STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215044	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Elizabeth Rehabilitation & Nursing Center	3320 Benson Avenue Baltimore, MD 21227

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 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. Based on record review and interview it was determined the facility staff 1) failed to determine on admission if a resident had an advance directive and provide information about the right to formulate an advance directive; and 2) failed to identify a primary decision-maker for a resident determined not to have decision-making capacity. This was evident for 1 (Resident #5) of 17 residents reviewed for Quality of Care and Treatment during the complaint survey. The findings include:1) Resident #5's medical record was reviewed on 8/25/25 at 12:30 PM. An admission BIMS (Brief Interview of Mental Status) cognitive screening tool dated 5/25/25 revealed Resident #5 score was 14. A score of 13-15 is categorized as cognitively intact. The admission Record revealed the resident was his/her own Responsible Party. The section of the admission record titled, Advance Directive was blank.No documentation was found in the resident's medical record to indicate the facility staff determined if Resident #5 had an Advance Directive on admission, that they informed the resident of his/her right to establish an Advance Directive and provided him/her assistance if he/she wished to establish one.2) The record review also revealed that Resident #5 experienced changes in his/her condition including but not limited to increased confusion. On 8/5/25 2 physicians assessed Resident #5 and certified that s/he lacked the capacity to make informed medical decisions. Further review of the medical record failed to reveal who was responsible for making decisions on Resident #5's behalf nor how they identified Resident #5's decision maker.On 9/29/25 at 9:20 AM the Surveyor requested all documentation related to Resident #5's Advance Directives and determination of decision maker.On 9/29/25 at 11:10 AM the Administrator indicated that the resident did not bring Advance Directives with him/her on admission. He was made aware of the above concerns and asked to provide evidence that the facility offered the resident an opportunity and assistance to develop advanced directives upon admission and documentation reflecting the determination of a surrogate decision maker for Resident #5.He returned at 1:48 PM on 8/29/25 and indicated that he was unable to find any additional documentation and added that the facility's Social Worker at that time no longer worked in the facility.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record and statement from Staff # 13, the facility failed to notify Responsible party after the Resident fell on 8/23/24. This was evident for 1 (Resident # 21) out of 1 resident reviewed during the complaint survey. Findings include:On 8/23/24 Resident #21 was lowered to the floor by Staff # 13. Resident #21 was assessed and put back to bed. The Resident's daughter came to visit and noticed he/she was slumped to the left side of wheelchair and left ankle was swollen. Resident # 21 had a history of blood clots and asked that resident be checked for blood clots and have his/her left lower ankle be x-rayed. On 8/25/24 Lower left ankle was x-rayed and venous doppler was done. Results were the same as before, mild degeneration changes done on 8/26/24. On 8/26/24 Resident #21 could not stand or put pressure on his/her foot. The Resident was sent out 911 to hospital on 8/26/24 and noted to have a left hip fracture. The Resident had it repaired and was sent back to facility.The Responsible party was not notified of the fall that occurred until 8/26/24 when she went to the hospital. DON and administrator aware and stated they spoke with Staff # 13 asking about a fall that resident had on 8/23/24. Staff #13 stated she lowered resident to the floor so she did not consider this a fall so she never reported this. Staff was counselled on 9/5/24 on importance of reporting all incidents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews with resident, staff and review of the grievance process it was determined that the facility failed to give adequate responses to grievances presented by a resident/family regarding an allegation of neglect. This was found evident in the review a facility reported incident of neglect that was also a reported grievance from Resident #2 reviewed during the complaint survey.The findings include:A review of the medical record for Resident #2 on 8/28/25 at 8:25 AM revealed admission to the facility in June of 2025 for therapy and antibiotics. On the nightshift of 7/6/25 into 7/7/25 Resident #2 put on their call-light repeatedly asking for help to be changed out of a soiled brief. According to a grievance form completed by Resident # 2's family on 7/9/25, GNA #7 failed to provide any activities of daily living on the night shift for Resident #2. According to the response and resolution on the form the employee was terminated, however, there is nothing noted that there was follow up with the family or the resident. Resident #2 was interviewed on 8/28/25 at 8:42 AM. Resident #2 was very tearful and revealed that at that moment s/he was still very upset and scared as according to the resident there was no follow up and s/he did not know if the GNA that neglected him/her that night was coming back. Interview with the facility DON