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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45139 Based on observations, record review, and interviews, it was determined that the facility failed to maintain a resident's dignity by 1) by standing over a resident while assisting him/her during a meal, and 2) by failing to cover the urine drainage bag with a privacy bag. This was evident for 3 (#61, #35, #4) of 3 residents reviewed for dignity, and 1 (#28) of 3 residents reviewed for urinary catheter or UTI. The findings include: 1) On 6/18/24 at 8:09 AM, an observation revealed LPN staff # 7 assisting Resident #61 with a meal. Resident #61 was lying in bed with the head of the bed elevated. Staff #7 was standing over the resident while assisting the resident with eating. Further observation revealed that a vacant chair was available in the room. On 6/18/24 at 8:09 AM, an observation revealed Resident #35 was lying in bed with the head of the bed elevated. GNA #6 was standing up over the resident and assisting the resident with eating. Further observation revealed that there was a chair available in the room. On 6/18/24 at 8:11 AM, the surveyor and the Director of Nursing (DON) made observations of Resident #61 and Resident #35 being assisted with eating. The DON reported that the facility's best practice is that staff sit next to the resident while assisting the residents with meals. On 6/18/24 at 8: 13 AM, an observation was noted of the DON entering Resident #35 and Resident #61's rooms and following that intervention by the DON, it was noted that Staff #7 and Staff #6 were seated while assisting the residents with eating. 48259 2) A meal observation on the long-term care unit on 6/17/24 at 12:39 PM showed staff #31, a geriatric nurse aid (GNA), standing over Resident #4, who was lying in bed while assisting him/her in eating lunch. In a continued observation, staff #31 took Resident #4's meal tray out to the meal cart and then was observed going back to Resident #4's room with a dessert. Staff #31 continued to feed the Resident dessert while standing over the Resident. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review on 6/17/24 at 1:01 PM showed that Resident #4 had been living in the facility since June 2013 and required maximal assistance from staff with eating. In an interview with staff #31 on 6/17/24 at 1:16 PM, she stated that she usually stood up while assisting residents with eating. During a subsequent interview on 6/26/24 at 9:32 AM, the DON stated that she expected staff to be seated while assisting residents with eating and not to stand over them. 48470 3) On 6/18/24 at 10:08 AM, Resident #28's urine drainage bag was observed hanging on the right side of the bed frame without a privacy bag. A healthcare provider typically inserts a Foley catheter before surgery or to treat conditions like urinary incontinence or urinary retention. It can also be used for patients who have had gynecological or urological surgery. Most catheters are only needed until the person can urinate on their own again, but older adults or people with permanent injuries or illnesses may need to use them long-term or permanently. A Foley bag, also known as a urine drainage bag, is a collection bag that connects to a Foley catheter to drain urine from the bladder when a person is unable to urinate on their own. On 6/25/24 at 12:54 PM, Resident #28's medical records were reviewed and revealed an order to ensure their Foley bag was housed in a privacy bag every shift. Further review of the resident's medical records at 1:23 PM revealed that this order was marked as done for day shift by the Registered Nurse (RN Staff #46) On the same day at 2:21 PM, an observation of Resident #28's urine drainage bag without a privacy bag was again made by the surveyor. Shortly after at 2:27 PM, the Unit Manager (Staff #13) accompanied the surveyor to Resident #28's room and confirmed the observation that the urine drainage bag was exposed and was not in a privacy bag. Staff #13 looked around the resident's room but could not locate a privacy bag. The resident's orders were also reviewed with Staff #13 and confirmed that Staff #46 had already marked the order as done to ensure that the Foley bag was housed in a privacy bag. The concern was discussed with Staff #13 that the nursing staff had marked an order as done without ensuring it and that it was a dignity concern. Staff #13 acknowledged the concern. On 7/10/24 at 2:56 PM, the findings were discussed with the Director of Nursing (DON) that 2 of 2 observations of Resident #28's urine drainage bag failed to utilize the privacy bag to ensure the resident received services with dignity. The DON acknowledged the concern.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45139 Based on observation, pertinent document review, and interview, it was determined that the facility failed to have a process in place to communicate with a resident in their preferred language. This was evident for 1 (# 61) of 2 residents reviewed for communication-sensory during a survey. The findings include: On 6/20/24 at 9:49 AM, the hospital discharge summary of Resident #61, a long-term resident, was reviewed. The review revealed that Resident #61 had a history of dementia and deafness. Also, that she communicated using American sign language (ASL). On 6/18/20 at 7:43 AM, during an interview with GNA staff #6, she reported that she routinely provides care to Resident # 61. She reported that she communicated with the resident through writing on a white board. Staff #6 reported that the resident would also use gestures or pointing to communicate. In addition, she reported she has never used an ASL interpreter to communicate with the resident. On 6/18/24 at 11:49 AM, an observation was made of the Maryland State Service Coordinator for DDA services (an outside provider, staff #18), signing with the Resident #61. On 6/18/24 at 12:14 PM, the DDA service provider reported that she had worked with Resident #61 in the community as an outreach sign language service coordinator for Maryland DDS. She reported that Resident #61's language was ASL. She reported that she has worked with the resident for several years and that the resident has a decrease in anxiety and delusions when provided with increased oppurtunities for communication when others are using ASL. On 6/20/24 at 12:05 PM, an interview was conducted with Nurse (RN) unit manager Staff # 13. He reported that he is the supervisor of the unit where Resident # 61 resides. He reported that he has never used an interpreter in ASL, either personally or virtually to communicate with Resident #61. He reported that a whiteboard is used to communicate with the resident. On 6/20/24 at 1:04 PM, review of care plan revealed that the resident uses sign language and a communication board to communicate with staff. On 6/24/24 at 2:51 PM, the Long-Term Care Social Worker Coordinator Staff #16 was interviewed. She reported that the preferred way to communicate with a deaf resident is to use a ASL interpreter. She reported that the facility has not used an ASL interpreter (in person or virtually) for the resident during her/his stay at the facility. On 7/5/2024 at 7:45 AM, Resident #61 was interviewed with the assistance of a qualified ASL Interpreter. The surveyor and [NAME] President of Clinical Operations were present during the interview. The resident reported (via the ASL interpreter) that the best way for her to communicate is with sign language. Resident # 61 said the white board has been okay, but signing is best. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/5/2024 at 8:00 AM, the Surveyor discussed with the [NAME] President of Clinical Operations the concerns of Resident #61. Primarily, that she had not had any opportunity to communicate in her preferred language, over the year of her stay at the facility. The [NAME] President of Clinical Operations reported that education has already begun with the facility staff on how to use the virtual interpreter. Additionally, she would discuss with the facility when to use the virtual interpreter and when it is appropriate to use the white board along with gestures for communication.

