STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review and interview it was determined that the facility failed to recognize the rights of a Resident. This was found evident of 1 (Resident #56) of 46 residents reviewed during the survey. The findings include: On [DATE] at 11:20 AM, the surveyor reviewed Resident #56's medical record. The record revealed that Resident #56 had a Maryland Order for Life Sustaining Treatment (MOLST) form dated [DATE] that indicated Resident #56 decided for him/herself that he/she wanted Cardiopulmonary resuscitation (CPR) in the event of cardiac arrest. On further review the surveyor reviewed a psychologist note dated [DATE]. In the note Psychologist Staff #29 documented that Resident #56 was non-verbal in that he/she cannot clearly speak. She further documented that Resident #56 could however, communicate using a flip phone and text. She wrote; Resident #56's writing suggests he/she is bright with good vocabulary and faster than expected speed of processing, based on the speed in which he/she types/texts. On [DATE] at 11:13 AM, the surveyor reviewed a social history assessment dated [DATE]. The assessment documented that Resident #56 did not have decision making capacity and named a health care proxy. On further review a wound note written by Nurse Practitioner (NP) #28 wrote she contacted Resident #56's Power of Attorney and obtained consent for multiple debridement's. However, there was no documentation in the medical record to indicate that Resident #56 was determined to be incapable of making his/her own decision. On [DATE] at 12 noon, the surveyor requested the documentation to support that Resident #56 was not his/her own decision maker. On [DATE] at 1:06 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON produced documentation dated [DATE] that determined Resident #56 lacked adequate decision making capacity by two providers. The surveyor asked prior to today whether the resident was able to make his/her own decisions. The DON stated he was unable to find the documentation from a prior evaluation and made sure there was one today. The surveyor relayed the concern that Resident #56 right to make his/her own decision appeared not to be honored without appropriate evaluations in place.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 51786 Based on resident interview, medical record review, and staff interviews, it was determined that the facility failed to adjust the care plan to reflect the resident's preferences. This was evident for 1 (Resident #22) of 8 residents reviewed during the annual survey. The findings include: On 2/18/25 at 11:46 AM, during an interview with Resident #22, the resident reported that the facility failed to honor his/her preference for female healthcare providers. On 2/21/25 at 10:34 AM, a review of Resident #22's medical record failed to reveal documentation of Resident #22's healthcare provider preference. On 2/21/25 at 11:00 AM, an interview with Staff #26 was conducted. Staff #26 stated that Resident #22 only requested female healthcare providers to care for him/her. Staff #26 also reported that all staff members and the facility management were aware of Resident #22's preferences. On 2/21/25 at 12:09 PM, an interview with the Director of Nursing (DON) was conducted. The DON confirmed that the facility failed to update Resident's #22 care plan to reflect his/her preferences.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on record review and interview, it was determined that the facility staff failed to ensure the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) order. This was found to be evident for 1 (Resident #24) out of 5 residents reviewed for MOLST orders and advance directives during an annual survey. The findings include: Maryland Medical Orders for Life-Sustaining Treatment (MOLST) portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. An incapacitated person cannot sign a Medical Orders for Life-Sustaining Treatment (MOLST) form. Instead, a health care agent or surrogate can sign the form on their behalf. Record Review, on 02/18/25 at 03:33 PM, found that MOLST was from year 2020 with Resident #24 as the decision maker for his medical treatments. However, a legal court Gaudian Appointed Order was issued on 6/16/2022. Further record review, on 02/20/25 at 09:04 AM, indicated the following: the MOLST signed by Nursing Practitioner Staff #34 on 12/31/20 who discussed with and had the informed consent of this resident. Also, a copy of the Circuit Court of [NAME] County appointed a legal guardian on 6/16/22 that was present in the medical file. Interview, on 2/20/25 at 10:00 AM, Unit Manager, Staff #5, stated that she did not review Resident 24's record. That made her aware of the discrepancy which there was an appointed legal guardian to follow-up with. Interview, on 02/25/25 at 10:43 AM, Director of Nursing (DoN) revealed that he reviewed both documents and the facility staff had made an error; not incorporating the court appointed legal guardian order and to update a new MOLST back in June 2022. The DoN agreed that the practice was a deficiency

