STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215048	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montcare at Wheaton	11901 Georgia Avenue Wheaton, MD 20902

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, reviews of a closed medical record, and staff interview, it was determined that the facility staff failed to notify a resident and the resident's representative of his/her rights upon admission by not executing an admission contract. This was evident for 1 (#90) of 2 residents reviewed for personal property during a complaint and recertification survey. The findings include: Review of complaint MD00187269 on [DATE] revealed an allegation the facility staff failed to return Resident #90's belongings to the family after the resident suddenly died . A review of the facility admission contract/financial agreement on [DATE] at 11:14 AM revealed Section H, Limitations of Liability, paragraph one that stated: The facility is obligated to take reasonable precautions to provide the Resident and the Resident's personal belongings with security, including providing a reasonable amount of secured space for Resident's belongings. The facility, however, cannot be responsible for loss or damage to the Resident's valuables unless that loss or damage is caused by the negligence or willful action of the facility staff. Review of Resident #90's closed medical records on [DATE] revealed that Resident #90 was admitted to the facility on [DATE]. The nursing staff completed a personal inventory of Resident #90's belongings which included a phone, blouses, shirts, comb, brush, glasses, and a pair of slacks. The nursing staff updated Resident #90's personal effects list on [DATE] and [DATE] by adding 3 pairs of eyeglasses and an IPAD as being received into the facility. In an interview with the complainant on [DATE] at 12:35 PM, the complainant stated that after Resident #90 died on [DATE], the facility failed to return Resident #90's phone, blouses, shirts, comb, brush, glasses, and a pair of slacks. The complainant stated that s/he nor Resident #90 were approached by staff to sign an admission contract. The complainant stated that s/he was not aware of any rules, how to place a grievance nor a complaint, how to obtain or review a copy of the medical record, or any limitations about receiving reimbursement for lost or misplaced items. (continued on next page)

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to exit conference on [DATE], in an interview with the facility administrator at 11:25 AM, the facility administrator stated that s/he was not aware that Resident #90 was admitted with a phone. The facility administrator stated that s/he did speak with the complainant about the IPAD and that administration reimbursed the complainant with a check for the IPAD. The administrator confirmed that a request had been created for the offsite medical record storage facility to send a copy of Resident #90's signed admission contract. In a phone conversation with the facility administrator on [DATE] at 12:45 PM, the administrator stated that the offsite storage company was unable to locate a signed admission contract by Resident #90.

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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. 50573 Based on medical record review and staff interviews, it was determined that the facility, 1) failed to notify the provider that the resident was not receiving a medication due to an allergy, 2) failed to notify a resident's family representative after a resident had a change in condition, and 3) failed to notify the provider when a resident's blood pressure was below prescribed parameters, and blood pressure medication was not administered. This was evident for 1 (#5) of 1 residents reviewed for notification of change, 1 (#91) of 11 residents reviewed for neglect and 1 (#95) of 4 residents reviewed for discharge The findings include: 1) Review of Resident #5's medical record on 6/28/24 revealed that the resident had been residing at the facility since March 2024, needed partial to maximal assistance with Activities of Daily Living (ADLs), was alert and oriented, and able to verbally communicate. On 06/17/24 at 02:32 PM, during an interview with Resident #5, he/she reported having blisters on the back of her/his legs. Record review revealed that, on 5/31/2024 at 10:41, there was a progress note completed that on assessment they found a, penny size blister on Left posterior thigh, and that an order was received to apply skin prep twice a day to the blisters. Record review revealed that on 6/14/24 there was an order for Silver Sulfadiazine Cream 1% to be applied to the area of blisters every day shift and as needed. An interview with Divisional Director of Quality Assurance (Staff #5), on 06/27/24 at 03:05 PM, revealed that that Resident #5 had an allergy to sulfa so the order for Silver Sulfadiazine Cream 1% was discontinued on 6/21/24 and that pharmacy never sent the medication. Staff #5 presented the surveyor with a printed email receipt from the pharmacy, dated 6/17/24 which revealed, .Please note patient has a sulfa allergy. Please clarify has patient used this cream before? An interview, on 06/26/24 at 12:54 PM, with Registered Nurse (Staff #22) who attended the wound rounds, revealed that to her knowledge, the wound physician had ordered the sulfadiazine in relation to the wound. When the surveyor asked if the physician was notified of the medication not being delivered, she reported, I believe but did not report having informed the physician herself. On 06/27/24 at 10:29 AM, an interview with Licensed Practical Nurse (LPN, Staff #12) revealed there was a silvadene order active for a week. When the surveyor asked what the process was if a medication was not delivered, she indicated that the nurses would have to call the doctor and let them know. Further review of the medical record revealed an order to discontinue the Silver Sulfadiazine Cream on 6/21/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review on 06/28/24 at 9:58 AM failed to reveal documentation that the provider was notified of Resident #5's allergy to sulfa, or that the Silver Sulfadiazine Cream was not delivered or administered prior to the discontinuation order on 6/21/24. On 06/28/24 at 11:00 AM, the surveyor reviewed the concern with Nursing Home Administrator (Staff #1) that the medication was ordered on 6/14/24, and the pharmacy alerted the facility on 6/17/24, but there was no documentation found to indicate the physician was notified prior to the discontinuation of the order on 6/21/24. 45139 2) On 7/5/24 at 9:41 AM, intake # MD00174028 was reviewed. On 7/5/24 a review of progress notes, dated 11/5/22, revealed that Resident #91 was observed by nursing staff on the floor lying next to her bed. Further review revealed that the resident's daughter was notified, of the fall, on 11/5/22, On 7/5/24 continued review of progress notes from 11/5/22 through 11/10/22 failed to reveal that there was an attempt to contact the resident's PR regarding the fall. On 7/5/24 at 9:41 AM, intake # MD00174028 was reviewed. Further review revealed a concern that the facility failed to notify Resident #91's husband who was the documented personal representative (PR) for Resident # 91. On 7/05/24 at 2:24 PM, the RN Unit Manager Staff # 13 confirmed that the husband was the official PR. He reported that another family member would be contacted if the PR is unavailable. Staff #13 failed to provide documentation that an attempt was made to contact Resident # 91's PR. 37276 3) On 7/11/24 at 9:00 AM, a review of Resident #95's August 2022 Medication Administration Record (MAR) revealed an 8/3/22 order for Diltiazem (Cardizem) (antihypertensive drug) tablet by mouth to be given every 6 hours for hypertension (HTN) (high blood pressure). The order stated to hold for systolic blood pressure (SBP) (top number of a blood pressure reading) less than 110 or heart rate (HR) (pulse) (P) less than 60. The MAR documented the Resident #95's blood pressure and pulse were outside of the physician ordered parameters and the diltiazem was not given. This was evident on 5 (8/3 at 12 AM, 8/6 at 12 AM, 8/9 at 6 AM, 8/11 at 6 AM and 8/12 at 12 PM. In addition, the MAR indicated the resident's Diltiazem medication was held with no BP or pulse documented in the medical record. This was evident for 21 Diltiazem administration times (8/3 at 12 PM, 8/4/22 at 12 PM, 8/6/22 at 12 PM, 8/7 at 12 PM, 8/9 at 12 AM, 8/9 at 12 PM, 8/10 at 12 AM, 8/11at 12 AM, 8/14 at 12 AM, 8/15 at 12 AM, 8/15 at 12 PM, 8/17 at 12 AM, 8/18 at 12 AM, 8/19 at 12 AM, 8/19 at 12 PM, 8/23 at 12 AM, 8/25 at 12 AM, 8/26 at 12 AM, 8/28 at 12 AM, 8/28 at 12:00 PM, and 8/29 at 12 AM) in August 2022. Continued review of the Resident #95's medical record failed to reveal documentation to indicate the attending physician was notified the resident's blood pressure or pulse was not within parameters and the multiple times Resident #95's blood pressure medication was not given. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administer (NHA) was made aware of the above concerns related to physician notification on 7/11/24 at 11:29 AM and the NHA acknowledged the concerns at that time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 16218 Based on medical record review, pertinent documenatation and staff interviews, it was determined that the facility failed to complete a thorough investigation of an allegation of abuse potential abuse. This was evident for #4 (#137, #104, #107, #108) of 12 residents reviewed for abuse. The findings include Review of Resident #137's medical record on 6/22/24 revealed that the resident had a brief admission to the facility in January 2022. 1) Review of MD00182200, a facility self report of an abuse allegation, revealed that the resident's family had submitted a concern form alleging rough handling by staff while at the facility. Review of the final report by the facility, received by the State Survey Agency on 2/2/22, revealed the alleged events took place on 1/23/22 - 1/24/22 but failed to include a specific shift or name a specific staff member involved. The final report included: Interviews with staff assigned to [him/her] revealed the patient was neither physically or verbally abused . Further review of the facility investigation documentation revealed staffing sheets for evening and night shift of 1/23/22 and day and night shift for 1/24/22 (no sheet was found for 1/24 evening shift). Review of the staffing sheets revealed the resident was cared for by at least 3 different nurses and 3 different geriatric nursing assistants (GNA) on those two days. Further review of the documentation provided by the facility revealed a total of four witness statements: one by a nurse (Staff #12) and three by residents. No documentation was found to indicate that interviews were conducted with any of the other multiple staff that worked with the resident on 1/23 and 1/24/22. Further review of the documentation failed to reveal the concern form that the family had submitted to the facility. It is unclear from the facility report as to when the allegation was initially made to the facility. On 6/21/24 at 2:43 PM, the Nursing Home Administrator (NHA) reported there was no additional documentation regarding this facility report. Surveyor reviewed the concern that, based on the documentation provided, there was a concern form but it was not included, the NHA indicated he would look for the concern form. Surveyor also reviewed that the report indicated that interviews were conducted with staff assigned to the resident but only one staff interview was found despite staffing sheets indicating several different staff were assigned to care for the resident. As of time of survey exit on 7/11/24 at 3:30 PM, no additional documentation was provided regarding these concerns. 