and NHA on 8/28/25, the DON stated that she had followed up with the resident regarding the incident that occurred on 7/6/25 however, she was unable to provide any documentation that there was follow-up.According to the facility grievance policy 10. e. The grievance official will keep the residents appropriately appraised of progress towards resolution of the grievances. f.the Grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on medical record review and interview with staff and resident it was determined that the facility staff neglected his assigned patients and failed to provide care to them causing identified harm to a resident when the care was refused to be administered. This resulted in psychosocial harm to Resident #2 and was evident during the review of a facility reported incident reviewing documented neglected care of 13 (Residents #2, #29, #33, #39 #40 #30, # 31, #32, #34, #35, #36,# 37, and # 38) of 13 residents reviewed during the complaint survey. The findings include: 1. A review on 8/27/25 at 8:45 AM of the facility investigation into the allegation of neglect for Resident #2 revealed allegations that the resident repeatedly requested throughout the nightshift on 7/6/25 assistance for incontinent care. However, according to all available statements, documentation and interviews, staff GNA #7 failed to ever provide that care.Staff ADON # 8 made a statement in the investigation and again on 8/27/25 that the charge nurse from the night shift reported to her on the morning of 7/7/25, concerns that GNA #7 was not providing care to Resident #2 even after repeatedly being asked by said charge nurse. Staff ADON #8 approached Resident #2 on the morning of 7/7/25 after the night shift and found him/her soiled and took a picture of what was left by GNA #7 for the investigation packet. The image in the packet showed Resident #2 in a soiled brief with evidence of stool on the resident's leg and bed. ADON #8 then proceeded to change Resident #2 into a new brief. ADON #8 documented that when she changed Resident #2's brief, the resident's perineal and buttock area were excoriated which was a new occurrence. An order was placed to apply Calmoseptine to the perineal and buttock area after each incontinent episode and the facility DON was notified of the findings. Review on 8/28/25 at 8:30 AM revealed Resident #2 scored with a brief interview of mental status (BIMS) of 13 on admission, meaning that s/he is cognitively intact. S/he was also assessed on the 7/2/25 MDS as being dependent on staff for toileting hygiene. A comprehensive review of GNA #7's documentation from the night of 7/6/24 was completed. Review of the ‘documentation survey report', where GNAs document the care that they provide to residents revealed that form documents the level of care and assistance that a GNA provides a resident for specific activities of daily living. According to the documentation survey report the following was identified as documented by GNA #7 on the nightshift 11-7 am on 7/6/24 into 7/7/24 regarding Resident #2: 1, M, 1 for bowel, NA for bladder. This coding meant that he changed the resident, s/he was dependent for care, incontinent of bowel and there was no urine in the brief when he changed the resident documented at 6:59 AM. A review of Resident #2's medical record revealed that s/he was seen on 7/16/25 by the facility psychiatrist secondary to the incident that occurred on 7/6/25. Resident #2 expressed to the psychiatrist that s/he had intermittent thoughts of hopelessness and stated, I personally would rather die than continue. The assessment continued to document that the resident was frustrated surrounding the events of ‘perceived neglect' and was exacerbating [his/her] emotional vulnerability. There were recommendations to continue support, and s/he was provided with a crisis line for support. Resident #2 was seen again on 7/17/25 with notes that a safety plan would be implemented.The Administrator was interviewed on 8/27/25 and 8/28/25 regarding the status of the ‘safety plan' that was identified and recommended for Resident #2 in the psychiatry notes from admission to the incident that occurred on 7/6/25. As of exit, there was no safety plan provided to the survey team for Resident #2 after the recommendations from the facility psychiatrist and with collaboration from the facility for Resident #2.Resident #2 was interviewed on 8/28/25 at 8:45 AM. S/he was very tearful during the interview regarding the incident that occurred on 7/6/25 and stated s/he had told GNA #7 at the beginning of the (11pm-7am) shift that [s/he] really needed to be changed and he stated, ‘well no we will have to wait until the morning.' S/he stated that s/he was scared as he would just stand there and not do anything and is still scared as the facility has yet to follow up directly with him/her about the status of the employee and if he is ever coming back and if he will ever care for him/her again. S/he further stated that the excoriation on his/her buttocks has gotten worse and is painful. The DON and NHA were interviewed on 8/28/25 regarding this after the interview with Resident #2. The DON stated that she had followed up and met with the resident, however, could not verify what she told the resident or when she followed up with the resident.2. Record review of Resident #29 on 8/27/25 at 11:21 AM revealed MDS assessments showing on 7/7/25; a BIMS of 15 and according to section ‘GG' that assesses functional abilities, Resident #29 was documented as always incontinent of bowel and occasionally incontinent of urine and requires supervision assistance with the wheelchair/walker. Review of an interview with Resident #29 documented in the facility investigation noted that s/he was ‘ignored on purpose and given the silent treatment' according to question

