thus far he/she has not been taught how to run the report. On 05/02/24 at 1:32 pm during an interview with LPN #17, the surveyor asked if the resident is on any precautions. LPN #17 verbalized, 'You would have to ask the nurse manager. ' 4. On 04/29/24 at 8:08 am, 4/30/24 at 9:23 am, and 05/07/24 at 10:11 am, upon entering Resident #33 room, the surveyor observed the resident in bed with 3L of oxygen via nasal cannula (NC). On 04/30/24 at 10:18 am a review of Resident #33 electronic medical record revealed an order written on 01/10/19 at 2:49 pm oxygen 2L NC every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/24 at 10:14 am during an interview with LPN #22, the surveyor asked how much oxygen the resident was receiving; LPN #22 replied, 2L. The surveyor asked the nurse if they assessed the resident's oxygen concentrator and LPN #22 replied no. The surveyor made LPN #22 aware the resident had received 3L oxygen via NC since 04/29/24. The surveyor asked if Resident #33 was experiencing shortness of breath or any respiratory symptoms which may warrant an increase in oxygen therapy. LPN #22 responded, no. 48167 5. On 05/02/24 at 1:05 PM review of the resident medical record revealed that a physician ordered on 12/14/2023 for resident #1 to receive Tylenol Extra Strength 500mg 1 tab by mouth every 6 hours as needed for pain and Tramadol HCL 50mg 1 tab by mouth every 6 hours as needed for pain. Further review revealed that on 02/26/2024 a pharmacy review was completed and a Letter to Physician was sent to the physician recommending specifying when Tylenol Extra Strength and Tramadol should be used and given to resident #1 by using a pain scale. On 02/29/2024 the physician wrote an order for Acetaminophen pain level 1 -5 and Tramadol pain level 6 -10 and this order was not transcribed or processed. On 05/02/24 at 01:30 PM during an interview with staff #3 she stated that the physician order had not been transcribed or processed. 6. On observation rounds on 04/29/24 at 10:55 AM it was observed that resident #100 was on 4.5 liters of oxygen by nasal cannula. During an interview on 04/29/24 at 11:10 AM with staff #17, she stated that resident was on 4.5 liters of oxygen and should be on 2 liters of oxygen by nasal cannula. After surveyor intervention, staff #17 placed resident #100 on 2 liters of oxygen by nasal cannula. Review of resident's #100 medical record on 04/29/24 at 11:27 AM revealed a physician order dated 3/31/2024 for resident #100 to be administered 2 liters of oxygen by nasal cannula continuously.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30440 Based on observations and interviews with facility staff it was determined the facility failed to ensure that water temperatures remained within acceptable range. This was found to be evident during 11 room observations made of the Harbor View Unit and 2 residents (#31,#32) during the facility's survey. Findings include: 1. On 4/30/24 at 10:39 AM the surveyor made observations of water temperatures in resident rooms located on the Harbor View Unit. Bathroom temperatures for the following rooms were observed: Room# 148 had a temperature of 122 degrees Fahrenheit (F) Room # 149 had a temperature of 122 degrees F Observations were made on the same date at 11:05 AM of the water temperatures of the sink located inside the resident rooms as follows: Room # 149 sink temperature was 120 degrees F Room # 150 sink temperature was 120 degrees F After the surveyor identified elevated temperatures on the above unit, the Director Maintenance of (DOM), Staff # 21 was notified and arrived on the unit at 11:30 AM to obtain temperatures on the Harbor View Unit with the surveyor. The following temperatures were obtained: Room # 149 Bathroom sink temperature was 124.2 degrees F Room # 150 Bathroom sink temperature was 123.8 degrees F Room # 152 Bathroom sink temperature was 121.2 degrees F Observations were made in the following resident rooms of sink temperatures by the DOM as follows: Room # 149 sink temperature was 123.9 degrees F Room # 150 sink temperature was 122.5 degrees F After the DON obtained the above temperatures on the Harbor View Unit, he was told that that the temperatures are a concern. He stated that this morning, the facility powered down the boiler for use of the chiller, to use the air conditioner. He stated that this could affect the water system as the rooms are located above the boiler room. When the surveyor asked if water temperatures were obtained in the resident rooms while powering down the boiler, he could not provide documentation of this to the survey team. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Let it be noted that the residents that resided in the rooms with the elevated temperatures are unable to use the bathroom and or sink in the above noted rooms except for resident # 31 and # 32. During an interview with resident # 32 on 4/30/24 at 1:05 PM the resident stated that s/he uses the bathroom with assistance and denied any burns to the hands when using the water from the sink. During an interview with resident # 31 on 4/30/24 at 1:20 PM the resident stated that s/he does not use the bathroom, however, s/he uses the sink inside of the room to brush his/her teeth, wash face and hands and that s/he never experienced any problems with the water being too hot. All concerns were discussed with the Administration team on 4/30/24 at 1:45 PM. 47200 2. On 4/30/24 at approximately 10:11AM the surveyor tested the temperature of the water in the following resident rooms with a calibrated thermometer: room [ROOM NUMBER] was found to be 133.9F, and room [ROOM NUMBER] was found to be 135.9. On 4/30/24 at 10:38AM the water temperature in room [ROOM NUMBER] was observed to be 121.3F On 4/30/24 at 10:38AM the water temperature in room [ROOM NUMBER] was observed to be 122.9F On 4/30/24 at 10:39AM the water temperature in room [ROOM NUMBER] was observed to be 121.2F On 4/30/24 at 10:42AM the water temperature in room [ROOM NUMBER] was observed to be 137.5F On 4/30/24 at 10:48AM the water temperature in room [ROOM NUMBER] was observed to be 130F On 4/30/24 at 10:52AM the water temperature in room [ROOM NUMBER] was observed to be 130.1 On 4/30/24 at 10:59AM the water temperature in room [ROOM NUMBER] was observed to be 125.3F at the sink in the resident's room and 124F at the resident's bathroom sink. On 4/30/24 at 11:03AM the water temperature in room [ROOM NUMBER] was observed to be 121.5F at the sink in the resident's room and 128.5F at the resident's bathroom sink. On 4/30/24 at 11:05AM the water temperature in room [ROOM NUMBER] was observed to be 126F at the sink in the resident's room. On 4/30/24 at 11:14AM the surveyor requested a dual observation of water temperatures in resident rooms with Staff #21, Director of Maintenance, and observed them obtain their thermometer. On 4/30/24 at 11:16AM the surveyor observed Staff #21 obtain a water temperature of 133.4F at the sink in room [ROOM NUMBER], and then a water temperature of 132.3F in the resident's bathroom sink. On 4/30/24 at 11:19AM during an interview conducted by the surveyor with Staff #21 they stated that the area of the building with higher water temperatures was located above the facility's boiler for that area of the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24 at 11:19AM the surveyor observed Staff #21 obtain a water temperature of 129.9F at the sink in room [ROOM NUMBER], and a water temperature of 129.2 F in the resident's bathroom sink. On 4/30/24 at 1:31PM surveyors conducted an interview with the Administrator and Staff #21 which revealed water temperatures in resident rooms was not being monitored. The Administrator communicated to surveyors that this was an oversight, they thought the temperatures were being done, but it was not being done in resident rooms, temperatures were being taken of the boiler.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 42863 Based on interviews and record review the facility failed to demonstrate that annual performance reviews were conducted for geriatric nursing assistants (GNAs)annually based on the employee's hire date. This was determined and evidenced to be true for 4 out of 4 GNAs, (GNA #40, 41,42, and 44) during the review of facility human resource and staff education files while performing the staffing facility task during the survey. The findings include: On 05.06.24 at 1:52 PM the surveyor requested the director of nursing (DON) to provide seven human resources records and seven staff education records. On 05.06.24 at 2:30 PM the surveyor received seven staff education records which included two registered nurses, one LPN and four geriatric nursing assistants. On 05.07.24 at 08:30 AM the surveyor reviewed the staff education records of four certified GNAs. The surveyor was not able to find any evidence of performance evaluations completed for four GNAs (#40,41, 42, 44) for the years of 2022 or 2023. During an interview on 05.07.24 at approximately 10:07 AM, with the director of nursing (DON) the surveyor asked what the expectation of the facility was regarding a supervisor performing annual performance reviews for each clinical staff member. The DON stated that she was behind in completing the annual performance evaluation and would need to get better. The DON and the surveyor reviewed one incomplete performance evaluation that was missing the signature of the employee, GNA # 40 for the year 2023. The facility was unable to provide of a completed performance reviews for GNAs # 40, # 41, #42, and #44. On 05.07.24 at 2:30 PM the surveyor interviewed staff #9, staff educator who stated that she that staff education was not a primary role or secondary role but she sometimes assisted with teaching of clinical staff and scheduling of clinical in-services and did not perform annual performance evaluations of the GNAs. The deficit practice was discussed with the facility's administrative team prior to and during the survey exit conference on 05.07.24 at 2:50 PM.