50573 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of Resident #104's medical record on 6/28/24 revealed that the resident resided at the facility for a month, needed partial to maximal assistance with Activities of Daily Living (ADLs), was alert and sometimes oriented, and able to verbally communicate. Review of MD00169154, a facility self report of an abuse allegation, revealed that, on 7/5/21 Resident #104 reported that a staff member slapped his/her wrist during morning ADLs and that the facility initiated an investigation. Further review of facility documentation for MD00169154 revealed a final report from 7/6/21 summarizing the incident and concluding that, based on their investigation, they were unable to substantiate the allegation of abuse. This final report indicated the alleged staff was GNA Staff #30. Further record review on 6/28/24 of the facility documentation provided for the investigation revealed that Resident #104 reported to Geriatric Nursing Assistant (GNA, Staff #26) on 7/5/21 at around 7:00 AM that she/he did not like how the night GNA took care of her/him, furthermore, that he was rough. Further review of documentation on 6/28/24 failed to reveal staffing schedules for the shift in which the alleged abuse occurred or how the alleged staff member was identified. On 06/28/24 at 12:48 PM, an interview with the Nursing Home Administrator (NHA, Staff #1) revealed that, when the surveyor asked about abuse allegations and what was the status of alleged employee during the investigation, he indicated that they were suspended. On 6/28/24 at 01:30 PM, an interview with the NHA revealed that there was no further documentation. On 6/28/24 at 02:40 PM, the surveyor reviewed the concern with the NHA that the documentation provided for MD00169154 failed to include staffing assignments and requested to see the schedules from the night shift on 7/4/21 and 7/5/21. Review of interviews with residents revealed that they were asked about GNA (Staff #25) by name, not GNA (Staff #30). Review of the 7/4/21 staffing sheets revealed GNA (Staff #25) was working with the resident on the 7/4/21 night shift. No documentation was found to indicate Staff #30 was working the 7/4/21 night shift. Further review of the staffing sheets revealed GNA (Staff #25) again worked the night shift on 7/5/24. On 07/03/24 at 11:10 AM, the surveyor reviewed the concern with the NHA that GNA (Staff #25) was the one that was working night shift 7/4/21 and then came back to work for night shift 7/5/21. 3) Review of Resident #107's medical record on 7/1/24 revealed that the resident resided at the facility for a month, needed partial to maximal assistance with Activities of Daily Living (ADLs), was alert and somewhat oriented, and able to verbally communicate. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MD00196992, a facility self report of a neglect allegation, revealed that, on 9/14/23, Resident #107's family member reported that, on 8/5/23, it took 45 to 60 minutes for someone to come in and change Resident #107 after the family member had asked and that the facility initiated an investigation. Review of the final report indicated that staff interviews were conducted. On 7/03/24, review of MD00196992's investigative documentation revealed that Licensed Practical Nurse (LPN) and Geriatric Nursing Assistant (GNA) who were assigned to the resident on 8/5/23 were identified and a document titled Coaching/Counseling Form signed by both staff members of alleged neglect (LPN, Staff #12 and GNA, Staff #26) indicating that they agreed to answer call lights in a timely manner. However, no documentation of interviews with either of the staff were found. Final review of MD00196992 revealed that the facility was unable to substantiate the alleged neglect. On 07/03/24 at 03:25 PM, the surveyor reviewed the concern with the NHA (Staff #1) that there was no documentation provided to indicate that an interview was conducted with the staff to determine what had occurred that day. 4) Review of Resident #108's medical record on 06/26/24 at 09:53 AM revealed that the resident resided at the facility for over a year, needed partial to maximal assistance with Activities of Daily Living (ADLs), was alert and oriented, and able to verbally communicate. Review of MD00163688, a facility self report of an abuse allegation, revealed that, on 2/12/21, Resident #108 reported that she/he was punched in the leg by a night shift nurse aid and that the facility initiated an investigation. Further review of MD00163688 revealed that the alleged staff perpetrator was identified, but the documentation provided failed to reveal the name of the staff member or any interviews with the alleged staff member and that there is no documentation of the residents that were interviewed or what they had reported. Final review of the documentation provided by the facility on MD00163688 revealed the facility concluded there was no evidence to substantiate the allegation of the abuse incident. On 06/28/24, an interview with the Nursing Home Administrator (NHA #1) revealed that there was no further documentation pertaining to MD00163688. On 06/28/24 at 02:40 PM, the surveyor reviewed the concern with NHA #1 that the facility documentation provided for the incident failed to show documentation identifying the staff of alleged abuse and there was no documentation of any interviews.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on medical record review, pertinent documentation and staff interviews, it was determined that the facility failed to provide the resident and/or the resident representative, in writing, of a notice of transfer, along with the reason for the transfer. This was evident for 2 (#2, #100) of 4 residents reviewed for hospitalization . The findings include: 1) Resident #22 was admitted to the facility in mid-2022. A quick look in the resident's medical record revealed that s/he was cognitively intact and was his/her own resident representative (RP). On 6/17/24 at 2:53 PM, Resident #22 was interviewed regarding hospitalization s. The resident reported that s/he was hospitalized early this year and did not get any written notification regarding the transfer. A review of Resident #22's medical record on 6/20/24 at 10:40 AM, revealed that s/he was hospitalized on [DATE]. A transfer form was documented by a Registered Nurse (RN Staff #43) that indicated the resident was observed with slurred speech and was unable to hold things with his/her hand, and the attending physician decided to transfer the resident to the hospital. On 6/21/24 at 11:02 AM, the Director of Nursing (DON) was interviewed and reported her expectations from the nursing staff when a resident was ordered to be transferred out. The DON also reported that the nursing department does not do anything regarding the bed hold policy and was not aware of the transfer notifications, she indicated that the Unit Managers (UM) would know more about these requirements. On the same day at 12:10 PM, the UM (Staff #13) for the long-term care unit was interviewed and enumerated the documents that the nursing staff prepares for a resident transfer. Staff #13 reported that they do a verbal notification to the resident and/or RP, and the Nursing Home Administrator (NHA) sends the written notification and bed hold afterwards. The NHA was interviewed on 6/21/24 at 2:19 PM. The NHA reported that he keeps a copy of the envelopes that he sends out a day after a resident was transferred but that the envelopes only contained the bed hold policy. The NHA indicated that he would look for written notice of transfers for the resident and RP. Later at 3:24 PM, The NHA reported and confirmed that the facility was not sending notifications of transfers to residents and/or RP's. The NHA acknowledged that it was a concern that the facility would be addressing. 18819 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of complaint MD00168858 on 07/01/24 at 1 PM revealed an allegation that Resident #100 did not receive quality of care. Resident #100 was sent to the emergency roiagnom on [DATE] around 1 PM due to a change in condition. Further review of Resident #100's closed medical record failed to reveal that Resident #100 nor Resident #100's representative was notified in writing of the reasons for the transfer to the hospital. In an interview with the facility assistant director of nurses (ADON) on 07/02/24 at 11:30 AM, the ADON stated that the staff were unable to determine what documents were sent with Resident #100 or to the family after being sent to the hospital on 06/19/21.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48259 Based on medical record review and interviews, it was determined that the facility failed to notify residents and/or their representatives in writing of the bed hold policy upon transfer to an acute care facility. This was evident for 1 (#107) of 11 residents reviewed for neglect. The findings include: A medical record review completed on 7/3/24 at 12:10 PM showed that Resident #107 was admitted to the facility in July 2023. A continued review found a nurse's note, dated 8/21/23, indicating that Resident #107 had a change in condition. The attending provider was notified and gave an order for Resident #107 to be transferred to the emergency room for evaluation. Further review showed that Resident #107's representative was in the facility at the time of the transfer. However, the review failed to show that a copy of the facility's bed hold policy was given to the Resident's representative. In an interview on 7/3/24 at 2:21 PM, the nursing home administrator said he started mailing out the facility's bed hold policy to residents' representatives in March 2024. This means Resident #107's representative was not notified in writing of the facility's bed hold policy when he was transferred to an acute hospital in August 2023.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37276 Based on medical record review and resident and staff interview, it was determined that the facility failed to provide the resident or resident representative with a summary of their baseline care plan and a summary of their medications on admission. This was evident for 1 (#64) of 5 residents reviewed for unnecessary medications. The findings include: A baseline care plan must be prepared for all residents within 48 hours of a resident's admission. Its purpose is to provide the minimum healthcare information necessary to properly care for a resident until a comprehensive care plan can be completed for the resident. The baseline care plan, along with a copy of their medications, is given to the resident and details a variety of components of the care that the facility intends to provide to that resident. This allows residents and their representatives to be more informed about the care that they receive. 1.1) On 6/20/24 at 12:30 PM, a review of Resident #64's medical record revealed that Resident #64 was admitted to the facility towards the end of April 2024, Review of Resident #64's admission assessment with an assessment reference date (ARD) of 4/28/24 revealed documentation that Resident #64 was able to make him/herself understood and was able to understand others, and the resident was moderately cognitively impaired. Review of an Admission/Readmission Evaluation form, with an effective date of 4/24/24 at 9:59 PM, revealed nurse documentation that Resident #64 had been evaluated and a base line care plan had been developed. On 4/24/24 at 4:42 PM, in a care plan progress note, the nurse documented that when asked, Resident #64 indicated it was okay for the nurse to review the baseline care plans the resident, and the nurse reviewed the baseline care plans, and medications with the resident. There was no documentation to indicate that a copy of their baseline care plan, along with a summary of their medications was offered and/or provided to Resident #64 at that time. Continued review of Resident #64's medical record failed to reveal documentation to indicate that the facility offered or provided the resident and/or the resident representative with a copy of their baseline care plan along with a summary of their medications. 