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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. Based on record review and interviews it was determined the facility staff failed to report incidents within required timeframes. This was evident for 2 (#21 and #2) of 12 residents reviewed for neglect and 2 (#15 and #4) of 6 residents reviewed for abuse during the complaint survey. The findings include:1) On 8/23/24 Resident #21 was lowered to the floor by staff # 13. Resident #21 was assessed and put back to bed. The Resident's daughter came to visit and noticed the resident was slumped to the left side of wheelchair and left ankle was swollen. Resident # 21 had a history of blood clots and asked that resident be checked for blood clots and have his/her left lower ankle be x-rayed. On 8/25/24 Lower left ankle was x-rayed and venous doppler was done. Results were the same as before, mild degeneration changes done on 8/26/24. On 8/26/24 resident could not stand or put pressure on foot. Resident was sent out 911 to hospital on 8/26/24 and noted to have a left hip fracture. It was repaired and the resident was sent back to facility. Responsible party was not notified of the fall that occurred until 8/26/24 when he/she went to the hospital. DON and administrator aware and stated they spoke with Staff # 13 asking about a fall that resident had on 8/23/24. Staff #13 stated she lowered resident to the floor so she did not consider this a fall so she never reported this. Staff was counselled on 9/5/24 on importance of reporting all incidents. Staff # 13 never reported a fall or lowering a patient to the floor that day on 8/23/24. There were no nursing notes. When administrator and DON found out Staff # 13 lowered a resident to the floor on 9/5/24 there was still no investigation done and no one else was interviewed on how resident received a broken hip. When administrator and DON were asked these questions, there was no response. 2) On 8/26/25 at 11:31 AM, a review of a facility’s self-reported incident, 347659, alleged that Resident #15 reported an allegation of possible sexual abuse to a family member, who then reported the allegation to the facility staff. The facility’s investigation documented that the facility staff became aware of the incident on 11/16/24 at 3:00 PM. Further review of the facility’s documentation revealed an email confirmation that documented the facility's initial self-report was submitted to the state survey agency, the Office of Health Care Quality (OHCQ) on 11/17/24 at 6:02 PM. The facility failed to report the allegation of abuse immediately, but not later than 2 hours after the allegation was made. The concerns with the late reporting of an allegation of abuse was discussed with the Director of Nurses (DON) on 8/29/25 at 1:25 PM. The DON acknowledged the concerns and offered no further comments at that time. 3) Review on 8/27/25 at 8:45 AM of the facility reported incident regarding Resident #2 involving an allegation of neglect revealed that the facility was aware of the allegation on the morning of 7/7/25, however, did not make a report until 7/10/25 to the Office of Health Care Quality (OHCQ) as there was an official grievance completed by the family on 7/9/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concern was reviewed with the facility DON and NHA (Nursing Home Administrator) on 8/27/25 at 1:24 PM. Although the facility had initiated an internal investigation, there was not a formal report to OHCQ for 48 hours post the finding of a resident being neglected for activities of daily living. 4) Facility reported incident 347683 was reviewed on 8/27/25 at 1:00 PM. The report indicated that on 5/11/25 at approximately 2:45 PM Resident #4's family member reported that the resident stated “bum, bum, bum.” The facility reported an allegation abuse to the state agency, and the police were notified. The facility investigation included statements from several staff members. A statement from Staff #19 a GNA (Geriatric Nursing Assistant) dated 5/11/25 7-3 indicated that on Saturday 5/10/25 she arrived at 7 AM and checked on residents. She stated: [Resident #4] was very upset, crying, and doing a hand movement gesture waving back and forth saying something happened, but I couldn’t understand him/her, and it kept making [him/her] more upset. So, I said don’t worry I’ll be back”, “but [s/he] didn’t say anything the rest of the day”. Staff #19 added “today” the resident’s family member reported Resident #4 made similar remarks to them. There was no evidence that Staff #19 reported the resident’s distress or report that “something happened” immediately to a nurse or supervisor on 5/10/25. On 8/29/25 at 12:32 PM Staff #3 the Corporate Administrator (former NHA of the facility) and the current NHA were made aware of these findings. The Corporate Administrator indicated that agitated and upset behavior was baseline for Resident #4 and not unusual. However, the facility’s summary from the investigation indicated - Resident #4 had “no signs of mood disturbance at this time. However, s/he does have a history per nursing staff. There have been no mood or behavior disturbance reported at this time.”