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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. 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on medical record review and staff interview, it was determined the facility staff failed to reveal evidence that the resident or resident representative was informed of their right to formulate an advanced directive. This was evident for 2 (#44, #59) of 6 residents reviewed for advanced directives. The findings include: Advanced Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual is not able to make their own decisions. A Medical Orders for Life Sustaining Treatment or MOLST form contains medical orders regarding life-sustaining treatments, the use of medical tests, whether to transfer a patient to a hospital and any other matter considered appropriate by the Department to implement the treatment preferences of patients. A MOLST form is not an advance directive. A MOLST form contains written medical orders related to a patient's medical condition. 1) Resident #44 has been residing at the facility since 2022. On [DATE] at 11:46 AM, the resident's medical record was reviewed and revealed a MOLST form labeled as advanced directive. No other documentation was found to reveal an advanced directive was in place. On [DATE] at 11:26 AM, Resident #44's medical record was reviewed and revealed a care conference progress note with a reference date of [DATE] that indicated the resident was his/her own decision maker. Later at 10:29 AM, further review of the resident's medical record revealed a psychosocial evaluation with a reference date of [DATE] that indicated the resident's memory was intact, cognition was functionally intact, and judgement was adequate. On [DATE] at 10:10 AM, the Social Services Director (SSD) was interviewed about her process with advanced directives. The SSD also reported her knowledge of the difference between a MOLST form and an advanced directive. The SSD was asked if the resident had an advanced directive in place and she indicated that she would check the resident's medical records. On [DATE] at 10:06 AM, the SSD indicated that she did not find an advanced directive in place for Resident #44 or that it was discussed and/or offered to the resident during admission. The concern was discussed with the SSD about the resident's right to receive information and to formulate an advanced directive. The SSD acknowledged the concern and reported that the resident was admitted before she was hired. On [DATE] at 11:09 AM, further review of Resident #44's medical records revealed a progress note done by the SSD on [DATE] at 11:47 AM, after discussing with the surveyor, that indicated an advanced directive was discussed with the resident, and that s/he did not have one in place and refused to formulate one at that time. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37276 2) On [DATE] at 10:58 AM, a review of Resident #59's EHR (electronic health record) and paper medical record failed to reveal evidence that Resident #59 had an advanced directive in place and no documentation was found in the medical record to indicate Resident #59 had been informed of his/her right to formulate an advanced directive. On [DATE] at 10:13 AM, a review of Resident #59's medical record revealed the resident was admitted to the facility in the middle of [DATE], following an acute hospitalization and the resident was his/her own representative. Resident #59's admission assessment with an assessment reference date (ARD) of [DATE] documented Resident #59 BIMS (brief interview for mental status) summary score was 12, indicating the resident had moderate cognitive impairment. Further review of the medical record revealed a [DATE] at 3:41 PM, Social Services Note that documented Resident #59 was alert and oriented x 3 (oriented to time, person and place). The social services note documented the resident's MOLST was addressed and is full code, indicating Resident #59 had elected to attempt CPR, if cardiac and/or pulmonary arrest occurred. The documentation contradicted the resident's [DATE] MOLST which documented Resident #59 elected No CPR. There was no further documentation in the social services note to indicate that advanced directives had been discussed with Resident #59. Continued review of Resident #59's EHR revealed a [DATE] care conference note, signed by the SSD, that included a check off list labeled Topics Discussed followed by a list of 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 advanced directive and the MOLST were topics that were not discussed with Resident #59 during the care conference. Review of Resident #59'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. Continued review of Resident #59's medical record failed to reveal documentation to indicate whether Resident #59 had formulated an advanced directive or that the resident had been informed of his/her right to formulate an advanced directive. The above concerns were discussed with the Social Service Director on [DATE] at 10:16 AM. The SSD acknowledged the concerns and offered no further comments at that time.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 16218 Based on observation and interview, it was determined that the facility failed to ensure that items in need of repair were reported to the maintenance department. This was found to be evident for 2 out of 23 resident rooms observed in the initial stage of the survey. The findings include: 1) On 6/17/24 at 2:18 PM, surveyor observed in Resident #5's room several areas of the wallpaper with staples in sections where the sheets of wallpaper were separating. Also observed at this time, the material covering the right arm rest padding of the resident's wheel chair was not intact, with a small section missing. On 7/1/24 at 1:44 PM, interview with geriatric nursing assistant (GNA Staff #27) revealed that, if environmental concerns were identified, the staff were able to initiate a computer report for repairs. When asked if a resident's arm rest was peeling or torn, the GNA responded that they would definitely report it. On 7/8/24, Resident #5 was observed in the dining room. Observation of the armrest on the resident's wheelchair again revealed that the material covering the right arm rest padding was not intact with a section missing. On 7/9/24 at 11:35 AM, the maintenance director (Staff #28) confirmed they use a computerized system, known as TELS, for reporting maintenance issues. He reported there were no current TELS for Resident #5 and denied any recent work on the resident's wheelchair. Surveyor reviewed the concern that damage had been noted to the resident's armrest at the beginning of the survey and recent observation revealed the same observation. The maintenance director reported staff usually would tell him about issues like that. Also during the 7/9/24 interview, the maintenance director reported there were no plans at present for wallpaper removal. On 7/9/24 at 11:45 AM, surveyor and maintenance director observed the wallpaper in Resident #5's room. There were at least four areas where the wallpaper had started to separate and had been stapled together. The stapled areas were approximately 12 inches in length each. Upon observation of the stapled wallpaper, the maintenance director reported that was before his time. 2) On 6/18/24 at 9:59 AM, surveyor observed in Resident #67's room cracks in four floor tiles. The tiles were located between the bathroom and the left wall of the room upon entrance. The cracks ran the length of each tile. During the 7/9/24 11:35 AM interview with the maintenance director, he reported that he had replaced tiles in a couple of rooms. (continued on next page)

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Montcare at Wheaton	11901 Georgia Avenue Wheaton, MD 20902

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at approximately 11:40 AM, surveyor and maintenance director observed the cracked tiles in Resident #67's room, additional cracks were observed in a similar area in the room next door. The maintenance director reported this was a structural problem.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and staff interviews, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days following a significant decline in residents' conditions. This was evident for 2 (#37, #4) of 3 residents reviewed for hospice. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each resident receives the care they need. The nursing home should complete a Significant Change in Status MDS assessment within 14 days when there's a major decline or improvement in a resident's status. 