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Citizens Care Center	415 South Market Street Havre DE Grace, MD 21078

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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. 49304 Based on record review and interview with facility staff, it was determined that the facility failed to address a pharmacy recommendation in a timely manner. This was evident for 1 (Resident #3) of 5 residents reviewed for unnecessary medications. The findings include: The medical abbreviation PRN stands for 'pro re nata,' which means that the administration of medication is not scheduled at prescribed times, but instead, the medication is taken on an as needed basis. On 5/3/24 at 9:48 AM review of the medical record revealed a document titled Letter to Physician from the pharmacist, Staff #37, with a medication regimen review (MRR) dated 3/8/24 that stated: Resident has an order for PRN lorazepam. Please note all PRN psychotropic drugs require a stop date, regardless if resident is hospice. Please specify a stop date of 14 days or, in order to extend a PRN order past 14 days: 1) The prescriber must document their rationale in the medical record (such as end of life) and 2) Indicate the duration for the PRN order (consider 3 or 6 months and then reevaluate). In the section, titled Physician/Prescriber Response, of the Letter to Physician document, none of the boxes [agree, disagree or other] were checked. Further review of the medical record revealed an active PRN order for Lorazepam Oral Tablet 0.5mg (milligrams). Give 1 tablet by mouth every 4 hours as needed for restlessness/anxiety that was ordered on 2/21/24. On 5/3/24 at 12:57 PM, in an interview with Nurse Manager #15, they stated the expectation is for the provider to check one of the three boxes [agree, disagree or other] along with signing and dating the document. When asked about Resident #16's MRR dated 3/8/24, Nurse Manager #15 looked in the medical record and then stated I do not see any documentation that the PRN Lorazepam order was discontinued. On 5/7/24 at 10:17 AM, in an interview with the Director of Nursing (DON), they provided documentation that the PRN Lorazepam was discontinued on 5/6/24 at 10:31 AM.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50457 Based on medical record review and interviews it was determined that the facility staff failed to monitor a resident for side effects who was prescribed psychotropic medication. This deficient practice was evident for 1 (#33) of 2 medical records reviewed for side effects of medications during the Survey. The findings include: On 4/29/24 at 9:49 AM the surveyor reviewed Resident #33 medication administration record (MAR) and treatment administration record (TAR) revealed on 08/05/22 at 10 am the resident was ordered Zyprexa 2.5 mg by mouth every am and on 06/05/23 at 9 pm the resident was ordered Zyprexa 7.5 mg by mouth at bedtime. On 5/7/24 at 10:00 AM on further review of Resident #33 MAR/TAR revealed there was no documentation to verify the resident was being monitored for psychotropic medication side effects. On 05/07/24 at 11:21 am during an interview with License Practical Nurse (LPN) #22, the surveyor asked what the process is for monitoring a resident on psychotropic medications for side effects. Nurse #22 reported that if he/she noticed a change in behavior, it will be reported. Also, a note would be written to document the residents' side effects. On 5/7/24 at 10:45 am during an interview with Director of Nursing (DON) #2 when asked with is the exception of the staff to monitor and document potential side effects of psychotropic medications, DON #2 verbalized Resident #33 should have an order for the staff to document side effects of psychotropic medications. Review of Resident #33 orders revealed there was an order to monitor side effects of psychotropic medications. A review of Resident #33 MAR/TAR revealed there was no documentation to verify the staff was monitoring the resident for psychotropic medication side effects.