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview with facility staff it was determined that the facility staff failed to thoroughly investigate allegations of abuse and neglect. This was evident for 2 (Residents #15 and #4) of 6 residents reviewed for abuse and for 1 (Resident #2) of 12 residents reviewed for neglect during the complaint survey. The findings include:1) On 8/26/25 at 11:31 AM, a review of a facility’s self-reported incident, 347659, alleged that Resident #15 reported an allegation of possible sexual abuse to a family member, who then reported the allegation to the facility staff. The facility’s investigation documented that staff became aware of the incident on 11/16/24 at 3:00 PM. The facility’s follow-up investigation report on 11/21/24 documented that Resident #15 was moderately cognitively impaired and resided on the memory care unit. The self-report further documented that Resident #15 was interviewed by the DON (Director of Nurses) and there were no witnesses to the allegation. The facility’s investigation concluded that the allegation of sexual abuse was not verified, there was no evidence to show that any sexual assault had occurred, and interviews with family, the resident and staff did not show any evidence of sexual activity. The self-report documented that Resident #15 was assessed by the physician on 11/18/24, that lab work was ordered to determine any underlying medical condition that might be related to the resident’s allegation, and the medical work was unremarkable. Continued review of the facility’s investigation and review of Resident #15’s medical record failed to reveal evidence that a physical assessment of Resident #15 had been conducted on 11/16/24, when the facility staff became aware of the resident’s sexual abuse allegation. Further review of the facility’s investigation revealed no resident interviews were conducted during the facility’s investigation of the alleged sexual abuse. A review of the facility’s midnight census report for 11/16/24 documented that on that date, 22 residents resided on Unit A-1 (Noah’s Place), including Resident #15. Continued review of facility’s documentation failed to reveal evidence that during the facility’s investigation of the alleged sexual abuse, interviews had been conducted with any of the residents who resided on the same nursing unit Resident #15. In addition, there was no evidence that during the alleged sexual abuse investigation, vulnerable residents who resided on the same unit as Resident #15 had been assessed for potential abuse. On 8/29/25 at 1:31 PM, the concerns with failing to complete a thorough investigation were discussed the Nursing Home Administrator (NHA), the Corporate Administrator, and the Director of Nurses (DON). The DON acknowledged the concerns at that time and stated residents were not interviewed because of their cognitive status, and indicated resident assessments should have been completed and documented in the facility’s self-report 2) Review on 8/27/25 at 8:45 AM of the facility reported incident regarding Resident #2 involving an allegation of neglect revealed that the facility DON was made aware of an allegation of neglect on the morning of 7/7/25. The facility initiated an investigation and GNA (Geriatric Nursing Assistant) #7 was suspended. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review at this time of the facility investigation revealed that the facility ADON (Assistant Director of Nursing), was so concerned about that status she found Resident #2 in that she took a picture of him/her in their soiled brief prior to initiating activities of daily living and changing the resident into a new brief. When the ADON changed Resident #2 she noted that Resident # 2's sacrum was red and excoriated and immediately ordered Calmoseptine, a multipurpose moisture barrier cream to help with the excoriation. Further record review failed to reveal any documented skin assessment showing the presence of the sacral excoriation. Surveyor reviewed the medical records of the 12 other residents on GNA#7's assignment. The documentation survey report was reviewed and revealed that GNA #7 documented the same thing for-Resident # 33, 39 and #40 as was documented for Resident #2; 1, M, 1 for bowel, NA for bladder, even though it was established care was not provided for Resident #2. This coding meant that he changed the resident, s/he was dependent for care, incontinent of bowel and no urine was in the brief when he changed the resident, all documented between 6:51-6:59 AM. The remaining residents on his assignment were documented as ‘RU,’ (not available) for 7/6/25 or ‘NA’ (not applicable): Resident #30, 31, 32, 34, 35, 36, 37, 38 all were signed off on the documentation survey report between 6:50 AM and 6:59 AM. Further review revealed that GNA #7 worked the 11-7 AM shift on 7/4, 7/5 and 7/6 and that this documentation and lack of care occurred over 3 consecutive days. The DON and NHA were interviewed regarding these concerns on 8/27/25 at 11:58 AM. They were asked about the thoroughness of the investigation, including completing a skin assessment of the residents and/or assessments of the other identified residents and their skin status from the incident. The DON and the NHA also verbalized that they were unaware that GNA #7 had coded 8 residents that were in the facility as ‘NA’ and ‘RU' for ADL care over 3 nights. 