1) A medical record review on 6/17/24 at 1:46 PM showed that Resident #37 was admitted to the facility in June 2020 with diagnoses including stroke with one-sided weakness. Further record review contained an attending provider's order, dated 2/13/24, that stated that Resident #37 was admitted to hospice care with an effective date of 2/13/24. The review also found a Significant Change in Status MDS assessment, dated 2/23/24. The MDS assessment was completed and signed in sections Z0500B & V0200B2 on 3/5/24, 22 days after admission to hospice care and eight days late. In an interview on 6/18/24 at 2:52 PM, staff #9 reported that a Significant Change in Status MDS assessment should be completed within 14 days of noticing a decline in a resident's condition. However, Resident #37's Significant Change in Status MDS assessment, dated 2/23/24, was completed 22 days after he/she was admitted to hospice care. In a subsequent interview on 6/26/24 at approximately 8:55 AM, staff #9 confirmed that Resident #37's Significant Change in Status MDS assessment, dated 2/23/24, was completed late. 2) A medical record review on 6/17/24 at 3:47 PM, showed that Resident #4 had been residing in the facility since June 2013. Continued review found an attending provider's order that stated that Resident #4 was admitted to hospice care effective 5/1/24. Further review contained a Significant Change in Status MDS assessment for Resident #4 dated 5/15/24, completed and signed in sections Z0500B & V0200B2 on 5/24/24, 24 days after admission to hospice care and ten days late. In an interview on 6/18/24 at 2:55 PM, staff #9, an MDS coordinator stated that she completed a Significant Change in Status MDS assessment 14 days after learning about a resident's admission to hospice and not within 14 days of the start of hospice care. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview on 6/26/24 at 8:47 AM, staff #9 confirmed that Resident #4's Significant Change in Status MDS assessment dated [DATE] was completed late.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 48259 Based on interviews and medical record review, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#24) of 4 residents reviewed for position and mobility, 1 (#37) of 3 residents reviewed for vision/hearing, 1 (#84) of 4 residents reviewed for hospitalization , and 2 (#35, #67) of 4 residents reviewed for pressure injuries. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need. 1) In an interview on 6/17/24 at 12:25 PM, Resident #24 was asked about having any limitation in his/her range of motion (ROM). The resident responded that he/she could not lift his/her right leg. A medical record review on 6/28/24 at 1:14 PM contained a physical therapy evaluation and plan of treatment dated 12/9/23, that recorded that Resident #24 had a limited range of motion in the left and right legs. Continued review, on 6/28/24 at 2:40 PM, found three MDS assessments for Resident #24 dated 12/20/23, 3/20/24, and 5/3/24. The MDS assessments had recorded that Resident #24 could not walk, required assistance from staff with transferring from one surface to another, and had no limitation in range of motion in section GG0115. In an interview on 6/28/24 at 2:47 PM, staff #9, an MDS coordinator, stated that her process for assessing a resident's limited ROM was through observation and review of documentation by physical therapy, occupational therapy, and nurses. Staff #9 continued to say that she would record the limitations on a resident's MDS assessment if the impaired ROM affected the resident's movement or ability to move. In a subsequent interview on 7/1/24 at 9:46 AM, staff #36, a physical therapist, said a resident's impaired ROM to his/her legs would affect the resident's ability to transfer or walk. However, Resident #24's MDS assessments for 12/20/23, 3/20/24, and 5/3/24 failed to capture his/her limitation in range of motion to the legs. 2) In an interview on 6/17/24 at 2:46 PM, Resident #37's representative reported that Resident #37 had poor vision and hearing. A record review on 6/24/24 at 1:58 PM found an admission MDS assessment, dated 7/1/20, that recorded Resident #37 had moderately impaired vision in section B and blindness to the right eye in section I. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review contained an attending provider's note, dated 11/17/2022, which documented that Resident #37 had right eye blindness. A subsequent record review, on 6/24/24 at 3:58 PM, contained a nutritional assessment, dated 12/4/23, which recorded that Resident #37 was edentulous (edentulous is having no natural teeth or tooth fragments in the mouth). Further review found an MDS assessment, dated 2/23/24, which recorded in section L-Oral/Dental status that Resident #37 was not edentulous and in section B that Resident #37 had adequate vision. However, the MDS assessment failed to capture Resident #37's edentulous and impaired vision status. In an interview on 6/26/24 at 8:38 AM, staff #9, an MDS coordinator, reported that she documented sections B and L of Resident #37's MDS assessment, dated 2/23/24 in error. 16218 3) On 6/20/24, review of Resident #84's medical record revealed a Minimum Data Set discharge assessment, with an assessment reference date of 3/25/24, that included documentation that the resident was discharged to a short term general hospital. Further review of the medical record failed to reveal documentation to support that the resident was discharged to a hospital. Review of the medical record revealed a My Transition Home document, dated 3/25/24, which included in Section D Social Services, which was signed by Director of Social Service (Staff #17), the reason for the discharge was the completion of therapy and discharge goals met. The transfer setting was listed as Home/Community (eg.private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements). The area for discharge address was noted to be blank. The section titled My Discharge Goals included that the goal was discharge to ALF. An ALF is an assisted living facility which is a less intense level of care than a skilled nursing facility. Review of a 3/25/24 11:59 AM nursing note revealed .Resident schedule to be discharge to ALF today Review of a 3/25/24 at 4:24 PM nursing note revealed: Resident has an order to be transferred to ALF - [name of a skilled nursing facility]. Transportation arrived and Resident left in stable condition. Review of a 3/25/24 at 4:46 PM social service note, written by Staff #17, revealed: Resident was discharged to another SNF [skilled nursing facility] ([name of the other facility]) on 3/25/24 .Resident was set up with home health services with [name of a home health agency] . Further review of the My Transition Home document, which was signed by the resident's responsible party, failed to reveal documentation to indicate the resident was being discharged to a skilled nursing facility or a hospital. Review of a 3/26/24 at 12:27 PM nursing note, written by the unit nurse manager (Staff #14) revealed: Post discharge and transition home call was made spoke with resident's one of [his/her] daughter, how was how was the first day of discharge home, daughter stated thank you for every thing. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 2:59 PM, the MDS nurse (Staff #9) reported she reads the notes to determine where a resident is discharged to. After surveyor reviewed the concern that the discharge MDS indicated the resident went to a hospital, the MDS nurse reported that must have been an error, let me check, I'll do a correction now. On 6/20/24 at 4:26 PM, surveyor reviewed the concern with [NAME] President of Clinical Operations (Staff #20) that based on record review, surveyor cannot determine where the resident went after discharge. Staff #20 indicated she would investigate. On 6/21/24 during a 10:00 AM interview, the Nursing Home Administrator (NHA) reported that he spoke with the family this morning and confirmed the resident was currently at [name of the SNF referenced in SS note]. He confirmed this SNF is not an ALF. On 6/21/24 at 12:15 PM, review of the modified MDS revealed documentation that the resident went to a home/community setting, not a SNF. This assessment was locked but had not yet been submitted. When asked about this discharge assessment, the MDS nurse reported there was some confusion due to documentation that indicated the resident went to an ALF, but that social work reports the resident went to a nursing home. MDS nurse indicated she will change the assessment again. On 6/21/24, surveyor confirmed with the state licensing office that, according to the receiving SNF MDS submission, the resident was admitted to a SNF on 3/25/24. 45139 4) On 6/20/24, review of records revealed that Resident #35 had been a long-term resident of the facility for several years. On 6/25/24 at 11:20 PM, an observation was made of a wound care treatment for resident # 35. The observation revealed that Resident #35 had contractures in both legs. On 6/26/24, review of Resident #35's physical therapy discharge documentation, dated 1/13/2020, was reviewed. Review failed to reveal that Resident #35 had any contractures of his/her right or left legs. On 6/28/24 at 12:12 PM, The hospice visit notes, written by Nurse Practitioner Staff #47, dated 3/20/2021, were reviewed. Review revealed that the resident had a significant contracture of the right knee. On 6/26/24 at 7:55 PM, the MDS for Resident # 35, with the following assessment reference dates, were reviewed for section G0400, Functional Limitations in Range of Motion. The noted dates were: 4/18/21, 10/17/21, 1/17/22, 6/29/22, and 8/13/22. The review failed to reveal that the significant contracture was coded. 06/28/24 at 3:11 PM, MDS Coordinator Staff #9, was interviewed to determine what data sources had been used to document the information in section G0400, Functional Limitations in Range of Motion. The MDS coordinator reported she reviews the following: Residents chart, any physical examinations, nurses' notes, and the GNA documentation. The MDS coordination agreed that 40 percent contracture of the knee was significant and confirmed that it was an error in coding. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50573 5) Review of Resident #67's medical record revealed the resident had resided at the facility since January 2024 to present, used a wheelchair independently, needed partial to maximal assistance with ADLs,was alert and oriented, and able to verbally communicate. Further record review of the initial assessment note, completed on 1/24/24 at 08:49 PM, revealed that Resident #67's skin was intact upon admission. Record review revealed that, on 2/2/2024 at 11:29 PM, a change of condition progress note was completed indicating that during a shift assessment, there was a wound noted on Resident #67's left buttocks and that the wound doctor (Staff #40) was notified. Record review revealed that on 4/19/24 at 01:40 PM, Unit Nurse Manager (Staff #14) completed a nursing progress note which indicated, right lateral heel eschar was noted . Eschar is dead tissue that sheds or falls off from the skin and is commonly seen with pressure ulcer wounds. Further record review revealed that, on 4/19/24 at 02:20 PM, an eINTERACT SBAR Summary for Providers progress note was completed, which indicated that Resident #67 had an open area on the left ischium and left heel. The ischium is part of the pelvis bone that forms the lower and back part of the hip bone. Record review revealed on 4/26/24, a wound note by Medical Doctor (Staff #40) that indicated they were managing Resident #67's wound on the left ischium. Further record review revealed an MDS, with an assessment reference date of 4/28/24, which indicated that Resident #67 had one pressure wound and that the wound was present upon admission. On 06/24/24 at 02:17 PM, an interview with MDS coordinator (Staff #9) revealed that she used the nursing assessments and notes from the wound doctor to complete the skin section of MDS assessments. The surveyor explained that, according to the 4/28/24 MDS for Resident #67, he/she had 1 wound and it was marked as being present upon admission. Staff #9 explained she would look into it and get back to the surveyor to confirm. On 06/24/24 at 02:47 PM, an interview with Staff #9 confirmed that Resident #67 developed the wound at the facility and the coding of it being present upon admission was an error. Surveyor requested clarification from Staff #9 regarding the number of pressure wounds that were present at the time of the 4/28/24 admission. On 6/24/24 at 3:40 PM, Staff #9 confirmed Resident #67 had two additional wounds that were not captured on the 4/28/24 MDS assessment. On 06/27/24 at 02:01 PM, the surveyor expressed the concern to the Director of Nursing that an MDS assessment failed to correctly reflect a resident's status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 16218 Based on medical record review and interview, it was determined that the facility failed to ensure that an order for a hospice consult was acted upon. This was found to be evident for one (#83) of 2 residents reviewed for death. The findings include: On 6/20/24, review of Resident #83's medical record revealed the resident had resided at the facility for several years. On 5/22/24 at 4:31 PM, an order for a Hospice Consult and evaluation was placed in the medical record. The resident passed away on 5/26/24. Hospice care includes a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members. Further review of the medical record failed to reveal documentation to indicate the hospice referral was addressed with the resident or the resident's family after the initial order was put in place. No documentation was found to indicate that a hospice provider was contacted regarding this consult order. On 7/9/24 at 4:31 PM, the Assistant Director of Nursing (Staff #8) reported that a Hospice consult is reviewed by the interdisciplinary team and then social service will spearhead by calling the hospice, based on what the family chooses. Surveyor then reviewed the concern that there was an order for hospice on 5/22/24 and their was no documentation in the medical record to indicate that social services addressed the issue with the resident or the family prior to the resident's expiration on 5/26/24. As of time of survey exit on 7/11/24 at 3:30 PM, no additional documentation, or other information, was provided regarding the failure to address the hospice consult order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37276 Based on observation, closed medical record, complaint and pertinent documentation review and staff interviews, it was determined that the facility staff 1) failed to store oxygen cylinder tanks securely. This was evident for 1 of 2 nursing units observed 1) Compressed Oxygen Cylinders, also known as oxygen tanks, store pressurized oxygen and need to be secured to prevent them from tipping over and becoming damaged. If the valve on the oxygen tank broke off, causing a leak, the oxygen tank could become a flying projectile. On 6/24/24 at 10:00 AM, during an observation of Unit 2's nursing station, 2 surveyors observed an unsecured oxygen cylinder leaning against a counter in the left, back corner of the nurse's station. The Assistant Director of Nurses (ADON), Staff #8, was on the unit and was immediately shown the unsecured oxygen cylinder. At that time, the ADON confirmed the findings and indicated she would make sure the oxygen tank was secured.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45139 Based on records review and interviews, it was determined that the facility failed to have an effective system in place to monitor and address a resident's significant weight loss. This was evident for 1 (#1, #72) of 4 residents reviewed for nutrition. The findings include: 1) On 6/17/24 at 2:15 PM, Resident #1, a long-term resident at the facility was interviewed. During the interview s/he reported that s/he had recently lost wight. On 6/20/24, review of Residents #1's medical record, under the category weights, revealed the following: 6/8/2024 11:41 103.8 Lbs. 6/7/2024 15:05 97.4 Lbs. 6/4/2024 10:15 99.8 Lbs. 5/24/2024 13:41 104.2 Lbs. 4/7/2024 21:55 124.4 Lbs. 3/1/2024 16:10 124.0 Lbs. On 6/20/24 at 8:48 AM, a dietician's note, dated 5/24/24, written by Dietician staff #15, was reviewed. The review revealed that dietitian Staff #15 recognized and documented a significant weight loss warning for Resident #1.The weight documented on 5/24/24 indicated a 16 percent weight loss in 47 days. Staff # 15 requested a re-weigh to verify the weight change. On 6/20/24, review of Resident #1 documented weights revealed that the resident was not re-weighed until 6/4/2024. Review of the re-weight revealed the resident had lost an additional 4% in body weight. On 6/20/24 at 11:04 AM, Registered Dietician staff # 15 was interviewed. During the interview, he reported that he does not receive notification of a resident's weight loss or when a re-weight is completed. To obtain weight loss and re-weight information he needs to go into the Electronic Health Record and review a weight loss report. Dietician#15 failed to explain why the re-weight for Resident #1 was done 13 days after the re-weight was requested. 48470 2) Resident #72 was a newly admitted resident of the facility. During an interview on 6/18/24 at 11:47 AM, the resident indicated that s/he had lost a lot of weight and stated, I don't want to lose anymore because I feel like I will get sicker if that happens. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 9:52 AM, Resident #72's medical records were reviewed and revealed his weight was 138.8 lbs. taken on 5/13/24 and 131 lbs. taken on 6/4/24 which was a 5.62% weight loss in 22 days. Further review of the resident's medical record revealed a note from a dietician (Staff #48) with an effective date of 6/4/24 at 11:10 AM that indicated a weight warning and requested a reweight for the resident to confirm the weight loss. However, there was no evidence that the resident was reweighed, nor any change in the resident's dietary orders. On 6/21/24 at 1:15 PM, the Registered Dietician (Staff #49) was interviewed and reported that Staff #48 no longer worked for the facility. Staff #49 explained her process on monitoring the residents' weights and indicated that she runs a report to generate a list of residents with significant weight loss. Staff #49 was asked to review the note of Staff #48 on 6/4/24 for Resident #72 and was asked if there was any follow up done for the resident. Staff #49 reviewed the note and Resident #72's medical records and confirmed that the resident had a significant weight loss, reweight was not done, and that she was not aware that the resident needed to be followed up on and stated, His/Her name is not on our list. Staff #49 reported that she did the resident's admission evaluation and put the resident in a dietary program to increase weight but was not aware of Staff #48's note. On 6/21/24 at 2:44 PM, the concern was discussed with the Nursing Home Administrator (NHA) that Resident #72 had a significant weight loss since admission and was noted by Staff #48. However, the facility staff failed to act upon the request for reweight and Staff #49 failed to follow up on Resident #72's significant weight loss. The NHA acknowledged the concern. On 6/24/24 at 9:24 AM, Resident #72's medical records were again reviewed and revealed a progress note from Staff #49 with an effective date of 6/21/24 at 11:07 PM, indicating nutrition order changes that included further increase in the resident's dietary intake and weekly weights to monitor nutritional status with diet change.