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47200 Based on observation and interview of facility staff it was determined the facility failed to ensure a medication was not left unattended and failed to: (1) ensure a medication cart was locked evident for one medication cart observed : (2) discard expired medications, properly store medical supplies, and check the refrigerator temperatures for biologicals and supplements. This deficient practice was evident in 2 out of 2 medication storage rooms assessed during the survey. The findings include: 1. On 5/6/24 at 12:49PM, the surveyor observed one medication cart on the Bay Lane Unit unattended with the lock mechanism protruding, indicating the cart was unlocked. Upon further observation of the cart, the surveyor observed one labeled Baclofen (muscle relaxant) medication blister packet containing a pill sitting on the work surface of the cart with a pair of scissors next to it. Upon sliding each drawer mechanism, the surveyor was able to open all drawers of the cart which contained various medications and supplies. On 5/6/24 at approximately 1:00PM Staff #36, Registered Nurse, approached the surveyor at the medication cart and the surveyor shared their concern. Staff #36 acknowledged and confirmed the surveyor's concern and reported the medication was for Resident #7, and stated the following: I walked away to look for something and forgot, I needed tube feeding supplies. The surveyor noted the supply room was located at the opposite end of the hallway. On 5/6/24 at 1:05PM the surveyor shared their concerns with the Director of Nursing who confirmed understanding of the concerns. 50457 2. On 05/03/24 at 12:48 pm The surveyor checked the treatment cart in the medication room located on Harbor View. In the upper cabinet on the right side was an opened Collagen Alginate package. In drawer #2 on the treatment cart there was an opened package of Medihoney that was exposed, an opened package of Calcium Alginate that was exposed, and loose Calcium Alginate in the drawer. In drawer #3 of the treatment cart was a used and opened vial of Lidocaine1% for injection in a blue plastic container labeled Podiatrist. In drawer #4 there was another opened package of Medihoney that was exposed and drawer #5 had another package of exposed Calcium Alginate. The surveyor received a copy of the temperature logs of the refrigerators. Review of the temperature logs revealed the refrigerators temps were not being recorded daily in January, February, March, April, and May of 2024. Licensed Practical Nurse (LPN) #23 was made aware of the surveyor's findings and verbalized the opened dressing supplies and the opened vial of Lidocaine 1% should not have been on the treatment cart. The room is locked so the nurse with the key has access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/24 at 12:22 pm During an interview with RN Unit Manager # 33 they reported maintenance is responsible for checking the refrigerator temperatures and the nursing staff should check them as well. The nurses are responsible for checking the supplies for the treatments and every resident should have their own stack of supplies. On 05/06/24 at 1:52 pm The surveyor checked the medication room on Bay Lane which revealed the upper right cabinet had an expired tube of Ultra Strength Bengay, expiration date 02/24. The surveyor checked the left upper cabinet and observed an opened and unlabeled packet of multivitamin capsules in a blister pack, a loose white oblong tablet, an exposed 18 gauge needle, loose 2x2 gauze, and 2 coffee creamers. The surveyor observed expired yogurt, an opened water bottle, expired chocolate milk (12/19/23), and three expired (10/24/23, 02/06/24, 03/04/24) thickened lemon flavored water containers in the supplement refrigerator. The supplement refrigerator and the resident food refrigerators did not have a temperature log to verify the staff were checking the temperatures daily. A review of the temperature log for the refrigerated medications revealed the temperature was not documented daily in February, March, April, and May. On 05/06/24 at 2:26 pm while the surveyor checked the medication cart C105 on Bay Lane, the surveyor discovered an unlabeled container of Biotin Gummy Vitamins, an opened container of Acetaminophen in drawer #3, an opened and exposed package of 2 x 2 gauze sponges, an opened Piston irrigation syringe package, an opened package of Calcium Alginate, and 21 blisters of medications for residents who were no longer in the facility per Assist Director of Nursing (ADON) #3. On 05/07/24 at 10:52 am during an interview with Director of Nursing (DON)#2, the surveyor reported, there were expired biologicals in the medication rooms and the refrigerator temperatures were not being checked daily. DON #2 verbalized central supplies go through bulk mediation to make sure none have expired. Night shift is supposed to check refrigerator temperatures, and the dressing supplies should be checked as well. Every nurse should check the medication carts to make sure the medications and supplies are good for use.