3) Review of facility reported incident 347683 on 8/29/25 at 12:02 PM revealed that on 5/11/25 at approximately 2:45 PM Resident #4’s family member reported that the resident stated “bum, bum, bum.” The facility reported an allegation of abuse to the state agency and the police and conducted an investigation. The facility’s investigation included 11 statements from staff. Staff did not identify the date or shift to which their statement pertained in 9 of the 11 statements. Review of the nursing staffing schedule for Sarah’s Circle where Resident #4 resided revealed there were no statements from 7 staff who worked on the unit on 5/9/25 and 5/10/25. The census on Sara’s Circle on 5/9/25 and 5/10/25 was 32 – 33 residents. Physical Abuse interviews were conducted with only 4 of the 32/33 residents. There were no physical assessments of residents who were not interviewable. These concerns were reviewed with the Administrator, DON & Corporate Administrator on 8/29/25 at 2:00 PM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview it was determined that the facility failed to complete accurate assessments of a resident related to the Brief interview of mental status (BIMS) assessment completed on the minimum data set (MDS). This was evident for 1 of 5 residents (Resident #2) reviewed during the complaint survey. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each resident receives the care they need. BIMS (mandatory, cognitive screening tool used in long-term care facilities to identify and monitor cognitive changes in residents upon admission and periodically thereafter)Review of the medical record for Resident #2 on 8/28/25 at 8:25 AM revealed that on admission to the facility in 2025, the resident signed the admission contract and was identified as their own representative. The facility social worker also completed a BIMS assessment on admission on [DATE] and Resident #2 scored a 13 meaning that s/he was cognitively intact. However, further review of the medical record for Resident #2 revealed that the submitted MDS assessments for section ‘C' cognitive status since admission all noted that the BIMS for Resident #2 was not assessed or rated and should be scored by the facility staff. The facility social worker who completed all the BIMS assessments and MDS assessments was interviewed on 8/28/25 at 11:35 AM. She stated that she was not sure and could not recall and would like to review her notes.Follow-up from the facility social worker at approximately 12:30 PM on 8/28/25 revealed that yes there was an error in documentation on the submitted MDS related to Resident #2 related to the coded BIMS and that another resident's information was entered under him/her and that it will be corrected.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interview with facility staff it was determined that the facility failed to develop a comprehensive resident-centered care plan regarding the resident's pertinent diagnosis. This was evident for 1(Resident #5) of 17 residents reviewed for Quality of Care and for 1 (Resident #2) of 6 residents reviewed for Abuse during the complaint survey.The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.A PEG (percutaneous endoscopic gastrostomy) tube is a thin, flexible tube inserted through the skin and into the stomach. It provides a direct route for administering food, fluids, and medications and is used in patients who cannot swallow safely.1) Resident #5’s medical record was reviewed on 8/25/25 at 12:30 PM. The Resident’s diagnoses included but were not limited to: Dysphagia (swallowing disorder) with a history of pneumonitis (inflammation of the lungs) due to inhalation of food and vomit, Pulmonary fibrosis (scar tissue in the lungs which makes it difficult for the lungs to expand to take in oxygen), Dependence on supplemental oxygen, Atherosclerotic heart disease (caused by plaque buildup in arterial walls), Paroxysmal atrial fibrillation (irregular heart beat), Idiopathic hypotension (low blood pressure), severe protein-calorie malnutrition, Type II Diabetes, Parkinson’s disease, Stage 2 (mild) Chronic Kidney Disease, and Anxiety disorder. A plan of care was developed on 5/22/25 with the Focus: Nursing care needs: [Resident #5] has clinical care needs r/t Acute resp. (respiratory) failure, T2DM (Type II Diabetes Mellitus), A-fib (Atrial fibrillation), Hypotension, CKD (chronic kidney disease) stg 2, Parkinsons disease, Malnutrition, Anxiety. Resident #5’s goal was: [Resident #5] will not experience any acute complications, or if experienced any acute complications r/t current diagnoses, the condition will be managed/stabilized through the next review date. The interventions identified were: Administer medication as ordered by the physician. Monitor side effects and report to MD if any noted. Labs/radiology tests as ordered by the physician or as needed. Report any noted/assessed acute change of condition to the physician. Vital signs as needed or indicated by patient change of condition. The facility failed to develop individualized resident specific care interventions related to Resident #5’s identified problems: Type II Diabetes, Parkinson's Disease, Cardiovascular needs - Hypotension, Atrial Fibrillation & Heart disease, and Respiratory/pulmonary needs including oxygen use. The plan did not include measurable objectives. Resident #5 had a PEG tube, was receiving prescribed nutrition via the PEG tube and had a physician order for NPO (nothing by mouth). (continued on next page)