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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. 47758 Based on record review, observation and interview, the facility failed to provide residents with an adequate supply of linens. This has the potential to affect all residents residing in the facility. The findings include: During a review of Intake #MD00164452 on 2/19/25 at 08:30 AM the complainant stated that the facility did not have enough towels and washcloths. On 2/20/25 at 09:30 AM, 2/20/25 at 12:30 PM and 2/21/25 at 8:00 AM, the surveyors observed that the linen carts in the hall contained only one or two towels and washcloths in the cart. During those observations Geriatric Nursing Assistants #7, #11, #12 and #13 were interviewed about the amount of linen they have to provide for resident care. They stated they have enough linen to provide care, but they often have to go down to the laundry to get extra linens. During an interview on 02/21/2025 at 8:06 AM, laundry staff #9 stated she never has enough laundry to give staff when they come down and request it because they are very short on all laundry but especially washcloths, towels, and gowns. During an interview on 02/21/2025 at 9:00 AM, the Regional Environmental Director stated that the linen Periodic Automatic Replacement (PAR) level is low in the facility. She stated the expected PAR is 3 linen changes per resident per day, however the facility is currently well below the expected PAR level, and they are ordering more linen from the vendor. She stated the expectation is the linen PAR level is checked monthly, and replacement linen ordered.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observation, record review, review of facility's policy and interview, it was determined that the facility staff failed to document ongoing re-assessments that would help determine the necessity of restraints for a resident who utilized a restraint. This was evident for 1 (Resident #10) of 1 resident reviewed for restraints during the survey. The findings include: Physical restraint includes all devices and practices used by the facility that restrict freedom of movement or normal access to one's body. On 2/18/25 at 9:13 AM, the surveyor observed a half gate across Resident #10's doorway. Resident #10 was noted walking up to the door and resting his/her hands on the top of the gate. When the surveyor approached the door Resident #10 smiled and walked back to his/her bed and sat down. On 2/25/25 at 1:46 PM, the surveyor reviewed the restraint order dated 11/17/17. The order stated, may apply a gate at the resident's door for safety every shift. Next the surveyor reviewed Resident #10's care plan. A care plan written on 2/20/18 stated, Resident #10 used a half gate restraint at his/her door to prevent him/her from going into others rooms and maintaining his/her safety related to anoxic (without oxygen, or deficient in oxygen) brain damage, aphasia (a language disorder that affects a person's ability to communicate effectively), attention and concentration deficits, lack of awareness of boundaries, and poor safety awareness. One of the interventions listed was, evaluate restraint use of the gait quarterly and as needed. Evaluate and record continued risk and benefits of the restraint and need for ongoing use and reason for restraint use. 02/26/25 12:03 PM, the surveyor reviewed the facility policy titled, Restraint - Use and Management. The policy stated that medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptoms but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptom. On 2/26/25 at 1 PM, the surveyor requested Resident #10's most recent physical restraint assessments from the Director of Nursing (DON). The facility provided a physical restraint follow-up quarterly assessment dated [DATE]. On 2/27/25 at 9:07 AM, the surveyor reviewed the concern that the facility was not documenting the re-evaluation of restraint use, or attempts to use a less restrictive intervention. The DON stated he would look for the documentation. At the time of exit no other documentation was provided to the surveyor.

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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. 51786 Based on medical record review and staff interview, it was determined that the facility failed to code the resident's discharge status accurately on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #141) of 1 resident reviewed during the annual survey. The findings include: 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 2/25/25 at 8:41 AM, a review of Resident #141's medical record revealed an order to discharge Resident #141 to home on 1/15/25. Further review of the record revealed a discharge summary dated 1/16/25 that indicated Resident #141 was discharged to home. On 2/25/25 at 9:08 AM, a review of Resident #141's MDS Section A -2105 assessment completed on 1/16/25 and signed 1/17/25, indicated that Resident #141 was discharged to a short-term general hospital. On 2/25/25 at 9:25 AM, an interview with the MDS Coordinator (Staff #21) was conducted. Staff # 21 stated that Resident #141 was discharged home and confirmed that the MDS was inaccurately documented.