1.2) Further review of the medical record revealed Resident #64 was transferred to the hospital in the beginning of May 2024 and readmitted to the facility in mid to late May 2024. Review of an Admission/Readmission Evaluation form, with an effective date of 5/21/24 at 6:18 PM, revealed nurse documentation that a readmission evaluation of Resident #64 was completed and a baseline care plan for the resident had been developed. There was no documentation in the form to indicate that Resident #64 had been provided a copy of their baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/24 at 4:31 PM, in a care plan progress note, the nurse documented that on that date, baseline care plans were reviewed with Resident #64. No documentation was found in the progress note to indicate that Resident #64 had been provided a copy of the baseline care plan. Continued review of Resident #64's medical record failed to reveal documentation to indicate that the facility offered or provided the resident and/or the resident representative with a copy of their baseline care plan along with a summary of their medications. The Director of Nurses was made aware of the concerns on 6/21/24 at 11:02 AM and offered no further comments at that time.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48470 Based on medical record review and staff interview, it was determined that the facility staff failed to develop and implement comprehensive, resident centered care plans. This was evident for 1 (#22) of 1 residents reviewed for rehab and restorative and 1 (#64) of 5 residents reviewed for unnecessary medication. 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. 1) During an interview with Resident #22 on 6/17/24 at 3:01 PM, s/he reported that s/he was not doing any kind of therapy and was told that it was not doing him/her any good. Functional mobility is a person's ability to move around independently and safely in their environment to participate in daily activities. This includes movements like standing, bending, walking, climbing, sitting down, and scooting around in bed. Functional mobility can take place at home, work, and in the community, and can contribute to a person's quality of life. On 6/20/24 at 12:22 PM, Resident #22's care plan was reviewed and revealed a functional mobility care plan that indicated a goal to improve as evidenced by blank. Blank was an area where the facility staff was supposed to indicate the evidence of the resident's improvement in functional mobility. Further review of this care plan history indicated that it was initiated as part of the baseline care plan and has had a revision 7 times. All 7 revisions failed to indicate evidence for improvement in the functional mobility goal. On 6/25/24 at 11:07 AM, the Physical Therapist (PT) was interviewed about his involvement in care planning. The PT reported that either he or the Director of Rehab (DOR) participate in care plan meetings but do not update the resident's care plan. The PT also indicated that he thinks it was the social workers who updated the care plan. Later that day at 2:03 PM, the DOR confirmed in an interview the PT's statement that they do not update the care plan and that it was the social services department who updated them. On 6/26/24 at 8:56 AM, the Social Services Director was interviewed, and she denied responsibility of updating the resident's care plan regarding functional mobility stating, I don't update the care plan for that, I wouldn't have any idea about their mobility. The Director of Nursing (DON) was then interviewed on 6/26/24 at 9:59 AM. Resident #22's functional mobility care plan was reviewed with the DON, and she stated, it looks like it came from a template. The DON confirmed that the care plan was not resident-specific. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the same day at 10:17 AM, the DON, together with Nursing Home Administrator, (NHA) discussed the care plan concern with the surveyor. Resident #22's care plan was again reviewed with both staff and confirmed that it did not reflect the resident specific information to convey appropriate treatment and services to maintain, restore or improve abilities with functional mobility. Also, the care plan has had several revisions but the only thing that changed were the revision dates. Both the DOR and the NHA acknowledged the concern. 37276 2) On 6/20/24 at 12:30 PM, a review of Resident #64's medical record revealed that Resident #64 was initially admitted to the facility in April 2024, then, following an acute hospitalization , Resident #64 was readmitted to the facility in mid to late May 2024 with diagnoses which included depression. Review of Resident #64's June 2024 MAR revealed an active 5/22/24 order for Mirtazapine (Remeron) (antidepressant) tablet by mouth at bedtime for an anti-depression that was documented as given every day as ordered from 6/1/24 - 6/19/24. Review of Resident #64's care plans revealed, a care plan, [Resident #64] may have the potential of feeling down/depressed or potential for depression, with the goal, Resident will be given opportunity to ventilate feelings within next 90 days, that had the interventions, 1) Encourage family involvement and visits when able, and 2) Psychology services as needed. The care plan was not comprehensive, with a resident centered, measurable goal and interventions to address the resident's depression and Resident #64's use of the psychotropic medication Mirtazapine, including monitoring the resident's response or lack of response to the medication for the targeted behaviors for which the psychotropic medication had been prescribed, and monitoring for adverse consequences and side effects of the medication. The above care plan concerns were discussed with the Director of Nurses (DON) on 6/21/24 at 11:02 AM. The DON acknowledged the concern and offered no comments at that time

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on medical record review and interviews, it was determined that the facility staff 1) failed to ensure that interdisciplinary team care plan meetings were held to review and revise the care plans following each MDS assessment, and 2) failed to have a system in place to ensure that therapy recommendations are incorporated into resident care plans. This was evident for 4 (#286, #24, #64, #43) of 9 residents reviewed for care planning, 1 (#10) of 4 residents reviewed for unnecessary medications, and 2 (#67, #5) of 4 residents reviewed for activities of daily living. The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility with the information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Participation in care planning by a resident and Resident representative can take many forms, such as holding care planning conferences (meetings) when the resident representative is available to participate, conference calls, or videoconferencing. 1) A medical record review on 6/17/24 at 10:42 AM, showed that Resident #286 was admitted to the facility in May 2024. Further review found that Resident #286 was alert and oriented, able to make his/her own decisions, and cognitively intact per an MDS assessment dated [DATE]. Continued review of the MDS assessment showed that it was completed on 6/12/24 however, the review failed to show that a care plan meeting occurred following the Resident's admission to the facility and completion of the Resident's admission MDS assessment. In an interview on 6/17/24 at 11:24 AM, Resident #286 responded, Not yet, no meeting of that sort, when asked if she/he participated in her/his care plan meeting after admission to the facility. An interview on 6/18/24 at 3:11 PM with staff #17, the director of social services, showed that care plan meetings for newly admitted residents were scheduled within 14 days of their stay in the facility. However, the interview failed to show that Resident #286's care plan meeting had been done since his/her admission to the facility in May 2024. In a subsequent interview on 6/27/24 at 10:16 AM, staff #17 stated that she usually schedules care plan meetings for new residents 7-14 days after their admission to the facility. Staff #17 confirmed that a care plan meeting had not yet been held for Resident #286 since his/her admission to the facility in May 2024. 2) A record review on 6/17/24 at 12:20 PM showed that Resident #24 was admitted to the facility in July 2022. The review revealed that Resident #24 was responsible for making his/her own decisions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continued record review found two MDS assessments, dated 3/20/24 and 5/3/24, which were completed on 3/21/24 and 5/8/24. However, further review failed to show that care plan meetings had been conducted following the completion of the MDS assessments. In an interview on 6/17/24 at 12:25 PM, Resident #24 stated, I've never been invited to any care conference meeting, and I am my own responsible party. During a subsequent interview on 6/26/24 at 10:42 AM, staff #17 reported that care plan meetings were usually conducted seven days after completing a resident's MDS assessment. However, the interview failed to show that care plan meetings had been conducted for Resident #24 after the completion of his/her two most recent MDS assessments. In an interview on 6/26/24 at 11:20 AM, staff #17 was asked to provide documentation for all the care plan meetings held in 2024 for Resident #24. She handed to surveyor care conference documentation with an effective date of 11/16/2022. Staff #17 stated, That's all the documentation I found for care plan meetings. Staff #17 continued to say that she could not deny or confirm any care plan meetings were conducted for Resident #24 after 11/16/2022. In a subsequent interview on 6/26/24 at 1:34 PM, staff #16, a social worker, stated that she could not prove that care plan meetings were conducted for Resident #24 since the last one on 11/16/22. 3) A record review on 6/26/24 at 8:12 AM showed that Resident #10 was admitted to the facility in October 2022. A subsequent review on 6/28/24 at 10:47 AM found a medication care plan, which was initiated on 7/19/2016 and revised on 4/16/2024, that stated that Resident #10 was At risk for adverse effects related to the use of anti-depression medication and use of hypnotic medication. Continued review found an MDS assessment, completed on 6/10/24, which documented that Resident #10 was receiving antidepressant medication. Further review showed an attending provider's order for an antidepressant medication for Resident #10, however, the review failed to show the Resident's use of a hypnotic medication. In an interview on 6/28/24 at 10:58 AM, staff #13, a unit manager, reported that when an annual, quarterly, or significant change in condition MDS assessment is completed, a resident's care plan is also updated to reflect any changes. In a subsequent interview on 6/28/24 at 11:31 AM, the assistant director of nursing (ADON) confirmed that Resident #10 did not receive hypnotic medications. The ADON stated that having a hypnotic medication on Resident #10's current care plan was an error. 