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	215044	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #18 a Speech Therapist was interviewed on 8/29/25 at 9:35 AM. She indicated that she worked 1:1 with Resident #5 on swallowing exercises and was gradually progressing with oral intake of pureed food and thickened liquids provided by Speech Therapy 5 times per week, Monday - Friday only. Otherwise, the resident was to receive nothing by mouth. She confirmed that the Resident’s nutrition was provided by the physician prescribed tube feedings. A plan of care for tube feeding related to dysphagia was dated 6/2/25. The plan of care failed to identify Resident #5’s specific NPO oral status nor Speech Therapy interventions, specific oral care needs. An ADL (Activities of Daily Living) plan of care interventions indicated: Eating: The resident is totally dependent on staff for eating. Personal Hygiene: The resident requires assistance by staff with personal hygiene and oral care. It did not identify that Resident #5 was to receive nothing by mouth except with Speech Therapy and did not identify his/her specific oral care needs considering the Resident’s NPO status. The Administrator, Corporate Administrator and DON were made aware of these concerns on 8/29/25 at 2:00 PM. 2) During the review of an allegation of abuse on 8/27/25 at 8:45 AM, regarding Resident #2 it was revealed that there was no care plan established regarding the resident’s psychiatric diagnosis’ and needed interventions. This was reviewed with the facility DON and NHA on 8/29/25.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to clean and change the brief of an incontinent resident. This was evident for 1 resident (Resident # 6) out of 5 residents reviewed during the complaint survey.Findings include:On 8/26/25 at 1:58 PM an investigation was done for Resident # 6 who complained about not being changed on a regular basis. According to the medical record, the resident is incontinent of bowl and bladder. The GNA Kardex is a record of what is being done for the resident. The GNA Kardex indicated the resident had not been changed on the following days:On June 2025 documentation states the nursing staff did not change Resident on the following:Day shift 6/2/25, 6/7/25, 6/8/25, 6/9/25, 6/16/25, 6/22/25Evening shift 6/1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 16, 17, and 29Night shift 6/1, 3, 4, 6, 8, 9, 10, 11, 12, 15.July 2025 documentation states the nursing staff did not change Resident on the following:Day shift: 7/4, 14, 25, 28Evening shift: 7/2, 5, 14, 30August 2025 documentation states the nursing staff did not change Resident on the following:Day shift: 8/5, 6, 7, 27On 8/27/25 at 1:10PM an interview was held with the Director of Nursing and Administrator who was in the room at the time of the interview, and stated the agency GNA's were not aware of where to sign off on the record that care was completed. A tour of the 3rd floor at 10:30 AM indicated [NAME] Circle smelled of urine and the resident in room [ROOM NUMBER]-1 complained of not being changed and having to wait a long period of time for someone to come in. The Administrator said nothing.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review and staff interviews it was determined the facility staff failed to ensure that Resident #25's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 1 (Resident # 25) of 4 residents reviewed during the survey process. The findings include:On 8/28/25 9:30 AM review of complaint 347660 alleged that Resident #25's did not receive showers in the month of December 2024.The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.Review of Resident #25's most recent MDS completed on 1/30/25, revealed that s/he is maximal assistance for bathing. The Brief Interview for Mental Status (BIMS) revealed a score of 13 indicating adequate cognitive ability.Further review of Resident #25's shower schedule which is every Wednesday and Saturday, as well as the Geriatric Nursing Assistant (GNA) task documentation of Activity of Daily Living (ADL) revealed that from 12/5/25 until 1/30/25, Resident #25 received showers on 1/16/25, and 1/19/25. Resident # 25 did not have any showers in the month of December.On 8/28/25 at 9:45 AM the DON stated that she could not find shower sheets.The Director of Nursing (DON) was made aware of this concern on 8/28/25 at at 11 AM.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, it was determined the facility staff failed to identify and provide needed care and services by 1) failing to respond timely when residents activated their call bells for assistance, and 2) failing to provide Gastrostomy Tube site care. This was evident for 1 (Resident #5) of 17 residents reviewed for Quality of Care during the complaint survey.The findings include:1) Complaint 2592016 was reviewed on 8/26/25 at 9:00 AM. The complaint included but was not limited to allegations that on numerous occasions staff failed to respond for over an hour after residents activated their call bells for assistance. This concern was confirmed with the complainant during a telephone interview on 8/26/25 at 9:03 AM.On 8/27/25 at approximately 8:00 AM, the Administrator was asked to provide the surveyors with the call bell logs. Review of 3rd floor call bell logs for a 1-week period from 8/1/25 - 8/7/25 revealed 114 occasions in which resident call bells were ringing for more than 30 minutes. On 31 of the 114 occasions staff failed to answer the call bells for more than 1 hour.The facility policy for Call Lights: Accessibility and Timely Response included but was not limited to: 10. All staff members who see or hear an activated call light are responsible for responding within a reasonable timeframe.During an interview on 8/28/25 at 1:14 PM the Director of Nursing (DON) was was asked to identify a reasonable timeframe for staff to answer resident call bells. She stated: at least within 15 minutes. If they're with another resident, about 25 minutes. She added that everyone working in the facility can answer call bells, if it's something they can't address, they should notify the nurse and tell the resident to turn the bell back on, if no one returns within 10 minutes. She was asked if the facility had identified any issues related to timeliness of staff answering call bells. The Administrator, who was also present, responded that the facility recently had a Town Hall meeting where answering call bells timely was discussed. When asked how they identified the need to address answering call bells