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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. 44440 Based on record reviews and interviews it was determined that the facility failed to provide treatments according to a Resident's plan of care. This was found evident of 2 (Resident #56, #51) out of 5 residents reviewed for pressure ulcers. The findings include: 1a) On 2/20/25 at 11:13 AM, the surveyor reviewed Resident #56's medical record which revealed that Resident #56 was being seen by a wound team for two wounds in February of 2025. The surveyor reviewed the February 2025 Treatment Administration Record (TAR). An order was written for the left buttock wound treatment to start on 2/6/25. This treatment was discontinued on 2/11/25. A new order was written for treatment to start on 2/14/25. The order stated, to cleanse wound with normal saline, pat dry, and apply Medihoney to the wound and cover with a dressing. A new order was written to start on 2/20/25 that stated, cleanse wound with normal saline, pat dry and apply calcium alginate to wound can cover dressing with a border dressing daily and as needed. The older order was not discontinued and both treatments were documented as being done on 2/20/25. On further review of the February 2025 TAR a treatment order was written for Resident #56' s right upper arm skin tear and treatment was to start on 2/20/25. The order stated, cleanse with normal saline, pat dry and apply xerofoam to the wound and roll gauze daily and as needed. Next the surveyor reviewed the wound note written on 2/28/25 by wound Nurse Practitioner (NP) # 28. NP #28 wrote a plan for treatments of Resident #56's two wounds. NP #28 recommended Resident #56's left buttock wound treated as, cleanse wound with normal saline, pat dry and apply calcium alginate to wound can cover dressing with a border dressing daily and as needed. Nowhere in the note did she recommend using Medihoney. She further recommended treatment to the right arm as, cleanse with normal saline, pat dry and apply xerofoam to the wound and roll gauze every other day and as needed not every day. On 2/26/25 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked who was responsible for writing the wound treatment orders. The DON stated the nurse that worked with the wound Nurse Practitioner was currently on leave and the nurse in charge of the resident would be taking orders for the new wound treatments. The surveyor reviewed the concern that the current orders and treatments being documented as being completed are not current with the recommendation from the wound team. 1b) On 2/26/25 at 9:24 AM, the surveyor reviewed Resident #51's medical record. The review revealed that Resident #51 had two wounds being treated by the wound team in February of 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On further review it was noted that Wound Nurse Practitioner (NP) #28 wrote progress notes on 2/4/25, 2/11/25, 2/28/25 and 2/25/25. The recommended treatment for Resident #51's right knee skin tear was the same for all of the February dates. The treatment recommendation was, cleanse wound with normal saline, apply Hydrogel to the base of the wound, secure with Abdominal (ABD) pad (these pads are used to absorb discharges from abdominal and other heavily draining wounds) and rolled gauze. The frequency was daily and as needed Next the surveyor reviewed Resident # 51's Treatment Administration Record (TAR). The treatment ordered was, cleanse the wound with soap and water, apply Hydrogel, and border gauze. The frequency was daily and as needed. On 2/26/25 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked who was responsible for writing the wound treatment orders. The DON stated the nurse that worked with the wound practitioner is currently on leave and the nurse in charge of the resident would be taking orders for the new wound treatments. The surveyor reviewed the concern that the current orders and treatments being documented as being completed are not current with the recommendation from the wound team.