50573 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Review of Resident #67's medical record revealed the resident has resided at the facility since January 2024 to present, uses a wheelchair independently, needs partial to maximal assistance with (Activities of Daily Living) ADLs, is alert and oriented, is able to verbally communicate and has an age-related cognitive decline diagnosis. Review of the 1/28/24 Minimum Data Set (MDS) assessment revealed Resident #67 had a BIMS (Brief Interview for Mental Status) score of 13; and the 4/28/24 MDS revealed a BIMS score of 12. BIMS is a tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. The total BIMS score ranges between zero to fifteen points. A score of 8-12 indicates mild cognitive impairment. On 06/18/24 at 10:03 AM, an interview with Resident #67 revealed she/he had asked about having a walker but indicated this was to be determined by therapy. On 06/24/24 at 03:13 PM, review of the therapy discharge summaries for Resident #67 revealed that she/he had been discharged from occupational therapy on 4/10/24 and from physical therapy on 5/1/24, both which included recommendations for a home exercise program. Further review of the medical record failed to reveal any specific information regarding what the home exercise program consisted of. Review of medical record revealed a care plan for Resident #67 addressing a need for assistance with ADL function and a goal that ADL function would improve. The review of interventions for this goal failed to reveal an intervention that would assist in improvement of ADL function, and instead were statements about the amount of assistance the resident required for certain ADLs. Further review of the medical record revealed the care plan addressing cardiac disease included an intervention, initiated on 1/24/24, for therapy evaluation and treatment as ordered for physical and/or occupational therapy. Further review of the care plans failed to reveal documentation to indicate the care plans were updated to reflect the PT and OT recommended home exercise programs. On 06/25/24 at 09:49 AM, an interview with Director of Rehabilitation (Staff #34) revealed that, if a resident is cognitively intact, they are given a print out of the exercises they are supposed to do for the home exercise program. If a resident is not cognitively intact then therapy would provide education by an inservice to the nursing staff on the shift when discharged from therapy. Staff #34 further explained that once the nursing staff receives the education that they should be passing it on from shift to shift and if it was a verbal explanation, that the provider should document what they did. Further interview with Director of Rehabilitation (Staff #34) revealed that a home exercise program is something provided verbally to the resident once they are discharged from therapy and they do not document it. The surveyor expressed the concern to Staff #34 that the discharge papers do not include what the home exercise program consists of when a resident is discharged from therapy when a resident has some cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/25/24 at 11:45 AM, Resident #67 reported that his/her Physical Therapist told her/him the exercises to continue doing after discharge but that they did not give a paper listing them. Resident #67 reported he/she thinks she/he remembered them and was able to list 3 exercises and reported that she/he does them every other day. On 06/27/24 at 02:01 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #2) about the recommendations from therapy not being incorporated into residents' care plan. 5) Review of Resident #5's medical record on 6/24/24 revealed that the resident had been residing at the facility since March 2024, needs partial to maximal assistance with Activities of Daily Living (ADLs), is alert and oriented, and able to verbally communicate. The resident has a BIMS of 15. On 06/17/24 at 02:28 PM, an interview with the resident revealed that he/she was able to walk when he/she came into the facility and was currently not walking because the staff was scared he/she would break a bone in his/her knee. On 06/24/24 at 03:13 PM, review of the therapy discharge summaries for Resident #5 revealed that she/he had been discharged from occupational therapy on 4/30/24 and from physical therapy on 3/27/24, both of which included recommendations for a home exercise program. Review of the medical record, revealed a care plan addressing the resident's fall risk which included a goal of having no injuries from falls. This care plan included therapy evaluation as needed of PT and OT as an intervention which was initiated on 12/3/23. Further review of Resident #5's care plan failed to reveal any update to the care plan based on the home exercise program which was recommended in the discharge summary from therapy. Interview with Physical Therapist (PT, Staff #36) on 06/25/24 at 11:05 AM revealed that either the Physical Therapist or Director of Rehab (Staff #34) would attend resident care plan meetings. When the surveyor asked about the home exercise program, he indicated that the exercises that the residents had been doing while in therapy should continue and that residents are given a paper upon discharge of the exercises they are to continue on their own at home. When the surveyor asked Staff #36 if he could provide details of the exercises recommended for Resident #5, he was not able to. Further interview with Physical Therapist (PT, Staff #36) on 06/25/24 at 11:05 AM revealed that they communicate the exercises of the home exercise program to the staff if the resident being discharged has cognitive impairment. He further explained that, if they are holding a session in a resident room, they would call in the Geriatric Nursing Assistant and the Nurse assigned to the resident that shift, and show them the exercises. Further interview revealed that they were not documenting what education they were providing to the staff nor which staff received the home exercise program education for the resident. On 06/25/24 at 11:20 AM, an interview with Physical Therapist, (Staff #36), revealed that Resident #5 was given a copy of the home exercise program. Staff #36 explained that he believed the resident still had it in his/her room and that he had given Resident #5 several copies of the home exercise program. Staff #36 indicated that he was not sure how to answer when the surveyor asked if the discharge recommendations from therapy should be a part of a resident's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/25/24 at 11:54 AM, Resident #5 denied knowledge of any exercise that he/she should be doing and denied having received papers for a home exercise program On 06/25/24 at 12:52 PM, during an interview with Director of Rehabilitation (Staff #36), the surveyor made her aware that Resident #5 was not aware of any home exercise program even though PT (Staff #36) indicated he had given the resident several copies. Surveyor reviewed the concern that the care plan was not updated to reflect the home exercise program. On 06/27/24 at 02:01 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #2) about the recommendations from therapy not being incorporated into the resident's care plan. 37276 6) On 6/20/24 at 12:30 PM, a review of Resident #64's medical record revealed that Resident #64 was initially admitted to the facility in mid to late April 2024, then, admitted to the hospital for a change in condition, and readmitted to the facility later in May 2024 following the acute hospitalization . Review of Resident #64's assessments revealed a revealed a 5 Day scheduled MDS assessment with an assessment reference date (ARD) of 5/27/24 that was signed as completed on 6/3/24. In a social services note, on 6/14/24 at 11:04 AM, the SSD (social services director) documented s/he had contacted Resident #64's son to meet with the resident to discuss care conference meeting and the SSD scheduled the meeting. There was no documentation found in the social service note or in the medical record to indicate that a care conference was scheduled. Continued review of Resident #64's medical record failed to reveal documentation to indicate that a care plan conference had been conducted with the resident and/or representative following the resident's re-admission to the facility or following the resident's admission assessment ARD 5/27/24. On 6/21/24 at 10:10 AM, during an interview, Staff #17 was made aware that no documentation was found in the medical record to indicate that a care plan meeting had been held with Resident #64 since his/her admission to the facility and following the resident's admission MDS. At that time, the SSD responded that a care plan meeting was supposed to be yesterday but needed to be rescheduled with no further explanation or comments offered. The Director of Nurses was made aware of the above concerns on 6/21/24 at 11:02 AM, and offered no comments at that time. 48470 7) A review of Resident #43 medical records revealed that s/he had been a resident of the facility since mid-2021. On 6/27/24 at 10:03 AM, a review of the complaints related to MD00175781 stated, the facility has never gone over a care plan with us. The event date of the allegations was April of 2022. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/24 at 3:17 PM, Resident #43's medical records were reviewed and revealed the mosr recent comprehensive assessment before the allegation was made had an assessment reference date of 2/18/22. The Nursing Home Administrator (NHA) was asked to provide documentation for the care plan meeting that was held after the completion of the comprehensive assessment. On 7/9/24 at 9:00 AM, the NHA provided the care plan meeting documentation. The document was reviewed with the NHA and revealed that the care plan meeting was held on 4/19/22. The NHA confirmed that the care plan meeting was held outside of the required time frame and reported his understanding of the regulation that care plan meetings must be done within 7 days after completion of the comprehensive assessments.

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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. 48259 Based on record review and interviews, it was determined that the facility failed to ensure that a resident who required assistance with Activities of Daily Living (ADL) was provided with showers. This was evident for 1 (#102) of 4 residents reviewed for ADL. The findings include: The MDS (Minimum Data Set) is a complete assessment of the Resident, which provides the facility with the information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. Medical record review on 7/1/24 at 2:09 PM showed that Resident #102 was admitted to the facility in June 2021 with diagnoses that included a right hip fracture post-surgery. A continued review found an MDS assessment, dated 6/24/21, which documented that Resident #102 had intact cognitive status and required extensive assistance from staff with transfers and bathing. A review of complaint record #MD00169826, on 7/1/24 at 2:09 PM for Resident #102, noted that the Resident had only one shower on 7/6/21 for his/her entire stay in the facility from 6/17/21 to 7/9/21. A subsequent review of the Geriatric Nursing Assistant ADL documentation for Resident #102 from June 17 to July 9, 2021, was done on 7/2/24 at 1:27 PM. The review found a record of bed baths on 6/24, 6/28, 7/1, 7/5, 7/8, and one shower on 7/6/21. Staff had documented N/A (not applicable) on 6/21; the remaining days were left blank. During an interview on 7/2/24 at approximately 1:35 PM with staff #8, the assistant director of nursing (ADON) confirmed that Resident #102 received bed baths from staff on 6/24/21, 6/28/21, 7/1/21, 7/5/21, 7/8/21 and one shower on 7/7/21. In a subsequent interview on 7/2/24 at 4:12 PM, the ADON revealed that Resident #102 was scheduled to have showers twice weekly on Mondays and Thursdays, and that he/she should have received six showers during his/her stay and bed baths on the non-shower days. However, the documentation revealed that the Resident only received one shower and five bed-baths for his/her entire stay in the facility.