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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. 47200 Based on record review, interview and observation it was determined the facility failed to: 1.) date and sign inventory sheets for resident personal effects, and 2.) failed to ensure accuracy of a medical order. This was evident for 2 out of 2 resident's inventory sheets (#39, #42) reviewed and 1 out of 3 residents reviewed for pressure ulcers during the facility's recertification survey. The findings include: 1.) On 4/30/24 at 10:04AM Resident #39 reported to the surveyor that their bottom dentures had broke in half and they preferred to have them. On 5/3/24 at 11:53AM the surveyor conducted a review of the medical record and observed the inventory sheet in the paper chart which listed personal effects for the resident, however, it did not include any denture(s) listed. Upon further review of the inventory form, there was no signature of anyone confirming the personal effects listed or date on the form to determine when the inventory occurred. On 5/3/24 the surveyor conducted an interview with Staff #30, Geriatric Nursing Assistant, who reported to the surveyor that they were not sure if the resident was admitted to the facility with both the upper and lower dentures, but currently only had the upper denture. On 5/3/24 at 12:05PM the surveyor conducted an interview with Staff #31, Unit Secretary, who reported the resident had no dental consults during their current stay at the facility, and on their most previous admission the resident came with the upper denture. On 5/6/24 the surveyor conducted an interview with the Director of Nursing who confirmed that facility staff are responsible for updating and documenting items including dentures on the inventory form. At this time, the surveyor shared their concern with the DON who confirmed understanding of the concern and acknowledged the concern. On 5/7/24 at 11:59AM the surveyor observed the inventory sheet in the paper chart of Resident #42 and noted there was no signature or date present on the documentation. 2.) On 5/7/24 at 11:49AM the surveyor conducted a review of the medical orders of Resident #42 and observed an active medical order for the following wound care: Cleanse right ischium (right side of bottom area of pelvis) with NSS (normal saline solution), pack with Vashe (wound cleanser) soaked gauze, cover with large allevyn (wound dressing) BID (twice daily). On 5/7/24 at 12:07PM the surveyor reviewed the most recent wound consult dated 5/1/24 for Resident #42 which documented the resident ' s wound was located on the left ischium (left side of bottom area of pelvis) and provided recommendations for wound care of that site. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 12:19PM the surveyor conducted an interview with the Director of Nursing (DON) who observed the medical record with the surveyor and confirmed the active medical order for treatment directed wound care to occur on the right ischium, although the wound consult documented the location of the wound was on the left ischium. At this time, the surveyor shared their concern with the DON who acknowledged understanding of the concern. On 5/7/24 at 12:35PM, after surveyor intervention, the DON reported to the surveyor that the medical order for wound treatment was corrected to reflect the resident ' s wound care occurring on the left ischium.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42863 Based on interviews and record review the facility failed to ensure that four geriatric nursing received and completed a total of 12-hours of clinical training annually. This was determined and evidenced to be true for four out of four GNAs, (GNA #40, 41,42, and 44) human resource and staff education files reviewed during the survey. The findings include: On 05.06.24 at 1:52 PM the surveyor requested the director of nursing (DON) to provide seven employee human resources records and seven employee staff education records. These files included 4 geriatric nursing assistants (GNAs), one licensed practical nurse (LPN#39), and two registered nurses (RN #43 and # 45). On 05.06.24 at 2:30 PM the surveyor received seven staff education records which included two registered nurses, one LPN and four geriatric nursing assistants. The DON was unable to provide written documentation that the four GNAs completed a total of twelve hours of clinical education training annually during 2022 and 2023. On 05.07.24 at 2:30 PM the surveyor interviewed staff #9, staff educator who stated that she that staff education was not a primary role or a secondary role but she sometimes assisted with teaching of clinical staff and scheduling of clinical in-services and did not perform annual performance evaluations of the GNAs. The deficit practice was discussed with the facility's administrative team prior to and during the survey exit conference on 05.07.24 at 2:50 PM.