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 45733 Based on review of staffing information, medical records and interviews, it was determined that the facility failed to ensure sufficient weekend staffing on each type of personnel on a 24-hour basis to provide nursing care and answering call lights. This was found to be evident weekends during the period of 12/29 to 2/1/25 of an annual survey. The findings include: Interviewed Residents #55, #102 and #292 during the tour of the facility on 2/11/25, revealed that the unit staff did not answer or late answering the call lights on weekends. During an interview, on 02/24/25 at 11:26 AM, Director of Nursing (DoN) stated that the staffing scheduling was managed by Bridgeway Staffing, Monday through Friday from 8AM to 5PM only and including finding replacements for call outs. And the facility's Administration staff managed the staffing, after-hours including weekends' call outs. Record review, on 02/24/25 at 12:31 PM, found that the staffing reports (from 12/29/24 to 02/1/25) weekends staff hours fell consistently below 3.0 hours per resident per day (HPPD): 12/29/24 required 422.98 hr. and filled 352.00 hr. which HPPD was 2.532 1/11/25 required 416.89 hr. and filled 388.00 hr. which HPPD was 2.832 1/12/25 required 416,89 hr. and filled 341.50 hr. which HPPD was 2.493 1/19/25 required 413.85 hr. and filled 404.25 hr. which HPPD was 2.972 1/26/25 required 422.98 hr. and filled 374.50 hr. which HPPD was 2.694 1/02/25 required 442.69 hr. and filled 438.79 hr. which HPPD was 2.906 The HPPD in the context of Long-Term Care (LTC) stands for Hours Per Patient Day and is a metric used to measure the amount of nursing care provided to Residents within a 24-hour period, essentially indicating the level of staffing in a facility; a higher HPPD signifies more nursing hours available per Resident per day. Interview, on 02/27/25 at 10:34 AM, the DoN reviewed the above findings of residents' complaints and the HPPD below 3.0 weekend staffing requirement. He admitted that on weekends' call-outs/ short staffing couldn't be replaced even if they tried. He admitted that the facility failed to ensure sufficient weekend staffing was a deficiency.

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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. 44440 Based on record review and staff interviews, it was determined that the facility failed to ensure medications were administered to a resident as ordered. This was evident for 1 (Resident #51) out 6 residents reviewed for medication regimen review. The findings include: On 2/18/25 at 10:33 AM, the surveyor interviewed Resident #51. During the interview Resident #51 stated that on multiple occasions he/she was not able to get his/her prescribed Pregabalin (a medication used to treat seizures and nerve pain). On 2/25/25 at 8:53 AM, the surveyor reviewed Resident #51's November 2024, December 2024 and January 2025 Medication Administration Record (MAR) for Pregabalin. The order was for Resident #51 to get Pregabalin 200 mg every 8 hours for neuropathic pain. The review revealed on 11/4/24, 9 was coded, as other/see progress notes. In November on 12/6/24, the 2 PM dose, and 10 PM doses were coded with a 9, as well as the 6 AM dose on 12/7/24. On 1/6/25 the 6 AM and 2 PM doses were coded as 9 and the 10 PM dose was coded as 5, Held/see progress notes. On 1/7/25 the 6 AM and 10 AM doses were coded with a 9. On further review of the progress notes, 5 of the above coded see progress notes stated that the medication was not available or waiting for pharmacy. On 2/25/25 at 9:56 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that Resident #51 should not have had his/her medication not available and would look into the concern.