timely, the DON stated, we looked at trends. She was asked to explain how they looked for trends and what trends they identified. She did not provide an answer but instead provided several examples of why call bells might not be answered timely. The Administrator attempted to explain the question to the DON, then indicated to the surveyor that he would sometimes stand in the hallway during his rounds, observing to see if call lights were on for a long time.They were made aware of the call bell audit review findings at that time.2) A percutaneous endoscopic gastrostomy (PEG) tube is a thin, flexible tube inserted through the skin and into the stomach. It provides a direct route for administering food, fluids, and medications and is used in patients who cannot swallow safely. TAR's (Treatment Administration Records) and MAR's (Medication Administration Records) are used to convey the physicians' orders to the nurse and are signed (initialed) off to document each time the nurse administered the prescribed treatment or medication.Complaint 2592016 included a concern that staff did not clean the area around Resident #5's PEG tube on a regular basis and that on numerous occasions it was covered in gunk.In an interview on 8/28/25 Staff #16, the Assistant Director of Nursing indicated that care of a PEG tube site should be documented on the TAR.Resident #5's medical record was reviewed on 8/28/25 at approximately 2:40 PM. A physician's order was written on 5/22/25 to Cleanse PEG tube site with soap and water and cover with dry gauze every night shift. The order was renewed for July 2025. However, the order was not included on Resident #5's July 2025 TAR or MAR (Medication Administration Record). The resident was transferred to the hospital on 7/28/25. No order was written for PEG tube care upon Resident #5's return to the facility on 7/30/25. The August 2025 physician orders, TAR, and MAR did not include PEG tube site care.In an interview on 8/28/25 at 3:05 PM, the DON (Director of Nursing) indicated that the nurse is responsible for performing routine PEG tube site care and that if there was an order it should be on the TAR. She confirmed that if a Resident had a PEG tube there should be a physician order for PEG tube care. During an interview on 8/29/23 at 9:53 AM, Staff #17 the 3rd floor Nurse Manager was made aware, reviewed Resident #5's medical record, and confirmed the above findings.The Administrator, DON and Corporate Administrator were made aware of these findings on 8/29/25 at 2:00 PM.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on review of medical records and other pertinent documentation, observations, and interviews, it was determined that the facility failed to prevent avoidable falls. This was found to be evident for 1 (Resident #7) out of 2 residents reviewed for accidents during the survey. The fall resulted in actual harm to Resident #7. The findings include:On 8/21/25 at 10 AM, review of Resident #7's medical record revealed the resident was admitted to the facility with diagnosis that included but not limited to dementia, polyarthritis, and contracture of muscle. On 8/26/25 at 11 AM, a review of the admission Minimum Data Set Assessment (MDS), section GG0100 with an Assessment Reference Date of 11/21/24 revealed the resident's Upper extremity (shoulder, elbow, wrist, hand) and Lower extremity (hip, knee, ankle, foot) were impaired on both sides. The resident was dependent for toileting, shower/bathe, dressing and personal hygiene. On 11/21/24 the MDS 3.0 Section C - Cognitive Patterns revealed A Brief Interview for Mental Status (BIMS) was conducted. The staff assessment for mental status revealed both short- and long-term memory problems and that the resident had severely impaired cognitive skills for daily decision making.On 8/26/25 at 12PM a review of the care plan that addressed the resident's requirement for assistance with activities of daily living revealed the following intervention, which was initiated on 05/30/2024, that Resident #7 will need assistance/escort to activity functions.On 8/21/25 at 10 AM, a review of the complaint #347680 revealed that, on 11/13/2024, the resident was pushed out of the dining room while in a wheelchair , after breakfast, by GNA # 4. While GNA # 4 was pushing the Resident in the wheelchair, the resident fell forward hitting her/his head on the floor. On 11/13/2024 at 12:42, the electronic medical record revealed a Nursing note that the resident had a sustained laceration to forehead. The area was cleansed with NSS, pressure applied to stop bleeding and dressing applied. The resident was then transferred to the hospital at 0850 for further evaluation per the physician's order. On 11/13/24 the resident was returned to the facility from the hospital with a report of closed head injury, skin tears and abrasion. The laceration could not be approximated with sutures because of missing skin tissue.On 8/21/25 at 11:55 am an interview with the Director of Physical Therapy (PT) revealed that if a resident is being wheeled to PT by staff a footrest is needed for the wheelchair. If the resident can self-propell then no footrest is needed. If a resident is receiving a wheelchair leg rests are provided and the resident can keep them in the room. The Director of PT did not remember Resident # 7. On 12/2/2024 the physician ordered PT to evaluate the wheelchair and positioning for resident #7. The Director of Physical Therapy (PT) stated that he could not confirm or deny that the evaluation occurred.8/21/25 at 12PM the Director of nursing revealed that if a resident is being wheeled by staff a footrest is needed for the wheelchair. If the resident can be self-propell then no footrest is needed. The DON did not remember the incident with Resident # 7. The DON gave the surveyor in-service education