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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 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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 45139 Based on interview and pertinent documents, it was determined that the facility failed to provide Physician/Nurse Practitioner services to the resident at least once every 60 days. This was evident for 1 (#53) of 4 Resident reviewed for dental during a survey. The findings include: On 6/18/24 at 11:40 AM, Resident #53, a long-term care (LTC) resident, was interviewed. During the interview resident #53 reported a concern regarding how frequently s/he sees a physician. On 6/21/24 at 6:57 AM, a review of progress notes from 11/22/23 to 3/8/23, failed to reveal documentation that a Physician or Nurse Practitioner (NP), visited Resident #53. On 6/21/24 at 7:46 AM, the Director of Nursing (DON) was interviewed regarding the required visit frequency of a NP or physician for a long-term resident. The DON reported that, once a resident has been at the facility for 90 days there is normally an order for a physician visit every 60 days for a LTC resident. On 6/21/24 at 8:07 AM, during a second interview with the DON, she failed to provide any handwritten physician visit notes for Resident # 53 from 11/22/23 to 3/8/23. She confirmed there were no progress notes documented of a provider visit from 11/22/23 to 3/8/23.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 16218 Based on observation, medical record review and interview, it was determined that the facility failed to ensure the accurate documentation and accounting of a controlled medication. This was found to be evident for 1 of 2 medication carts reviewed during the survey. The findings include: Review of Resident #138's medical record, on 7/3/24 at approximately 2:00 PM, revealed an order that was in effect since 6/28/24 for Lacosamide Oral Solution 100 mg/10 ml Give 20 ml via g-tube two times a day for seizure for 30 days. Lacosamide, also known as Vimpat, is an anticonvulsant medication. It is classified as a schedule 5 controlled substance. Review of the Controlled Substance Administration & Accountability policy, with a revision date of 12/1/23, included: 3. Ordering and Receiving Controlled Substances: e. The medications delivered are immediately recorded on the appropriate drug disposition record and stored in the controlled drug storage area by the nurse accepting delivery. On 7/3/24, review of the Medication Administration Record (MAR) revealed documentation that Lacosamide was administered to the resident on nine occasions since 6/28/24. The medication was not administered when due on 7/1/24 with a documentation of 9, indicating see nurse's note. Review of the corresponding nursing note revealed: Med on transit from pharmacy. On 7/3/24 at 1:08 PM, review of one of the two medication carts on the skilled unit, with nurse (Staff #12), revealed a bottle of lacosamide oral solution with a label indicating it was for Resident #138. Review of the Controlled Mediation Utilization Record (Control Sheet) that Nurse (#12) indicated corresponded to the lacosamide, failed to include the name of the medication or the name of a resident. This Contol Sheet included documentation of a total of two doses, the removal of one dose on 7/2/24 and the second dose on 7/3/24. Both of these doses were documented as removed by nurse (Staff #12). On 7/3/24 at approximately 1:10 PM, the nurse (Staff #12) reported that the Lacosamide medication was brought in by the family and confirmed it was not delivered or provided by the facility's pharmacy. Nurse (Staff #12) also stated that she had called the pharmacy and it still was not delivered. Further review of the medical record revealed that the original Lacosamide order was discontinued on 7/3/24 at 12:53 AM, with a new order put in place to start on 7/3/24 at 9:00 AM, that included May administer medication from [name of pharmacy (#42)] pharmacy until [name of facility's pharmacy (#41)]Pharmacy delivers. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 2:04 PM the unit nurse manager (Staff #14) provided surveyor a copy the Control Sheet which had been updated. This updated sheet revealed the following was hand written in: [Name of Resident #138] Lacosamide Oral Solution Give 20 ml by g-tube 2 times a day. This form failed to include the strength of the medication or the total amount that was originally distributed. On 7/3/24 review of the Unavailable Medications policy, with a revision date of 1/1/24, revealed: 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication.; b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold.; c. Determine whether resident has home supply. Only obtain and use medications that are packaged without evidence of tampering and are labeled with the resident's name, medication name and strength, route, and directions for use. The label should match the physician order. Further review of the medical record failed to reveal documentation to indicate the primary care provider was made aware that the facility's pharmacy had not provided the ordered medication prior to the updated order on 7/3/24. On 7/3/24 at 2:29 PM the [NAME] President of Clinical Operations (Staff #20) reported she was aware of the issue regarding a bottle of Vimpat with no information on the narcotic sheet [Controlled Medication Utilization Record]. Staff #20 went on to report that the the Director of Nursing (DON) was currently investigation the issue and that the nurse was reporting the family brought it in on Friday (6/28/24). On 7/8/24 at 11:16 AM the DON reported that the employees were unaware that the Vimpat was a narcotic (i. e. a controlled substance) and were not aware that it came from home. She went on to report that they have educated the staff to check the electronic health record system to determine what type of medication it is, stating that when entered, or signed, a C will come up to indicate the medication is a controlled substance. The DON also reported that the facility pharmacy has since supplied the medication. And confirmed that the family had brought the previous supply in to the facility directly from the [name of pharmacy (#42)]. Review of the Narcotic and Controlled Substance Shift-To-Shift Count Sheets revealed the following statement: All resident supply AND emergency supply controlled substances must be counted at every shift change. Review of the Shift-To-Shift Count Sheets revealed documentation that two nurses completed the count of the controlled substances at each of the shift changes from 6/28/24 through 7/3/24. During the 7/8/24 interview with the DON, the surveyor reviewed the concern that multiple staff had conducted the Shift-To-Shift Count, but had not identified or addressed the issue with the Vimpat. The DON acknowledged the concern. The DON provided documentation of education that had been provided since this issue was identified on 7/3/24 as well as an updated policy regarding Unavailable Medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Unavailable Medications policy, with a revision date of 7/5/24, revealed it was updated and now included: 4.c. Determine whether resident has home supply. Obtain orders to use home supply. Administer first dose after the medication is determined to be in the original dispensed packaging that is not tampered with, labeling includes the resident's name, name of medication, and instructions for administration. If a controlled substance, a countdown sheet will be added to the facility's method of controlled substance documentation records.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45139 Based on medical record review and staff interview, it was determined that the facility 1) failed to ensure that psychotropic medication was prescribed as needed (PRN), had an end date, and 2) failed to ensure that a resident who received psychotropic medication was monitored for behaviors and side effects. This was evident for 1 (#35, #64) of 5 residents reviewed for unnecessary medications. The findings include: 1) As needed (PRN) orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the extended PRN order. On 6/20/24, the records of Resident #35, a long-term resident of the facility, were reviewed. Review of Residents # 35's physicians orders revealed an order for Lorazepam, oral concentration 2mg/ml. Give 0.2ml by mouth, every 6 hours, as needed for anxiety. The order for Lorazepam had a start date of 8/17/23. Continued review revealed that the order was not limited to 14 days and did not have a discontinuation date. Review of the medical record failed to reveal that the physician documented a rational for continuing the order beyond 14 days. On 6/20/24 at 10:18 AM, the monthly pharmacy medications reviews from June 2023 through 6/17/24 were reviewed. The review revealed the following: on 9/7/23, 1/5/24 and 3/7/24, the pharmacist noticed the same irregularities and reported the irregularities along with his recommendations to the physician via a document titled, Note to Attending Physician/Prescriber. On 6/20/24, the facility provided the above-mentioned document: Note to Attending Physician/Prescriber for 9/7/23, 1/5/23 and 3/7/24. Further review of these documents revealed that the pharmacist determined that Resident #35 had an order for PRN Lorazepam without a stop date and there was a 14-day limitation on all PRN orders. After this period, a PRN psychotropic order may be extended beyond 14 days, if the provider documented the appropriateness of the extension and provided a specific duration of use. On 6/21/2004, a review of the Note to Attending Physician/Prescriber revealed a space for the physician to document his response to the pharmacist recommendations. Further review of the physician's response revealed that he maintained the Lorazepam order. It was prescribed as needed without a stop date, not limited to 14 days. Additional review failed to reveal that the physician documented a rational for continuing the order beyond 14 days in his written response to the pharmacist's recommendations dated 9/7/23, 1/5/24 and 3/7/24. On 6/25/24 at 8:38 AM, the pharmacy recommendations and the Physicians response provided in the Note to Attending Physician/Prescriber were discussed with the administrator. He reported he understood the concern and did not have any additional comments. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37276 2) 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, transferred to an acute care facility on 5/1/24, then readmitted in late May 2024 with diagnoses which included depression. Review of Resident #64's June 2024 MAR revealed a 5/22/24 order for Mirtazapine (Remeron) (antidepressant) tablet by mouth at bedtime for depression that was documented as given every day as ordered from 6/1/24 - 6/19/24. Continued review of the resident's medical record failed to reveal evidence that the facility staff monitored Resident #64 for changes in behaviors that necessitated the use of the psychotropic medications or for side effects related to the use of psychotropic medication. The record also failed to reveal that the facility conducted ongoing monitoring of the resident for resident specific behaviors for which the antidepressant had been prescribed and failed to monitor for side effects. In addition, continued review of Resident #64's care plans failed to reveal a care plan that addressed the resident's use of Remeron or the behaviors for which the antidepressant had been prescribed. The above concerns were discussed with the Director of Nurses (DON) on 6/21/24 at 11:02 AM. The DON acknowledged the concerns at that time, and stated the concerns with failing to monitor residents receiving psychotropic medications for behavior, was recently identified, brought to the company's attention, and she wasn't sure they had gotten to Resident #64 yet.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 16218 Based on observation, medical record review and interview, it was determined the facility failed to maintain a medication error rate of less than 5%. This was found to be evident based on 2 errors identified out of 26 opportunities for error. The findings include: 1) On 6/20/24 at 8:55 AM, surveyor observed nurse (Staff #35) prepare and administer Resident #36's medications. The nurse prepared a total of 10 medications, two of which were lidocaine patches. The nurse was observed applying one lidocaine patch to the resident's right knee and one lidocaine patch to the left knee. No other lidocaine patches were observed being administered at this time. After the administration, the nurse confirmed she signed off a total of 10 medications, stating there were two separate orders for the two lidocaine patches. On 6/20/24 at 10:09 AM review of the medical record revealed there was one order, with a start date of 1/30/24, for Lidoderm Patch 5% apply to both knees, R.[right] thigh/groin topically one time a day for pain management and remove per schedule. There was another order for a Lidoderm Patch, but this order, dated 1/11/24, was for Lidoderm Patch 5% apply to left lower back topically one time a day for pain management. Review of the Medication Administration Record (MAR) revealed one area for staff to document the administration of the patches to the knees and the right groin area (one sign off for all three ordered patches) and one area to document the patch to the left lower back. Nurse (Staff #35) had documented in both these areas, indicating she had administered the patches to the knees as well as one to the left lower back, when due at 9:00 AM on 6/20/24. On 6/20/24 at 10:35 AM, when asked about any other lidoderm patches for Resident #36, Nurse (Staff #35) indicated the resident had an as needed order for one on his/her back. The nurse confirmed she did not apply the patch to the resident's back today, stating: [s/he] did not ask. The surveyor then reviewed the concern with the nurse that the order does not indicate it was a prn [as needed] order and that the nurse had documented that she applied the patch to the back as ordered. On 6/21/24 at 11:33 AM, the surveyor reviewed with the Director of Nursing the medication error of failure to administer the lidocaine patch to the resident's back as ordered. 37276 2) On 6/24/24 at 9:21 AM, during an observation of medication administration, the surveyor observed Staff #12, LPN (licensed practical nurse) dispense 2 pills into a medication cup and administer the pills to Resident #34. One of the pills dispensed and administered was multi-vitamin (MVI) with minerals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the medication observation, a review of Resident #34's June 2024 Medication Administration Record (MAR) revealed a 2/12/23 physician's order for Multivitamin Oral Tablet (multiple vitamin), give 1 tablet by mouth one time a day for supplement which was documented as given at 9:00 AM on 6/24/24. Resident #34's physician order was for a multi-vitamin that did not include minerals. The medication administered to the resident contained minerals and was not the same formula as ordered by the physician. The Director of Nurses was made aware of the above findings on 6/24/24 at 2:25 PM and offered no comments at that time. On 6/24/24 at 2:29 PM, Staff #12 was made aware that a medication error occurred when the nurse failed to follow the physician's order to administer one multi-vitamin tablet by mouth and instead administered a multi-vitamin with minerals tablet to Resident #34. Staff #12 acknowledged the concerns at that time, and indicated the multi-vitamins were a stocked item and the stock medication provider would be notified and asked to provide multi-vitamins without minerals.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on observation, medical record review and interview, it was determined the facility failed to ensure a resident was free from a significant medication error. This was found to be evident for 1 (#36) of 26 residents observed for medication administration. The findings include: Review of Resident #36's medical record revealed that the resident was admitted in 2023 and whose diagnosis included, but was not limited to, rheumatoid arthritis. Review of the 1/10/24 physician progress note revealed an assessment of left back pain and a plan to order lidocaine 5% to left lower back. A corresponding order, dated 1/11/24 for Lidoderm Patch 5% apply to left lower back topically one time a day for pain management was also found. On 6/20/24 at 8:55 AM, surveyor observed nurse (Staff #35) prepare and administer Resident #36's medications. The nurse prepared a total of 10 medications, two of which were lidocaine patches. The nurse was observed applying one lidocaine patch to the resident's right knee and one lidocaine patch to the left knee. No other lidocaine patches were observed being administered at [NAME] time. After the administration, the nurse confirmed she signed off a total of 10 medications, stating there were two separate orders for the two lidocaine patches. On 6/20/24 at 10:09 AM, review of the medical record revealed two current orders for lidoderm patches. There was one order, with a start date of 1/30/24, for Lidoderm Patch 5% apply to both knees, R.[right] thigh/groin topically one time a day for pain management and remove per schedule. The other order, for Lidoderm Patch 5% apply to left lower back topically one time a day for pain management was still in effect since originally ordered in January 2024. Review of the Medication Administration Record (MAR) revealed one area for staff to document the administration of the patches to the knees and the right groin area (one sign off for all three ordered patches) and one area to document the patch to the left lower back. Nurse (Staff #35) had documented in both these areas, indicating she had administered the patches to the knees as well as one to the left lower back, when due at 9:00 AM on 6/20/24. On 6/20/24 at 10:35 AM when asked about any other lidoderm patches for Resident #36, Nurse (Staff #35) indicated the resident had an as needed order for one on his/her back. The nurse confirmed she did not apply the patch to the resident's back today, stating: [s/he] did not ask. The surveyor then reviewed the concern with the nurse that the order does not indicate it is a prn [as needed] order and that the nurse had documented that she applied the patch to the back as ordered. On 6/21/24 at 11:33 AM surveyor reviewed the concern with the Director of Nursing (DON) regarding staff documenting the administration of a lidoderm patch to a resident that was not actually administered and the staff's report that the order was for it to be given as needed. The DON reported she has been told the staff was nervous when she reported that. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the MAR revealed that staff had documented the administration of the lidoderm patch to the resident's back every morning from 6/1/24 thru 6/20/24. Nurse (Staff #35) documented the administration of the patch to the resident's back on 15 out of these 20 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on observation and interview, it was determined that the facility failed to ensure medications were stored in accordance with acceptable professional standards. This was found to be evident on two out of two nursing units. The findings include: 1) On 6/20/24 beginning at 6:12 AM, an observation of the night shift medication pass was made. On 6/20/24 at 6:15 AM, an observation was made of med cart #1 on the first-floor nursing unit. Observation revealed a vile of insulin resting on top of the cart. On 6/20/24 at 6: 20 AM, an observation of medication cart #2 revealed 2 clear plastic bins laying on top of the medication cart. One of the plastic bins was labeled team 2 and the other one was labeled team1. Further observation revealed the bins contained Insulin medications, including vials and insulin pens. On 6/20/24 at 6:21 AM, LPN nurse Staff #10 was interviewed. During the interview Staff # 10 reported that the bins contained insulin, and they were separated by teams. After showing the surveyor the 2 bins (containing the insulin), she placed them back on top of the med cart. On 6/20/24 at 6:28 AM, an observation of Staff #10 was made. The observation revealed Staff #10 placing the 2 bins containing insulin on the top of medication cart 1 and then Staff #10 walked around the corner to medication cart #2 unlocked that cart, retrieved an item, and then locked the cart. Medication cart #1 was around the corner and out of sight of Staff #10 when she was located at medication cart #2. On 6/20/24 at 6:30 AM, an observation was made of staff #10 walking into room [ROOM NUMBER] and closing the door. Further observation revealed that the 2 bins of insulin remained on top of the medication cart unlocked, in the hallway. On 6/20/24 at 6:31 AM, a second observation was made of staff nurse #10 entering a resident's room while the 2 bins containing insulin remained of top of the medication cart #1 On 6/20/24 at 6:33 AM, an observation was made of Staff #10 leaving the medication cart #1 and walking down the hall with the Director of Nursing (DON) with her back towards the medication cart. On 6/20/24 at 6:34 AM, the surveyor and DON observed the medication cart #1and the 2 bins, containing insulins, on top of the cart. On 6/20/24 at 6:35 AM, during a brief interview, DON reported that it was not facility policy to leave medications of top of the medication cart, unlocked and unmonitored. On 6/20/24 at 6:36 AM, an observation was made of the DON instructing the nurse to maintain medications in a secure location for the safety of the residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 8:21AM, the DON provided the facility's Policy titled Medication Storage. Review of the policy revealed that all drugs and biologicals will be stored in locked compartments (i.e., medication carts cabinets, drawers, refrigerators, medications room) under proper temperature controls. 16218 2) On 7/3/24 at 1:16 PM review of the long term care unit Team 1 medication cart with nurse (Staff #37) revealed a vial of ceftriaxone for Resident #68 with a date of 5/17/24. The nurse reported that it needed to be sent back to the pharmacy. Ceftriaxone is an antibiotic. After the observation review of the medical record confirmed that the resident had a one time only order for an injection of ceftiaxone on 5/17/24. 3) On 7/3/24 at 12:38 PM, observation of the medication storage room refrigerator, on the skilled unit with the unit nurse manager (Staff #14), revealed one levemir (insulin) pen with no resident name on it that the unit manager reported was brand new; one insulin lispro injection kwick pen, with a date of 5/31/24, but no resident name; and one Trulicity injectable with no resident name. 4) On 7/3/24 at 1:08 PM review of one of the two medication carts on the skilled unit, with nurse (Staff #12), revealed a Controlled Mediation Utilization Record (Control Sheet) that failed to include the name of the medication or the name of a resident. This sheet did include documentation of the removal of one dose on 7/2/24 and one dose on 7/3/24. Both of these doses were removed by nurse (Staff #12). When asked about this Control Sheet, Staff #12 showed surveyor a bottle of lacosamide oral solution with a label indicating it was for Resident #138. The nurse (Staff #12) reported this medication had been brought to the facility by the family. Lacosamide, also known as Vimpat, is an anticonvulsant medication. It is also classified as a schedule 5 controlled substance. Cross reference to F 755.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 45139 Based on interviews and pertinent document reviews, it was determined that the facility failed to provide a resident with dental services while he/she was a long-term resident at the facility. This was evident for 1 (#53) of 4 reviewed for dental during a survey. The findings include: On 6/17/24 at 12:05 PM, Resident # 53, a long-term resident of the facility, was interviewed. During the interview, S/he reported she had not been provided dental services during her stay at the facility. On 6/18/24 at 11:33 AM, a second interview was conducted with Resident # 53. S/he reported that s/he had purchased dental insurance offered to residents, while she was a resident at the facility. In addition, s/he reported s/he had requested dental appointments in the past, but had not seen a dentist since her admission to long-term care. On 6/20/24 at 3:57 PM, a review of the electronic medical records failed to reveal that Resident # 53 had a dental appointment while in the facility. On 6/21/24 at 7:50 AM, a review of orders for Resident #53 revealed an order with a start date of 6/17/24 Consults: Dental care as needed as needed. Continued review of Resident #53 previous or discontinued orders failed to reveal any order for dental consult prior to 6/17/24. On 7/09/24 at11:50 AM, during an interview with the Business Office Manager Staff #50, she reported that Resident $53 enrolled in the dental insurance coverage,on 2/10/23. Staff #50 confirmed that the dental provider provides dental services at the facility. 07/09/24 at 11:39 AM, the Administrator was interviewed regarding the dental services provided to the facility by an outside provider. During an interview, the administrator reported that the dental provider comes to the facility every 2 months to provide dental services to the resident. Once a resident enrolls in the dental coverage, they are placed on a schedule for visits. He reported this does include routine preventive examinations. In addition, he reported additional appointments would be made as needed. The administrator reported he would provide documentation of any dental appointments prior to June 2024. He did provide documentation that the resident was scheduled to receive dental services the next time the dentist visited the facility. On 7/11/24, the administrator failed to provide any documentation that the resident received any dental services while at the facility prior to the end of survey.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48259 Based on observation, record review, and interviews, it was determined that the facility 1) failed to ensure that a resident was served a meal according to a predetermined menu that incorporated the resident's preferences, and 2) failed to evaluate a resident prior developing a resident's therapeutic diet, resulting in the residents food preference not being considered. This was evident for 2 (#24, #57) of 4 residents reviewed for food during the survey. The findings include: 1) An observation made on 6/17/24 at 12:10 PM of Resident #24's untouched breakfast tray on his/her bedside table. It contained a bowl of oatmeal, three slices of toasted bread, three sausages, and scrambled eggs. The observation also noted a meal ticket on the tray that stated, standing orders-8oz [ounces] coffee, milk low fat. The resident said, I'm supposed to get milk and coffee with all my meals, but as you can see, I don't get it. A medical record review on 6/17/24 at 12:12 PM showed that Resident #24 was admitted to the facility in July 2022, alert, oriented, and able to communicate needs verbally. During an interview on 6/17/24 at 12:15 PM, staff #31, a geriatric nurse aid, reported that there was no milk when she brought Resident #24's breakfast tray to him/her. Staff #31 stated that the kitchen had said they were out of milk and did not have a cup for the resident's coffee. In an interview on 6/26/24 at 12:00 PM, staff #32, a corporate food service manager stated that standing order on the menu ticket meant that the resident should receive those food items for every meal. However, an earlier observation failed to show that Resident #24 received coffee and milk on his breakfast tray on 6/17/24. In a subsequent interview on 6/26/24 at 12:59 PM, staff #32 stated that he could not answer why Resident #24 had no coffee or milk on his/her breakfast tray on 6/17/24. 45139 2) On 6/17/24 at 3:01 PM, Resident #57, a long-term resident of the facility was interviewed. S/he reported that S/he is served puree food and is not sure why. He was told he had a swallowing issue but reported he had never had swallowing issues in the past. On 6/21/24 at 10:12 AM, a review of Resident #57 physician orders dated 2/20/24, revealed that the resident was on a regular diet with Puree texture. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 10:58 AM, The supervisor Speech Therapist (SLP) Staff #21 was interviewed regarding procedure to downgrade a diet. She reported that a nurse or physician can downgrade a diet for safety reasons. For example, a nurse can put a resident on a puree diet that had previously been on a regular diet. After a Residents diet is downgraded to puree, a referral is made to the SPT indicating that a diet is downgraded. The SPT would then complete an evaluation to determine the proper diet consistency. The SPT recommendations then would have been forwarded to the physician. On 6/26/24 at 11:05 AM, continued interview with Staff #12 regarding the resident's discharge summary, from a hospital stay Feburary 2024, documentation revealed that the Resident # 57 was Dysphagia for solid. Staff # 21 reported that if a resident is discharged with that documentation SLP would still need to complete an evaluation to determine the texture diet the resident would continue with at the facility. On 7/10/24 at 11:07 AM, Phone interview with remote Dietician Staff #15. He reported that he had worked remotely and his contact with the Resident #57 was via phone. He reported that he did evaluate Resident #57 prior to his diet recommendation. He reported his evaluation included a chart review, speaking with the nursing staff and speaking with the resident for about 2-3 minutes. He reported he did not speak to the SLP but reviewed documentation in the resident's chart. He reported he did not review any swallow evaluation for Resident #57. On 6/20/24 the facility provided Resident#57 most recent speech therapy swallowing evaluation. Review of the evaluation revealed that the resident's clinical bedside assessment of swallowing dated 8/31/23 documented that resident was assessed for a regular texture, mechanical soft. Chopped textures. The facility failed to provide a speech therapy swallowing evaluation after Resident #57 diet was downgraded on On 7/10/24 at 12:30 PM, The above concerns were shared with the administrator. He reported that Resident #57 received speech therapy services which included a swallow study on 6/19/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48259 Based on observations and interviews with facility staff, it was determined that the facility failed to store food in accordance with professional standards. This deficient practice has the potential to affect all residents. The findings include: 1) During an initial tour on 6/17/24 at 8:52 AM of the facility's walk-in refrigerator with staff #32, corporate food services manager, the following observations were made: - an opened thickened lemon-flavored water with an open date of 6/10/24 and a use-by date of 6/17/24. Staff #32 stated that once opened, the thickened water must be used in 5 days. Staff #32 then said, I will discard it. - an opened cranberry cocktail juice from concentrate with an expiration date of 9/12/23; staff #32 stated, I will discard it. - an opened thickened apple juice from concentrate, dated 5/24. Staff #32 stated that it was delivered on 5/24. However, it did not indicate an open date or use-by date. Staff #32 stated it should have an open date and use-by date. - opened thickened pomegranate flavored water with no open date and use-by date. - opened thick and easy milk dated 2/7. Staff #32 indicated 2/7 was the delivery but should also have an open and use-by date. - sliced American cheese in a zip-lock bag dated 6/8/24 and a use-by date 6/30/24. Staff #32 stated it should say use by 6/29/24 because we keep it for 21 days from the open date. - sliced ham labelled 6/8/24, and use by 6/30/24. Staff #32 stated, The use-by date should have been 6/22/24. - opened gold medal heavy duty (1 gallon) mayonnaise and not dated; staff #32 stated, It has no open or use by date. - sweet pickle relish (1gal) labeled opened 5/1 and had no use-by date. Staff #32 stated that it should have been thrown away on 6/1. - Half-cut fresh tomato and lettuce in saran wrap had no use-by date. Staff #32 stated, It's not fresh. Every fresh produce should be dated from the date we received it, and we have two weeks from that date to use it. I will discard them. - Cabbage in a box with no use-by date; staff #32 stated it should have been dated with a use-by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) On 6/24/24 at 9:22 AM, the surveyor observed the short-stay unit snack/refreshment refrigerator. The observation revealed pineapple slices in a plastic container not labeled with an open date or use-by date. Staff #22, a registered nurse, was present and stated, It's for a resident; it should have been labeled and dated. 3) An observation on 6/24/24 at 9:51 AM of the long-term care Unit snack/refreshment refrigerator with staff #13, a unit manager showed the following: -opened Thickened pomegranate berry flavored water with an open date of 5/29/24. Staff #13 stated he does not know how long it should be kept once opened. -cake in a gift bag with no use-by date. Staff #13 stated, It's from a family, but it has no date. Before staff take it and put it in the fridge, they should date it. -opened pineapple slices in a container with no date opened. Staff #13 stated, It's for a resident; it should have been labeled and dated. In an interview on 6/24/24 at 9:41 AM, staff #14, the unit manager for the skilled unit, stated that foods to be kept in the snack/refreshment refrigerators had to be labeled, dated, and discarded after three days. In a subsequent interview on 7/1/24 at 1:05 PM, staff #39, the General manager for food services, stated that they labeled the food items when they were to expire upon receiving them. Staff #39 added that the kitchen refrigerators were checked daily to see what items were due to be discarded.

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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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	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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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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48259 Based on observations, record review, and interviews, it was determined that the facility failed to 1) wear proper personal protective equipment (PPE) before giving direct care to a resident with an indwelling foley catheter and an open wound, 2) store a nebulizer mask in a sanitary manner to prevent the spread of infection. This was evident for 1 (#286) of 2 residents reviewed for respiratory care. The findings include: 1) An observation on 6/17/24 at 11:24 AM noted a signage on Resident #286's door that indicated Resident #286 was on enhanced barrier precautions, which required wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions are infection control interventions designed to reduce transmission of infection in nursing homes. It involves gown and glove use during high-contact Resident care activities like dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with central line, urinary catheter, feeding tube, tracheostomy, or any skin opening requiring dressing. Continued observation found that the Resident had used an indwelling Foley catheter. During a subsequent observation on 6/27/24 at 10:00 AM, staff #27, a geriatric nurse aide, was noted providing direct care to Resident #286. Staff #27 had put on gloves, however, the observation failed to show that staff #27 wore a gown. A medical record review later that day contained an admission evaluation assessment that noted Resident #286 was admitted with open wounds to the sacral and left hip areas. Further review found an attending provider's order to change dressing daily to Resident #286's left hip wound. The review also noted an MDS assessment, dated 6/7/24, which recorded that Resident #286 required maximal assistance or depended on staff for most of his/her self-care needs. In an interview on 6/27/24 at 10:02 AM, staff #27 stated she would typically put on a gown before direct contact with Resident #286, however, she forgot to wear it before providing care to the Resident. During a subsequent interview on 6/27/24 at 11:48 AM, the director of nursing was informed of the concern that staff was not wearing a gown during direct contact with Resident #286. The DON responded that staff #27 had already notified her of the concern. 2) On 6/17/24 at 11:37 AM, Resident #286 was observed wearing oxygen through a nasal cannula tubing attached to an oxygen concentrator set at 2L(Liters). The observation also found a nebulizer mask dated 6/12/24 lying bare on top of a nebulizer machine without any covering. A nebulizer is a small machine that turns liquid medicine into a mist to be inhaled through a mouthpiece or mask and enters the lungs directly. After use, the mask or mouthpiece is washed with mild soap, rinsed under running water, dried on paper, and kept in a sealable plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review, on 6/17/24 at 12:50 AM, showed that Resident #286 was admitted to the facility in May 2024 with diagnoses including acute hypoxemic respiratory failure (acute hypoxemic respiratory failure is a condition where the body does not have enough oxygen in the tissues of the body). A continued review found Resident #286's order summary report for June 2024 contained an attending provider's order, dated 6/1/24, for ipratropium-albuterol inhalation Solution via nebulizer four times a day for shortness of breath. In an interview on 6/17/24 at 1:50 PM, staff #38, a licensed practical nurse, stated that the mask should have been kept in a plastic bag after use and that she would discard it immediately after the surveyor's intervention. In a subsequent interview on 6/25/24 at 10:25 AM, the assistant director of nursing said the nebulizer mask was expected to be rinsed, dried, and kept in a plastic bag after each use to prevent infection