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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. 51786 Based on record review and interviews it was determined that the facility failed to 1) act upon recommendations made by consulting the Pharmacist in a timely manner; and 2) the attending Physician failed to document that he reviewed and addressed the Pharmacist's identified irregularities in the resident's medical record. This was found evident of 2 (Resident #56 & #92) of 5 residents reviewed for unnecessary medication during the annual survey. The findings include: 1.) On 2/26/25 at 9:50 AM, a review of Resident #92's medical record revealed four medical regimen reviews were conducted from November 2024 to February 2025. During these reviews, irregularities were identified on 1/28/25 and 2/14/25. Further review of Resident #92's record failed to show the details of the irregularities. The Director of Nursing (DON) was asked to provide details of the Pharmacist's identified irregularities. On 2/26/25 at 10:23 AM, the surveyor received the identified irregularities details for Resident #92. A review of the medication irregularities details revealed: On 1/28/25- The pharmacy recommended order clarification to change the route of medication from dental to mouth. On 2/14/25- The pharmacy recommended to add rinse mouth after albuterol use in the order directions. On 2/26/25 at 10:33 AM, a review of the facility's medical regimen review policy indicated that non-urgent irregularities should be addressed by the attending Physician no later than the resident's next routine visit or 60 days. Additionally, the consulting Pharmacist must provide the DON with a report of non-urgent irregularities within 72 hours. On 2/26/25 at 10:43 AM, a further review of Resident #92's medical record revealed that the resident was seen by the attending Physician on 2/4/25, 2/18/25, 2/20/25, and 2/25/25. On 2/26/25 at 10:55 AM, during an interview with the DON, s/he confirmed that s/he received Resident #92's Pharmacist's identified irregularities and recommendations for dates 1/28/25 and 2/14/25 on 2/26/2025. The DON also confirmed that the attending Physician reviewed and addressed the identified medication irregularities for 1/28/25 and 2/14/25 on 2/26/25. 2a.) On 2/26/25 at 10:45 AM, a review of physician notes on 2/4/25, 2/18/25, 2/20/25, and 2/25/25 failed to show that the Physician documented that s/he reviewed the Pharmacist's identified irregularities. On 2/26/25 at 10:50 AM, further review of Resident #92's records failed to reveal documentation of the Physician's actions taken or not taken to address the irregularities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:20 AM, a follow-up interview with the DON was conducted. The DON confirmed that Resident #92's medical record lacked the Physician's documentation that s/he reviewed and addressed the Pharmacist's identified irregularities. 44440 2b) On 2/26/25 at 10:20 AM, the surveyor reviewed Resident #56's pharmacy Medication Regimen Review (MMR) evaluations. The MMR evaluations were being conducted each month by pharmacy. On 9/11/24 and 11/13/24 the Pharmacist noted an irregularity and generated a report with recommendations. The surveyor asked the Director of Nursing (DON) for the reports. On 2/26/25 at 12:29 PM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON) Staff #15. During the interview Staff #15 stated he obtained the reports from his email and printed the reports. The surveyor asked how he would know the provider response to the recommendation if the report was just printed and there was nothing documented on the physician/prescriber response section. Staff # 15 stated he believed that the recommendations were ordered and completed. The surveyor further reviewed the recommendations from the 9/11/24 irregularity report. The report stated that Resident #56 received Valproic Acid and recommended a Valproic Acid level at the next convenient laboratory blood draw. Next the surveyor reviewed the progress notes for Resident #56. Nurse Practitioner NP #33 wrote a progress note dated 9/26/24 that stated Resident #56 was seen for a Keppra laboratory result that was normal. Nowhere in the note did NP#33 acknowledge the pharmacy's recommendation to have Resident #56's Valproic Acid level drawn. No laboratory order was written after NP #33 saw Resident #56 on 9/26/24 even though an irregularity report was written on 9/11/24 suggesting a laboratory level be drawn. On further review a Valproic Acid level was ordered on 10/2/24. This was a week after the provider had seen the Resident on 9/26/24. On 2/26/25 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #56's irregularity recommendations were not addressed by the provider on the next visit and without any documentation on the report it was difficult to know when the provider was notified of the recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51786 Based on observation and staff interview, it was determined that the facility failed to ensure a medication error rate of less than 5% during the medication administration observation. This was evident for 3 medication errors out of 25 opportunities which resulted in a medication error rate of 12%. The findings include: On 2/21/25 at 8:05 AM, a Licensed Practical Nurse (LPN) #24 was observed preparing medications for Resident #106. LPN #24 administered 1 tablet of Ibuprofen 600mg, and 2 tablets of Tizanidine 4 mg to the resident. (Ibuprofen is a non-inflammatory medication used to treat pain and Tizanidine is used to help relax tight muscles and reduce muscle spasms). On 2/21/25 at 9:30 AM, a review of Resident #106's medical record revealed Ibuprofen 600mg 1 tab order was discontinued on 2/16/25. Further review of the Physician's order revealed that the correct ordered dose to be given for Tizanidine was 6mg. On 2/21/25 at 9:46 AM, an interview with LPN #24 was conducted. The LPN confirmed that s/he gave Resident #106 a discontinued medication (ibuprofen 600mg), and an incorrect dose for Tizanidine (Tizanidine 8mg). On 2/21/25 at 8:15 AM, during another observation, LPN #24 prepared and administered Vitron C 1 tab to Resident #25. (Vitron C is an Iron supplement with Vitamin C). On 2/21/25 at 9:30 AM, a record review of Resident #25's ordered medications revealed that Vitron C was discontinued on 2/16/25. On 2/21/25 at 9:46 AM during a follow-up interview with LPN #24, s/he confirmed that s/he administered a discontinued medication (Vitron C) to Resident #25.