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Montcare at Wheaton	11901 Georgia Avenue Wheaton, MD 20902

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37276 Based on record review and interviews, it was determined that the facility 1) failed to provide appropriate treatment and services to a resident receiving gastrostomy tube (g-tube) feedings and 2) failed to develop and implement a care plan that addressed the care and maintenance of a resident with a feeding tube. This was evident for 1 (#73) of 1 residents reviewed for tube feeding, and 1 (#107) of 11 residents reviewed for neglect. The findings include: Enteral feeding (tube feeding) is the delivery of nutrients through a feeding tube directly into the stomach or the small intestine. A gastrostomy tube (g-tube) is a feeding tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications. The most common type is a percutaneous endoscopic gastrostomy (PEG) tube. Bolus feeding is the administration of a limited volume of enteral formula over brief periods of time. There are risks associated with residents using feeding tubes for nutrition which include aspiration (accidentally inhaling your stomach contents), accidental dislodgement (tube moving out of place or coming out), bleeding and perforation (hole in the wall of your bowel or intestine), infection near the site, pain, and stomach leakage to name some. Appropriate treatment and services are required to prevent complications of enteral feeding. 1) On 6/26/24 at 10:00 AM, a review of Resident #73's medical record revealed documentation that the resident was admitted to the facility in early May 2024 with diagnoses which included dysphagia (difficulty swallowing) following cerebral infarction (stroke) and the resident received enteral feedings through a g-tube for nutritional support. Review of Resident #73's physician orders revealed a 5/8/24 order for strict aspiration precautions every shift, a 5/8/24 order, Is the head of bed elevated to prevent SOB (shortness of breath) while lying flat?, a 5/20/24 enteral feed order 4 times a day, bolus feed on Glucerna 1.5, 1 can (237 ml) via PEG/g-tube, 4 times in 24 hours for a total of 948 ml formula, and a 6/1/24 enteral feed order to flush tube with 125 ml (milliliters) water before and after each bolus feeding to provide additional 100 ml (total of 1729ml including tube feeding). Continuous review of Resident #73's medical record failed to physician orders related to the care and maintenance of the resident's g-tube. No documentation was found to indicate that the g-tube insertion site was examined and cleaned daily, or that the feeding tube placement was routinely monitored. No documentation was found to indicate that before beginning a feeding or administering medication, staff routinely assessed the resident for g-tube functioning or gastrointestinal intolerance such as for checking for residual and no order was found to indicate when to hold the feeding based on amount of residual. No physician order was found to indicate the volume of fluid to flush the feeding tube before and after each medication administration, and no documentation found to indicate the feeding tube was being flushed, along with the the fluid volume, before and after each medication administration. In addition, though there was an order for strict aspiration precautions, and an order indicating the head of the bed was to be elevated to prevent SOB, there was no documentation to indicate positioning of the resident before and after administration of the tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Review of Resident #73's care plans revealed a care plan initiated by the dietician, [Resident #73] is at high nutr (nutritional) risk related to overweight w/ comorbidity (having 2 or more diseases at the same time), TF (tube feeding) at risk for aspiration, skin breakdown risk r/t impaired mobility & therapeutic diet needs. Will follow SLP's (speech therapy) recommendations & monitor nutr status for changes in interventions, with the goals, no s/s (signs/symptoms) TF intolerances, and able to maintain wt (weight) with no sig (significant) wt changes that had the interventions, 1) aspiration precautions, 2) follow recommendations from SLP, 3) monitor labs and wt, 4) monitor s/s TF intolerances, 5) provide diet as ordered, and 6) Provide TF and flushes as ordered The care plan addressed Resident #73's enteral nutritional needs; however, the care plan interventions did not address the care and maintenance of a resident with a feeding tube. Continuous review of the resident's care plans failed to reveal evidence that a comprehensive care plan had been developed and implemented that addressed the care and maintenance of a resident with a feeding tube with resident centered interventions such as g-tube site care and resident positioning, interventions to prevent complications from the tube feeding and resident centered interventions to minimize the negative psychosocial impact that may occur as a result of the tube feeding, A review of the facility's policy Care and Treatment of Feeding Tubes, with a reviewed/revised date of 1/1/24 revealed the policy: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible, Following the policy statement was the statement, Policy Explanation and Compliance Guidelines, which listed 13 steps or guidelines which included but were not limited to: #3. The resident's plan of care will address the use of feeding tube, including strategies to prevent complications. #6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding is in the right location, a) tube placement will be verified before beginning a feeding and before administering medications, b) the enteral retention device will be check daily to assure it is properly approximated to the abdominal wall and that the surround skin is intact. #7. Direction for staff on how to provide the following care will be provided: a. how to secure a feeding tube externally, b. the importance of, and frequency of providing personal, skin, oral and nasal care to the resident, c. examination and cleaning of the insertion site in order to identify, lessen or resolve possible skin irritation and local infection, e. frequency of and volume used for flushing, including flushing for medication administration and what to do when a prescriber's order does not specify #8. Direction for staff regarding the conditions and circumstances under which a tube is to be changed will be provided . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#11. Psychosocial factors will be considered and addressed in the resident's plan of care to minimize the negative psychosocial impact that may occur as a result of the tube feeding. On 6/24/24 at 12:30 PM, the Director of Nurses (DON) was made aware of the above concerns related to the monitoring, care and maintenance of Resident #73's feeding tube. The DON was made that that there was a care plan that addressed the resident's nutritional needs, however, a care plan with interventions that addressed the care and maintenance Resident #73's feeding tube had not been found in the medical record. The DON acknowledged the concerns at that time, and then on 6/27/24 at 12:50 PM, the DON provided the surveyor with a copy of the nutrition care plan for Resident #73 and stated that the care plan interventions were also nursing interventions. 48259 2) A gastrostomy (g-tube) feeding tube is placed into the stomach through an opening in the stomach wall. If one cannot eat or drink all the nutrients they need, liquids such as formula, fluids, and medicines are put through the g-tube tube. A review of complaint Intake #MD00196871 on 7/3/24 at 12:10 PM indicated that Resident #107's g-tube site was leaking all over the place. Continued record review showed that Resident #107 was admitted to the facility in July 2023 with diagnoses including Dementia and a history of stroke with one-sided weakness. The review also found an attending provider's order for Resident #107 for g-tube feedings with Jevity 1.5 formula; however, the review failed to show a plan of care to address the care of the gastrostomy tube site, including measures to prevent complications. In an interview on 7/3/24 at 12:15 PM, the assistant director of nursing (ADON) stated that, for every resident with a g-tube feeding tube, the nurses were expected to obtain orders from the attending provider for the management and care of the g-tube site. The ADON added that the nurses would usually document the g-tube site care in the medication administration record or treatment administration record and the progress notes. However, earlier record reviews failed to show that Resident #107's g-tube insertion site was being examined and cleaned daily to prevent, identify, and treat possible skin irritation. During an interview on 7/3/24 at 1:09 PM, staff #5, a Divisional Director of Quality assurance, stated that there was no documentation to show that the nurses provided treatment and care to Resident #107's g-tube site.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48259 Based on record review and staff interviews, it was determined that the facility staff failed to effectively manage a resident's pain. This was evident for 1 (#102) of 2 residents reviewed for pain management. The findings include: A review of Resident #102's medical record on 7/1/24 at 2:09 PM showed that the Resident was admitted to the facility in June 2021 with diagnoses including a right hip fracture post-surgery and was able to communicate needs verbally. A continued review found a discharge medication list from the hospital for Resident #102, which included an opioid medication to be taken every six hours as needed for severe pain. A review of complaint record #MD00169826 on 7/1/24 at approximately 2:15 PM showed that Resident #102 arrived at the facility after midnight on the day of admission, had critical pain but had to wait for more than 4 hours to have his/her pain managed by the staff. Further record review, on 7/1/24 at 2:29 PM, found an attending provider's progress note, dated 6/17/21, that stated that Resident #102 complained of severe pain to the right lower extremity and was given Tylenol, which did not provide pain relief. The progress notes continued to state that Resident #102's doctors sent in RX-[RX-prescription] to the facility upon discharge, but [he/she] has not received any Oxycodone since admission and has complained to the staff. Per nursing staff, overnight team did not find Rx for Oxycodone from the hospital team. Upon reviewing the discharge records myself, Rx found Oxycodone. Nursing informed and issues escalated to the IDT (IDT-interdisciplinary team). A subsequent record review on 7/2/24 at 10:31 AM found a care plan for pain initiated on 6/17/2021 for Resident #102. The interventions on the care plan included but were not limited to Encourage/Assist to reposition frequently to position for comfort. Continued review showed an attending provider's order initiated on 6/17/21 for opioid medication, one tablet every 4 hours as needed for moderate pain and two tablets every 4 hours as needed for severe pain. Further review of Resident #102's medication administration record for June 2021 showed that he/she had received one tablet of opioid medication on 6/7/21 at 09.30 AM for a pain level of 5 and post-medication assessment that stated effective. The Resident also received another tablet of the opioid medication on the same day at 01:34 PM for a pain level of 5, and the post-medication assessment stated: effective. A pain scale/level ranges from 0 to 10; 0 means no pain, and 10 means the worst pain. It is used to assess a patient's level of pain so that better treatment can be provided. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review failed to show that Resident #102 received pain management for complaints of severe pain and whether a follow-up pain level was assessed to help manage the pain effectively or that a non-pharmacological intervention was implemented (non-pharmacological pain management is an intervention without medications). In an interview on 7/2/24 at 11:40 AM, staff #13, a unit manager, reported that the process for obtaining an opioid medication to manage a new resident's pain was to fax the prescription to the facility's pharmacy and then get the pain medication from the facility's back up medication box. However, an earlier record review failed to show that Resident #102 received pain management for his/her severe pain until 9.30 AM on 6/7/21. An interview with staff #8, the assistant director of nursing, on 7/2/24 at 1:36 PM showed that the nurses were supposed to assess and document the Resident's pain level before and after administering pain medication to ensure effective pain management.