for the importance of leg rest during residents' transfer that was provided for staff dated 11/14/24.On 8/26/25 at 11:30 am the DON reported that she could not find a summary of the investigation, witness statement, or a root cause analysis/conclusion for Resident #7's fall.On 8/25/25 at 10:59 AM a telephone interview with GNA # 4 recalled when Resident # 7 fell from the wheelchair. GNA #4 remembered the resident had tennis shoes on but did not remember if the wheelchair had leg rests. GNA #4 stated that the resident put his/her feet down while being wheeled to the other room and his/her feet went under the wheelchair, and he/she fell forward. On 8/26/25 at 10:19 AM interview with Unit manger # 6 recalled when Resident # 7 fell from the wheelchair. The unit manager did not witness the fall, but heard the noise from the fall and investigated. The Unit Manager confirmed that the wheelchair did not have leg rests attached. On 8/26/25 at 12:58 PM, surveyor reviewed with the Director of Nursing the concern that the fall resulted in harm to Resident #7.On 8/28/25 at 12:30 PM at the time of exit conference the Administrator handed the surveyor a plan of correction that was incomplete and the Wheelchair leg rest policy which stated; when residents are transported by staff (pushed in wheelchair): leg rest and footplates shall be in place with both feet supported to prevent dragging, injury, or entrapment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview, the facility failed to monitor a resident's hydration and nutrition status resulting in the resident's change in condition that led to the resident being transferred to the local hospital to be treated for dehydration. This was evident for 1 (Resident #17) of 3 residents reviewed for neglect during a complaint survey. The findings include:On 8/25/25, the surveyor reviewed complaint 347682/MD00215742 which alleged that facility staff members failed to offer water to Resident #17 leading to the resident being transferred to the local hospital for emergency services. Review of Resident #17's medical record on 8/25/25 at 12:39pm revealed that the resident had a change in condition on 3/6/25. The resident was unable to speak, and his/her eyes were unfocused. Facility nursing staff assessed the resident, treated the resident with supplemental oxygen, and received orders to start an IV with a saline solution. Facility nursing staff were unable to establish the IV and the resident was transferred to the local hospital for treatment. Continued review of resident #17's medical record on 8/25/25 at 1:00pm revealed that the resident's last nutritional assessment was completed on 9/9/24. The assessment stated that the resident was dependent on facility staff for feeding. The resident was also assessed as having adequate fluid intake. Further review of resident #17's medical record on 8/25/25 at 1:10pm revealed a discharge summary from a local hospital dated 3/8/25. The discharge summary stated that facility staff told the hospital that the resident had decreased oral intake prior to the resident's change of condition on 3/6/25. The hospital records stated that the resident was diagnosed with dehydration and the resident was treated with IV fluids. Additional review of Resident #17's medical record on 8/25/25 at 8:00am revealed the resident had reduced oral intake on 3/1/25 - 3/5/25. The resident was documented as normally eating 75-100% of meals. From 3/1/25 - 3/5/25, the resident was documented as eating nothing for lunch on 3/1/25, no dinner on 3/4/25, and no meals at all on 3/5/25. On 8/26/25 at 9:08am, the surveyor interviewed Dietitian #15 regarding the hydration/nutritional management of residents in the facility. Dietitian #15 stated that all residents have a nutritional assessment quarterly. Any residents that are identified as being at risk would be monitored more frequently in daily and weekly clinical meetings. Dietitian #15 also stated that resident intake percentages are monitored regularly and reduced resident intake percentages should trigger an alert to the dietitian. The surveyor pointed out that Resident #17 had reduced intake percentages from 3/1/25 - 3/5/25 and there was no documentation that the resident was assessed by the dietitian. The surveyor also pointed out that resident #17's last nutritional assessment prior to the change in condition was on 9/9/24. Dietitian #15 confirmed that the resident should have had another nutritional assessment prior to the resident's change in status on 3/6/25. Also, the resident's reduced intake should have alerted the Dietitian in 3/2025.On 8/26/25 at 11:54am, the surveyor informed the Director of Nursing (DON) of the facility's failure to monitor the resident's reduced intake from 3/1/25 - 3/5/25 and provide interventions to prevent dehydration.

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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. Based on medical record review and interview it was determined the facility staff failed to maintain the medical record in the most complete and accurate form for a Resident. This was evident for 1 (Resident #7) of 2 residents selected for review during the survey process.The findings include:A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.On 8/21/ 25 at 10 AM a review of Resident # 7's electronic medical record revealed a physician order for PT to evaluate wheelchair and positioning on 12/2/24.On 8/26/25 at 10 AM an interview with the Director of Physical Therapy (PT) revealed that he could not confirm or deny that the evaluations occurred. The information was not available in the electronic medical record.On 8/28/25 at 1:30PM , in an interview with the Director of Nursing confirmed the facility staff failed to maintain the medical record in the most complete form for Resident #7.