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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. 51786 Based on observations, interviews, and record review, it was determined that the facility failed to: 1) properly store medications and 2) ensure medications were properly labeled with expiration date. This was evident for 2 of 3 medication carts observed during the annual survey. The findings include: 1.) On 2/21/25 at 8:05 AM, during medication administration observation, a Licensed Practical Nurse (LPN) #24 was observed administering medications to Resident #106 (Ibuprofen 600mg, pain relief medication) and Resident #25 (Vitron C, an iron supplement with Vitamin C). On 2/21/25 at 9:30 AM, a record review for Resident #106 and Resident #25 was conducted, The review of record revealed that Ibuprofen 600mg was discontinued for Resident #106. A review of Resident #25's medication orders revealed that Vitron C was discontinued. On 2/21/25 at 9:46 AM, an interview with LPN #24 was conducted. The LPN confirmed that the discontinued medications were stored in the medication cart. On 2/24/25 at 8:10 AM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON confirmed that discontinued medications should not be stored in the medication carts. 2.) On 2/24/25 at 7:55 AM, during medication storage observation conducted with Staff #25. The surveyor observed Resident #102's Methadone medication labels had no expiration dates. Methadone is used for pain relief and treatment of drug addiction. On 2/24/25 at 8:10 AM, an interview with Staff #25 was conducted. Staff #25 confirmed that Resident # 102's medication had no expiration dates on the label. On 2/24/25 at 1:58 PM, a review of Resident #102's methadone log form failed to show an expiration date. Staff #25 was made aware of Surveyor's concerns.

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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. 44440 Based on observations and interviews it was determined that the facility staff failed to properly store food in accordance with professional standards for food service and safety. This was found evident in 1 of 3 kitchen observations and 2 out of 2 unit storage refrigerators during the survey. This has the potential to affect all residents. The findings include: On 2/18/25 at 8:18 AM, the surveyor conducted initial observation of the facility kitchen. During the observation the facility's Dietitian and interim-Dietary Manager Staff #17 was present. On 2/18/25 at 8:20 AM, the surveyor along with Staff #17 observed the dry storage room. Staff #17 stated that dietary staff are expected to date the food items when they are received. The surveyor noted one can of sliced peaches without a labeled received date. The surveyor also noted that one can of mandarin oranges that did not have a receive date. The can also did not have an expiration date. On a different row 6 cans of the same product, mandarin oranges, we noted all to have recently received dates. The surveyor asked Staff #17 how without a date on the can she could assure that the can would not be left and used past the best buy date. Staff #17 stated she would be removing the non dated cans. The surveyor noted a three compartment container labeled Flour, [NAME] and Sugar. The Flour had no date. The [NAME] and Sugar were both dated 10/24/24. Staff #17 stated that the flour should have been dated when it was placed into the container. Next the surveyor observed the kitchen cooler. The surveyor asked how long items should be left in the cooler. Staff #17 stated leftover food should be tossed after three days. A container of cut pineapple was noted. It was covered in plastic wrap and dated 2/13/25 with a used by label dated 2/16/25. Staff #17 stated she would toss the pineapple. She further stated the Dietary Aid evaluates the food every morning. On further observation an unlabeled non dated, what appeared to be butter, was noted. Staff #17 stated she would get rid of the item. Additionally a tray of what appeared to be sausage patties were laid out on a covered tray, however it had no label or date. Staff stated that they were sausages that were thawing for the breakfast club that was to take place this morning but should have been labeled and dated. On 2/18/25 at 8:41 AM, the surveyor observed the kitchen freezer. A bag of cheese omelets were in the labeled box however, the bag was open and the food was open to air. No date was noted as to when the box was opened. The same was noted for a bag of turkey paddies. The surveyor noted a bag that was resealed and closed however there was no label or date as to when the bag had been opened. The bag was next to a box that was labeled breaded chicken portions and appeared to be additional breaded chicken portions. Also noted with no date or label was a bag of croissants. The surveyor reviewed the concerns of open bags, non label and dated items with Staff #17. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/25 at 8:52 AM, the surveyor observed an opened and resealed bag of Italian steak rolls on the top rack of the break rack. No date was noted on the bag. On further observation down a few racks additional bags of the Italian steak rolls were present. These bags had a closing tab that noted the best by date. Staff #17 stated she would toss the opened bag with no date. On 2/27/25 at 5:53 AM, the surveyor reviewed the first floor nourishment room. In the resident refrigerator a 1/4th full water bottle filled with a yellow substance was noted. No date or label was on the bottle. A bag of food labeled with a resident's room number was noted. The dates on the bag were 2/17/25 and 2/20/25. The surveyor also noted on the shelf next to the refrigerator a fast food bag and a half empty beverage. The surveyor reviewed the findings with Staff #30. After reviewing Staff #30 stated he would toss the items and that everything should be labeled and dated and thrown out after three days. On 2/27/25 at 6:02 AM, the surveyor observed the 2nd floor nourishment room. In the refrigerator 7 bags of food were labeled with one resident room number. No dates were noted on any of the bags. Additionally that same resident had a take out container labeled with a date of 2/18/25 on the container. A second resident also had a bag of food and the date on the bag was 2/18/25. The facility's apple sauce container was also noted in the refrigerator and dated 2/24/25. The surveyor noted on the shelf next to the refrigerator an open bag with what appeared to be a sandwich. A note was attached to the bag with a name on it. On 2/27/25 at 6:17 AM, the surveyor interviewed the charge nurse Licensed Practical Nurse (LPN) #31. The surveyor reviewed the observation with LPN #31. LPN #31 stated she would address the food in the refrigerator. She also stated she would toss the apple sauce and that the name on the sandwich bag was a day shift Geriatric Nursing Assistant (GNA)#32. She stated the employees' food should not be stored in that refrigerator and would get rid of the sandwich. On the day of exit the surveyor reviewed the concerns and findings of the nourishment rooms with the Staff #17.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44440 Based on observation and interviews, it was determined that the facility failed to maintain the outdoor garbage storage area in a manner to prevent the harboring pests. The findings include: On 2/25/25 at 10:37 AM, the surveyor took a tour of the outdoor dumpster that the kitchen utilized for waste removal. The surveyor noted that four mattresses were piled up next to the dumpsters with other materials surrounding the mattresses. On 2/25/25 at 10:40 AM, the surveyor conducted an interview with Maintenance Director Staff #6. During the interview the Staff #6 confirmed that the wooded area surrounding the building was a habitat for multiple types of potential vermin. The surveyor asked how long the mattresses were left there and why the mattresses and other material were not put into the dumpster. Staff #6 stated he did not now know long the mattresses had been there and that the garbage removal company would not take mattresses. He further stated that he had another dumpster he could move the mattresses to. On 2/25/25 at approximately 2 PM, the surveyor conducted a follow-up interview with Staff #6. During the interview Staff #16 confirmed that the 4 mattresses had been removed from the side of the dumpster.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44440 Based on interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 1 (Resident #50) of 46 residents reviewed during the survey. The findings include: Preadmission Screening and Resident Review (PASARR): is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. A preliminary assessment is done to determine whether a resident might have a Severe Mental Illness (SMI) or Intellectual Disability (ID). This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. On 2/29/25 at 8:38 AM, the surveyor reviewed Resident #50's medical record. The review revealed on 11/10/22 a level one evaluation was completed for Resident #50 with a positive Yes documented in the SMI section requiring a level II to be completed. On further review two out of the three questions asked were marked as yes and the last question was marked as no. The instructions for a positive test were to have all three-questions marked, yes. On 2/26/25 at 8:09 AM, the surveyor conducted an interview with the Director of Nursing (DON). The surveyor asked the DON if Resident #50 was required to have level II screening completed. The DON stated he would talk to the Social Worker. On 2/26/25 at 9:45 AM, the surveyor conducted an interview with the Social Service Assistant, Staff #23. During the interview Staff #23 stated that the need for level II screening was marked in error and that the resident did not need the level II screening.