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 37276 Based on medical record review and staff interview, it was determined the physician 1) failed to write, sign, and date progress notes at each visit, and 2) failed to review the resident's total program of care, including medications and treatments, at each visit. This was evident for 2 (#64, #73) of 5 residents reviewed for unnecessary medications, and 1 (#86) of 11 residents reviewed for neglect. The findings include: 1) On 6/21/24 at 9:00 AM, a review of Resident #64's electronic health record (EHR) revealed physician progress notes that were not written and, in the resident's medical record on the day the resident was seen: - There was a physician/practitioner progress note with an effective date of 5/14/24 at 9:51 AM that had a created date of 6/18/24 at 1:19 PM and - There was a physician/practitioner progress note with an effective visit date of 5/27/24 at 5:52 PM that had a created date of 6/18/24 at 1:47 PM. On 6/21/24 at 3:05 PM, the Nursing Home Administrator (NHA) was made aware of the physician visit notes that were not written, signed and dated on the day of the physician's visit. The NHA acknowledged the concerns offered no further comment at that time. 2) On 6/26/24 9:00 AM, a review of Resident #73's medical record revealed on 6/10/24 at 9:58 PM, in a lab/radiology note, the nurse documented that the physician was called to address the resident's lab results and the physician gave an order for Metformin two times a day; check fingerstick and if it is less than 150, hold Metformin. A review of Resident #73's June 2024 MAR revealed a 6/11/24 order for Metformin HCL (Glucophage) (antidiabetic medication) tablet by mouth two times a day for Diabetes, finger stick before giving Metformin and hold if it is less than 150. The MAR documented the Metformin was given to Resident #73 twice a day, every day, from 6/11/24 to 6/26/24. There was no documentation in the MAR to indicate the Resident #73's blood glucose (sugar) level was monitored via finger stick prior to administering the Metformin to Resident #73. Review of Resident #73's progress notes revealed a physician/practitioner progress note with an effective date of 6/10/24 at 8:54 PM and a created date of 6/11/24 at 8:56 PM that documented Resident #73 had a past medical history of diabetes with an assessment/plan that documented Resident #73 was on insulin for diabetes and the resident's metformin, glipizide (anti-diabetic) and detemir (long-acting insulin) medications were discontinued due to hypoglycemic (low blood sugar) episodes during hospitalization . (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of Resident #73's physician/practitioner progress note revealed that the attending physician had written progress notes related to resident visits made to Resident #73 on 6/14, 6/17, 6/21, and 6/24/24, and on each of those dates the attending physician documented that Resident #73's metformin, glipizide and detemir medications were discontinued due to hypoglycemic episodes during hospitalization . There was no documentation found to indicate the attending physician assessed the resident's diabetes status, or that the physician was aware the resident received Metformin twice a day for diabetes. There was no documentation found to indicate the attending physician was aware of Resident #73's 6/11/24 order for Metformin and that the resident received Metformin twice a day for diabetes. On 6/27/24 12:30 PM, the concerns with the physician failing to review the resident's total plan of care at each visit were discussed with the DON, who acknowledged the concerns and offered no further comment. 3) On 7/10/24 at 1:36 PM, a review of Resident #86's medical record revealed physician progress notes that were not written and, in the resident's, medical record on the day the resident was seen: - There was a physician/practitioner progress note with an effective date of 1/10/24 at 9:35 AM, that had a created date of 3/1/24 at 1:30 PM. - There was a physician/practitioner progress note with an effective date 11/13/23 at 6:11 PM that had a created date of 11/28/23 at 12:57 AM. - There was a physician/practitioner progress note with an effective date 10/12/23 at 5:40 PM that had a created date of 11/28/23 at 12:34 AM. - There was a physician/practitioner progress note with an effective date 9/21/23 at 5:30 PM that had a created date of 10/6/23 at 12:40 AM. - There was a physician/practitioner progress note with an effective date 8/14/23 at 6:22 AM that had a created date of 10/6/23 at 12:27 AM. - There was a physician/practitioner progress note with an effective date 7/14/23 at 9:55 AM that had a created date of 8/19/23 at 11:40 PM. On 7/10/24 at 2:55 PM, the DON was made aware of the concerns with Resident #86's physician visit notes which were not written, signed, and dated on the day of the physician visit. The DON acknowledged the concerns at that time and offered no further comments.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on records review and interviews, it was determined that the pharmacist failed to identify irregularities with resident medication orders, and failed to develop, maintain, and implement policies and procedures that address the time frames for each step in the medication regimen review process. This was evident for 2 (#44, #73) of 5 residents investigated for unnecessary medication review. The findings include: 1) A review of Resident #44 medical record revealed that the resident had been residing in the facility since May 2022. On 6/24/24 at 11:10 AM, further review of Resident #44's medical records revealed monthly Medication Regimen Reviews (MRR) were done by the pharmacist (Staff #45). Staff #45 documented in her progress notes that indicated an irregularity was identified and stated MRR complete see report for the month of April. Succeeding progress notes of Staff #45 for the month of May and June stated MRR complete no irregularities noted. Continued review of the resident's medical records failed to reveal the reports generated by the April MRR. On the same day, the report for the MRR was requested from the Nursing Home Administrator (NHA) and was provided at 12:39 PM. The report indicated that Resident #44 was receiving multiple pain medications without a pain scale to specify when each should be administered. The physician responded by adding a pain scale of 1 to 5 to the Tylenol 650 mg every 6 hours as needed for pain, and pain scale of 5 to 10 to the Oxycodone 5 mg every 6 hours as needed for pain. Resident #44's pain medication orders were reviewed later that day at 1:00 PM and revealed current orders of a) Tylenol 325 mg give 2 tablets every 6 hours as needed for pain with a start date of 4/25/24 and b) Tramadol 50 mg give 1 tablet every 6 hours as needed for pain with a start date of 4/25/24. Neither pain medication orders did not have a pain scale to specify when each medication should be administered. Further review of the pain medication order history indicated that the initial order of Tylenol and Oxycodone was changed to indicate the pain scales as instructed by the physician on 4/9/24 but was later discontinued because the resident was sent out to the hospital on 4/19/24. Resident #44 was readmitted on [DATE] with the current pain medication orders. On 6/24/24 at 1:40 PM, the Registered Nurse (RN Staff #46) who was assigned to Resident #44 was interviewed. Staff #46 was asked about what medication she would give the resident if s/he had complaints of pain. Staff #46 reported that she would give the Tylenol if the resident had a pain level of 1 to 3 and would call the physician for any pain complaints higher than 3. Staff #46 was asked if she knew what the pain medication orders were. Staff #46 reviewed Resident #44's orders in the computer and reported that s/he had Tylenol and Tramadol pain medications, but the orders had no pain scales to specify when each medication should be administered and stated, I would call the doctor to clarify which pain medication to administer first. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 11:56 AM, the pharmacist (Staff #45) was interviewed and explained her process with MRR. Staff #45 was asked about Resident #44's current pain medication orders and specifically about which pain medication should the nurse administer first? Staff #45 indicated that the staff nurses are aware of the resident's pain medication. The earlier interview with RN Staff #46 was reviewed with staff #45 and the concern was discussed that if Resident #44 was to complaint of pain, the current orders for as needed pain medications did not have a pain scale to specify which medication to administer first. Furthermore, the 2 MRR that was conducted after the resident was readmitted failed to identify these irregularities. Staff #45 acknowledged the concerns and indicated that they were missed. On 6/26/24 at approximately 12:30 PM, the facility's policy and procedure for MRR was reviewed and failed to specify a timeframe for the physician to respond to an identified irregularity. Later that day at 1:01 PM, the concerns were discussed with the Director of Nursing (DON) that the pharmacist failed to identify an irregularity with a resident's pain medications, and the facility's policy and procedures for MRR did not specify a timeframe for the physician to respond to an identified irregularity. The DON acknowledged the concerns. 37276 2) On 6/26/24 at 9:00 AM, a review of Resident #73's medical record was conducted. Review of Resident #73's progress notes revealed on 6/10/24 at 9:58 PM, in a lab/radiology note, the nurse documented that the physician was called to address the resident's lab results and the physician gave an order for Metformin two times a day; check fingerstick and if it is less than 150, hold Metformin. A review of Resident #73's June 2024 MAR revealed a 6/11/24 order for Metformin HCL (Glucophage) (antidiabetic medication) tablet by mouth two times a day for Diabetes, finger stick before giving Metformin and hold if it is less than 150. The MAR documented Resident #73 received the Metformin twice a day, at 9:00 AM and 5:00 PM every day, from 6/11/24 to 6/26/24. There was no documentation in the MAR to indicate the Resident #73's blood glucose (sugar) level was monitored via finger stick prior to the resident being administered the Metformin. Review of Resident #73's Pharmacy Consultant Notes revealed on 6/17/24 at 3:01 PM, in a pharmacy consultant note, the pharmacist documented Resident #73's medication regimen review was complete with no irregularities noted. The pharmacist failed to identify the irregularity related to the facility staff failing to monitor Resident #73's FS prior to administering Metformin twice a day. On 6/26/24 at 11:57 AM, during an interview, when made aware of the above concern, the Pharmacist (Staff #45) indicated that when Resident #73's medication regimen review was completed, the pharmacist not seen the directions for finger sticks in the residents Metformin order. The pharmacist stated she had never seen finger sticks ordered prior to receiving Metformin and thought the order for finger sticks within the Metformin order may not have been intended. The above concern with the pharmacist failing to identify the irregularities related to Resident #73's Metformin order was discussed with the Director of Nurses (DON) on 6/27/24 at 12:30 PM, and the DON offered no further comments at that time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 37276 Based on record review and staff interviews, it was determined that the facility failed to ensure that a resident received medications according to the physician's order, as evidenced by 1) by failing to ensure orders were accurately transcribed, and 2) failing to implement physician orders for parameters prior to administering medication. This was evident for 2 (#64, #73) of 5 residents reviewed for unnecessary medications, 1 (#95) of 4 residents reviewed for discharge, 1 (#37) out of 3 residents reviewed for behavior/mood, 1 (#94) of 11 reviewed for neglect, and 1 (#190) of 2 residents reviewed for death. The findings include: 1) On 6/20/24 at 12:30 PM, a review of Resident #64's medical record revealed that Resident #64 was initially admitted to the facility in mid to late April 2024, then readmitted to the facility in late May 2024, following an acute hospitalization . The medical record review revealed that, on 6/17/24 at 1:58 PM, in a skilled nursing note, the nurse indicated that Resident #64 had been out of the facility for a follow-up medical appointment, then returned to the facility with a new order and the resident's attending physician was updated. On 6/17/24 at 2:01 PM, in a skilled nursing note, the nurse documented that Resident #64 was to have a urinalysis (UA) in the morning and then start Cipro (Ciprofloxacin) (antibiotic). Review of a 6/17/24 consultant physician notes for Resident #64 revealed physician recommendations that included the resident have a UA for a urinary tract infection (UTI) and to start Ciprofloxacin twice a day for 14 days. Review of Resident #64's June 2024 Medication Administration Record (MAR) revealed a 6/18/24 order for Cipro by mouth two times a day for UTI which was documented as given every day as prescribed on 6/18/24 to 6/20/24, with no indication in the order when to discontinue the antibiotic. The facility staff failed to accurately transcribe the consultant physician's order for the resident to receive the Cipro for 14 days. On 6/21/24 at 11:02 AM, the concerns with the above antibiotic order failing to have a stop date was discussed with the Director of Nurses (DON). The DON acknowledged that the Cipro order should have had a stop date and offered no further comments at that time. 2) On 6/26/24 at 9:00 AM, a review of Resident #73's June 2024 MAR revealed an order for Metformin HCL (Glucophage) (antidiabetic medication) tablet by mouth two times a day for Diabetes, finger stick before giving Metformin and hold if it is less than 150. The MAR documented that Resident #73 received the Metformin twice a day, every day, from 6/11/24 to 6/26/24. There was no documentation in the MAR to indicate the Resident #73's blood glucose (sugar) level was monitored via finger stick prior to the resident being administered the Metformin. The facility staff failed to follow the physician's order by failing to monitor Resident #73's blood sugar via FS prior to administering the Metformin. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above concern with the facility staff failing to follow the physician's order to monitor the resident's finger stick prior to administering metformin was discussed with the DON on 6/26/24 at 9:44 AM. The DON acknowledged the concern and offered no further comments at that time. 3) On 7/11/24 at 9:00 AM, a review of Resident #95's August 2022 Medication Administration Record (MAR) revealed an 8/3/22 order for Diltiazem (Cardizem) (antihypertensive drug) tablet by mouth to be given every 6 hours for hypertension (HTN) (high blood pressure). The order stated to hold for systolic blood pressure (SBP) (top number of a blood pressure reading) less than 110 or heart rate (HR) (pulse) less than 60. 3a) The MAR documented that the Diltiazem medication was given to Resident #95 on 3 days in August 2022 when it was outside of parameters. The MAR documented Resident #95's BP and/or HR was outside of parameters and that medication was given and not held on: 8/6/22 at 6:00 AM - BP 107/61, HR 59 8/11/22 at 12:00 PM - BP 102/55 8/19/24 at 6:00 PM - BP 109/68 3b) the MAR documented that on 8/19/22 at 6:00 PM, Resident #95's BP was 107/68 and HR 52 and coded 9 (other/see nurses note). Review of Resident #95's nurses notes failed to reveal a correlating nurses note to indicate whether the Diltiazem was given outside of the parameters, or the medication was held per the physician's order. 3c) On 8/11/22 at 12:00 AM, the MAR indicated Diltiazem was not administered to Resident #95 and coded 6 (no insulin required per orders). The code was inapplicable to the order, and there was no BP or HR documented to indicate why the Diltiazem was not administered to the resident. 3d) On 8/15/22 at 12:00 AM, the MAR indicated that Diltiazem was not administered to Resident #95 and coded 4 (pulse below 60), with no BP documented and no HR documented to indicate why the Diltiazem was not administered to the resident. 3e) Further review of Resident #95's August 2022 MAR revealed multiple Diltiazem administration times that there was no BP or HR documented and was coded 5 (Hold/see nurses notes) indicating the Diltiazem was not given. This was evident for 18 Diltiazem administration times (8/3 at 12 PM, 8/4/22 at 12 PM, 8/6/22 at 12 PM, 8/7 at 12 PM, 8/9 at 12 AM, 8/9 at 12 PM, 8/10 at 12 AM, 8/14 at 12 AM, 8/15 at 12 PM, 8/17 at 12 AM, 8/18 at 12 AM, 8/19 at 12 AM, 8/19 at 12 PM, 8/23 at 12 AM, 8/25 at 12 AM, 8/26 at 12 AM, 8/28 at 12 AM, and 8/29 at 12 AM) in August 2022. Continued review of Resident #95's nurse's notes revealed eMAR (electronic MAR) notes, which populated the Diltiazem order into the note, at the time of administration, the medication was coded 5 in the MAR. Review of the eMAR notes for each of the administration times that were without parameters and coded 5 failed to reveal further documentation to indicate why the Diltiazem had not been administered to Resident #95. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/24 at 11:29 AM, the Nursing Home Administer (NHA) was made aware of the above concerns with with staff failing to to implement physician orders for parameters prior to administering medication and by failing to document a resident's BP or Pulse in the MAR, and failing to document the reason a medication was not given. The NHA acknowledged the concerns at that time and offered no further comments. 48259 4) Blood pressure (BP) is often written as an upper and lower number. Systolic blood pressure (SBP) is the upper number. It measures the pressure in the arteries during heart muscle contraction. Diastolic BP is the lower number. It measures the pressure in the arteries when the heart rests between beats. Heart rate (HR) is the number of times the heart beats per minute. A medical record review on 6/24/24 at 10:53 AM showed that Resident #37 had been residing in the facility since June 2022 and had diagnoses that included hypertension (high blood pressure). Continued record review found attending provider's orders for Resident #37 for antihypertensive medications. One order was initiated on 6/25/20 for Lisinopril 40mg to be given daily and had parameters to hold (not to give) the medicine for an SBP less than 110 mmHg (millimeters of mercury) or HR less than 55. Another order initiated on 2/7/24 was for hydralazine 50mg to be given with 25mg every 8 hours. The order had parameters to hold the medication for SBP less than 110 or HR less than 60. Resident #37's medication administration records (MAR)for April 1- June 24, 2024, were reviewed on 6/24/24 at 10:56 AM. The review showed that Resident #37's medications were administered as follows: 4/12/24 Hydralazine 50mg was administered for a HR of 58 4/26/24 Hydralazine 50mg was administered for a HR of 59 4/30/24 hydralazine 50mg was administered for a HR of 59 5/5/24 lisinopril 40mg was administered for a HR of 55 5/6/24 lisinopril 40 mg was administered for a HR of 58 5/15/24 Lisinopril 40mg was administered for a HR of 2 5/29/24 Hydralazine 50mg was administered for a HR of 56 5/30/24 hydralazine 50mg was administered for a HR of 53 6/4/24 hydralazine 50mg was administered for a HR of 58 6/23/24 Hydralazine 50mg was administered for a HR of 57 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/24 at 9:30 AM, staff #38, a licensed practical nurse, stated she would not give the medications per the attending provider's orders to hold them if the resident's HR was below 55 and 60. In a subsequent interview on 6/26/24 at 9:38 AM, the director of nursing confirmed that, per the MARs, Resident #37's antihypertensive medications were given to him/her on 4/12/24, 4/26/24, 4/30/24, 5/5/24, 5/6/24, 5/15/24, 5/29/24, 5/30/24, 6/4/24 and 6/23/24 even though the attending provider's orders were to hold the medications for a HR below 55 and 60. The DON stated that her expectation of the nurses was to hold the medicines per the attending provider's orders. 18819 5) Review of complaint MD00183126 on 07/01/24 revealed an allegation that Resident #94 did not receive quality of care while he was residing at the facility from 05/10/22 through 06/13/22. A review of Resident #94's closed medical record revealed a physician order, dated 05/18/22, that instructed the nursing staff to administer the blood pressure medication, hydralazine, 25 mg, orally, three times a day, and to hold the blood pressure medication if the systolic blood pressure reading is less than 110 mm/hg or the heart rate is less than 60 beats per minute. The nursing staff failed to follow the physician's order on the following days: 5a) 05/18/22, 10 pm dose, the nurse documented Resident #94's heart rate at 57 beats per minute. 5b) 05/30/22, 10 pm dose, the nurse documented Resident #94's heart rate at 56 beats per minute. 6) Review of complaint MD00201837 on 07/01/24 revealed an allegation Resident #190 did not receive quality of care while they were residing at the facility from 07/07/23 through 12/06/23. A review of Resident #190's closed medical record revealed a physician order dated 07/27/23 that instructed the nursing staff to administer the diuretic medication, Lasix, 20 mg, orally, every day, and to hold the Lasix medication if the systolic blood pressure reading was less than 110 mm/hg or the heart rate was less than 60 beats per minute. The nursing staff failed to follow the physician's order on the following days: 6a) 07/30/23, 9 am dose, the nurse documented Resident #190's blood pressure to be 100/69. 6b) 05/30/22, 10 pm dose, the nurse documented Resident #94's heart rate at 56 beats per minute.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 37276 Based on medical record review and staff interview, it was determined that the facility failed to provide a resident snacks as recommended by the dietician and consistent with the resident plan of care. This was evident for 1 (#96) of 6 residents reviewed for general concerns. The findings include: Type 2 diabetes is a long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels. Bedtime snacks can help people with type 2 diabetes stabilize their blood sugar levels overnight and prevent high blood sugar in the morning. On 6/28/2024 at 2:00 PM, a review of complaint #MD00180188 revealed the complainant reported that the dietician had stated Resident #96 could have an evening snack, however, the resident, who was a diabetic, was never offered an evening snack and had lost 9 pounds since admission. On 7/9/24 at 4:30 PM, a review of Resident #96's medical record revealed documentation that indicated the resident was admitted to the facility for rehabilitative services in mid-May 2022 following an acute hospital stay, then transferred to an assisted living facility in June 2022. Resident #96 was admitted to the facility with multiple diagnoses which included generalized weakness, COVID-19, non-Hodgkin's lymphoma (blood cancer), hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (high cholesterol), and Type 2 Diabetes Mellitus (DM). Review of Resident #96's progress notes revealed that, on 5/19/2022 at 10:04 AM, in a nutrition progress note, the dietician documented that Resident #96 was at nutritional risk related to their recent hospitalization with Covid-19, decreased appetite, history of lymphoma on chemotherapy, HTN, HLD and DM. The dietician documented recommendations which included an HS (hour of sleep) snack, alternating sandwich, peanut butter crackers, and yogurt for additional calories. On 5/23/22 at 12:21 PM, in a nutrition/weight note, the dietician documented that Resident #96 remained on a carbohydrate-controlled diet with routine HS snacks for additional calories/protein. Review of Resident #96's care plans, revealed a care plan, [Resident #96] is at nutrition risk r/t recent hospitalization with COVID-19, decreased appetite, history of lymphoma on chemotherapy, HTN, HLD with the goals, will experience no significant weight change, and will tolerate diet and texture/consistency, that had an intervention, snacks per patient preference Review of Resident #96's geriatric nursing assistant (GNA) task documentation for May 2022 revealed the intervention/task HS Snack, which documented Resident #96 received a snack on 2 (5/21 and 5/25/22) of 14 days. On 11 (5/18, 19, 20, 22, 23, 26, 27, 28, 29, 30, 31/22) of 14 days in May, the GNA documented NA (not applicable) indicating Resident #96 had not been offered or had not received an HS snack on 11 of 14 days in May. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #96's June 2022 GNA task documentation revealed on 5 (6/1, 2, 3, 5, 6/22) of 7 days in June, the GNA documented N/A) indicating Resident #96 had not been offered or received an HS snack on 5 of 7 days in June. The facility failed to follow the recommendations of the dietician and the resident's care plan by failing to provide routinely provide Resident #96 with an HS snack. On 7/9/24 at 5:20 PM, the Nursing Home Administer (NHA) was made aware of the concerns expressed by the complainant, and the identified concerns with to failing to provide snacks per the resident's care plan and as recommended by the dietician. The NHA acknowledged the concerns and offered no further comments at that time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on records review and interviews, it was determined that the facility failed to maintain resident medical records in accordance with accepted professional standards by failing to ensure accurate documentation. This was evident for 2 (#22, #59) of 9 residents reviewed for care planning, 2 (#84, #83) of 3 residents reviewed for closed records, 1 (#36) of 5 residents reviewed for medication administration, and 1 (#5) of 6 residents reviewed for general concerns. The findings include: 1) Resident #22 had been a resident of the facility since 2022. On [DATE] at 2:06 PM, a quick review of Resident #22's medical record indicated that a care plan meeting had taken place earlier that day at 9 :17 AM, with the Nursing Home Administrator (NHA), Social Service Director (SSD), Ombudsman and the resident. This was documented in Resident #22's progress notes by the SSD. To ensure that a resident-centered care plan is developed, a care plan meeting is held by a group of individuals including the resident and/or resident representative, if applicable, with the knowledge of the resident's needs and preferences to make decisions about the resident's care. Later at 2:41 PM, Resident #22 was interviewed about the different aspects of care s/he was receiving as a resident of the facility. The resident was asked to confirm if s/he attended the meeting that was documented by the SSD and stated, We didn't have a meeting today, we had a meeting last week and indicated that it was in the afternoon. On [DATE] at 9:12 AM, the NHA was interviewed about Resident #22. The NHA reported that the Ombudsman did come in for the care plan meeting, but it was not held last Monday (,d+[DATE]), it was held last week and indicated that it was in the afternoon as well. On the same day at 9:41 AM, the SSD accompanied by the NHA was interviewed about her process with care planning. The SSD was asked specifically about her note regarding the care plan meeting with an effective date of [DATE] at 9:17 AM. She reported that it was documented in error and confirmed that the meeting was held on [DATE] at approximately 3:30 PM. The concern was discussed with both staff regarding maintenance of accurate documentation in resident records. Both NHA and SSD acknowledged the concern. 37276 2) The MOLST (Maryland Medical Order for Life Sustaining Treatment is a portable and enduring medical order form that includes medical orders for Emergency Medical Services and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:58 AM, a review of a binder containing the active MOLST for each of the residents residing on Unit 1 revealed Resident #59 had an active MOLST, which was signed and dated [DATE], that documented Resident #59 elected No CPR, Option B, Palliative and Supportive care, indicating if cardiac and/or pulmonary arrest occurred, do not attempt resuscitation (No CPR) and allow death to occur naturally. On [DATE] at 10:13 AM, a review of Resident #59's electronic health record (EHR) revealed an uploaded MOLST dated and signed on [DATE], that documented Resident #59 elected No CPR, Option B, Palliative and Supportive care, No CPR. Further review of Resident #59's medical record revealed, on [DATE] at 3:41 PM, in a Social Services Note, the Social Service Director (SSD), Staff #17 documented Resident #59 was alert and oriented x 3 (oriented to time, person and place). The SSD further documented the resident's MOLST was addressed and is Full Code, indicating the resident had elected to receive CPR, if cardiac and/or pulmonary arrest occurred, and all medical efforts that are indicated during arrest. The SSD's documentation contradicted Resident #59's [DATE] MOLST which indicated the resident did not want CPR. Continued review of Resident #59's EHR revealed a [DATE] a care conference note, signed by Staff #17, SSD, that included a check off list with multiple topics that could potentially be discussed with a resident. The topics, Advanced Directive, and POLST (Physician Orders for Life Sustaining Treatment)/MOLST were not checked off, indicating the topics were not discussed with Resident #59 during the care conference. In addition, no other documentation was found in the EHR to indicate that Resident #59's MOLST and/or the resident's right to formulate advanced directives had been discussed with Resident #59. Review of Resident #54's care plans revealed a care plan with the focus, [Resident #59's] advanced directive is Full Code, which was initiated on [DATE] and had a revision date [DATE]. The care plan focus was inaccurate, as Resident #59's active MOLST documented the resident elected No CPR. On [DATE] at 10:16 AM, during an interview, Staff #17, SSD, was made aware that the SSD's care conference note documentation on [DATE] indicating the resident was a full code contradicted Resident #59's active MOLST in which the resident elected No CPR, and Resident #59's care plan focus, Advanced Directive is a full code, contradicted the resident's active MOLST in which the resident elected No CPR. The SSD acknowledged the concerns and indicated the discrepancy in the documentation of the resident's code status needed to be addressed, and the SSD offered no explanation or further comments at that time. The above concerns were discussed with the Nursing Home Administrator (NHA) on [DATE] at 1:54 PM, and the NHA offered no further comments at that time. 16218 3) On [DATE], review of Resident #84's medical record revealed a social service note, written by Staff #17 and dated [DATE] at 4:46 PM, that included: Resident was discharged to another SNF [skilled nursing facility] ([name of the other facility]) on [DATE] .Resident was set up with home health services with [name of a home health agency] . Further review of the medical record failed to reveal documentation to indicate home health services were set up, or indicated, in relation to the [DATE] discharge to another skilled nursing facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:00 AM during an interview with Director of Social Service (Staff #17) regarding the [DATE] note, She/he confirmed the note contained incorrect documentation regarding .set up with home health services with [name of agency] . Staff #17 confirmed that she documented something that she did not do. 4) On [DATE], review of Resident #83's medical record revealed the resident had resided at the facility for several years. Further review of the medical record revealed the presence of two unvoided MOLST forms. Maryland Medical Orders for Life Sustaining Treatment (MOLST) is a form that includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR)and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Included in the No CPR section are three options: A-1 Intubate; A-2 Do Not Intubate but comprehensive efforts may include limited ventilaroty support by CPAP or BiPAP; or Option B No CPR, Palliative and Supportive Care, do not intubate or use CPAP or BiPAP. The first MOLST, dated [DATE], included orders for No CPR [cardiopulmonary resuscitation] Option A-2 Do Not Intubate: Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate. The second MOLST, dated [DATE] revealed an order for No CPR Option B Palliative and Supportive Care: Prior to arrest , provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. On [DATE] at 4:26 PM, surveyor reviewed with [NAME] President of Clinical Operations (Staff #20) the concern regarding multiple active MOLSTs that had not been voided when a new MOLST was established. Staff #20 indicated that she understood the concern. 5) Review of Resident #36's medical record revealed the resident was admitted in 2023 and whose diagnoses included but was not limited to, rheumatoid arthritis. On [DATE] at 8:55 AM, surveyor observed nurse (Staff #35) prepare and administer Resident #36's medications. The nurse prepared a total of 10 medications, which included two lidocaine patches. Surveyor observed the nurse remove an old patch from the resident's left knee and one from right knee. After the observation, the nurse confirmed that the patches that were removed did not include a date. On [DATE] at 10:09 AM, review of the medical record revealed there was one order, with a start date of [DATE], for Lidoderm Patch 5% apply to both knees, R.[right] thigh/groin topically one time a day for pain management and remove per schedule. Review of the Medication Administration Record revealed an area for nursing staff to document the removal of these patches at 2100 (9:00 PM). Staff had documented the removal of these patches for the evening of [DATE]. On [DATE] at 10:39 AM, surveyor reviewed the concern with the unit nurse manager (Staff #14) that staff had documented the removal of the patches to the knees yesterday but they were observed on the resident this morning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50573 6) Review of Resident #5's medical record on [DATE] revealed that the resident has been residing at the facility since [DATE], needs partial to maximal assistance with Activities of Daily Living (ADLs) is alert and oriented, able to verbally communicate, and has an allergy to sulfa. On [DATE] at 02:32 PM, during an interview with Resident #5, he/she reported having blisters on the back of her/his legs. Record review revealed that on [DATE] there was an order for Silver Sulfadiazine Cream 1% to be applied to the area of blisters every day shift and as needed. Review of the Medication Administration Record revealed that on [DATE], Silver Sulfadiazine Cream 1% was administered. On [DATE] at 03:05 PM, Divisional Director of Quality Assurance (Staff #5) provided the surveyor with an email receipt which revealed the pharmacy alerted the facility on [DATE] that the resident has an allergy to sulfa. Staff #5 further indicated that the medication was then discontinued on [DATE] and the pharmacy never sent it. Further interview with Staff #5 on [DATE] at 3:05 PM revealed that when asked about the [DATE] documentation that Silver Sulfadiazine Cream 1% was administered, Staff #5 reported this was an error, it was never delivered, and she further indicated they were still investigating. On [DATE] at 11:00 AM, the NHA presented documentation that indicated that Licensed Practical Nurse (Staff #33) had signed the administration of the medication on [DATE] in error and an Employee Disciplinary Form dated [DATE], concerning the error which was signed by Staff #33. On [DATE] at 11:00 AM, the surveyor reviewed the concern with NHA that staff signed off a medication that was not actually administered.