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F 0910 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms meet each resident's needs. 51589 Based on observations and staff interviews, it was determined that the facility failed to provide adequate privacy in resident bathrooms. This was found to be evident throughout the facility during the recertification survey. The findings include: On 2/18/2025 at 9:10 AM, surveyors conducted on interview with Resident #442's family member who addressed concerns about bathroom privacy for the resident due to lack of blinds in the resident bathroom. On 2/18/2025, surveyors observed multiple bathrooms located in resident rooms on the ground floor with no blinds or curtains covering the windows. Brackets were observed hung in resident window frames in bathrooms without blinds or curtains. Windows in resident bathrooms were also observed not to be frosted. On 2/20/2025 at 2:30 PM, surveyors toured outside the facility. During this tour, surveyors were able to see inside residents' bathrooms from outside on the ground level. The Maintenance Director (MD) was interviewed on 2/25/2025 at 11:10 AM. The MD stated that he had worked at the facility for 8 years and was not aware at any time that blinds or curtains were used in resident bathrooms. On 2/26/2025 at 2:44 PM, the Director of Nursing (DON) was interviewed and acknowledged concerns about the lack of privacy in resident bathrooms.

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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** 44440 Based on observation and interview, it was determined that the facility failed to provide maintenance services necessary to maintain a clean, comfortable, and homelike environment in the kitchen and resident rooms. This was found evident on: 1) one exterior door leading to the garbage disposal area, and 2) 2 resident rooms (#113 and #117) and one resident shower room during the recertification survey. The findings include: 1) On 2/25/25 at 10:37 AM, the surveyor observed the door that the kitchen staff utilizes to remove the garbage to the outdoor dumpsters. The surveyor noted light coming in from the outside from an opening at the junction where the wall and the right corner of the door met. On 2/25/25 at 10:44 AM, the surveyor conducted an interview with the Director of Maintenance Staff #6. During the interview the surveyor was able to show Staff #6 the concern, the open area on the exterior door. Staff #6 stated that the hole had been concreted before but due to rough handling at the door the concrete had broken away. Staff #6 stated he would need to repair the open area again. 51589 2) On 02/18/25 at 10:30 AM, surveyors observed crumbling drywall in the bathroom window of room [ROOM NUMBER]. At 10:35 AM, surveyors observed multiple repair patches and water stains on the ceiling tile in room [ROOM NUMBER]. Extensive scratches on the wall next to bed A in room [ROOM NUMBER] were also observed. On 02/20/25 at 09:49 AM, the shower room across from room [ROOM NUMBER] was observed to have a nail sticking out of the wall between shower stall #1 and #2 approximately 12 inches off the ground. The Maintenance Director (MD) was interviewed on 2/25/2025 at 11:10 AM. The MD toured areas of concern with the surveyors. The MD stated it is the facility's expectation that staff make the maintenance department aware of issues by documenting in maintenance logs located at each nurse station or through direct phone call to the MD or other maintenance staff. On 02/26/25 at 02:44 PM, The Director of Nursing was interviewed by surveyors and acknowledged maintenance concerns.