STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215054	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towson Rehabilitation and Healthcare Center	509 East Joppa Road Towson, MD 21286

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 34484 Based on interview and medical record review, it was determined the facility staff failed to provide a resident a copy of the resident's medical record in a timely manner (Resident #15). This was evident for 1 of 36 residents reviewed during a complaint survey. The findings include: The Surveyor began on 5/17/24 a review of a complaint regarding a delay in obtaining a copy of the medical records for Resident #15 that was requested on 3/28/24 and still had not been received as of 5/17/24. Review of Resident #15's medical record on 5/17/24 revealed the Resident was discharged from the facility on 2/6/23. The Resident's representative provided to the Surveyor on 5/17/24 the request that was sent to medical records on 3/28/24 signed by the Resident for a copy of all the medical records during the Resident's stay at the facility. On 5/20/24 at 8:00 AM the Director of Nursing provided the Surveyor the closed record for Resident #15. During interview with Medical Records, Staff #22, on 5/20/24 at 9:18 AM, Staff #22 stated she did receive the request dated 3/28/24 for Resident #15's medical records but because the facility is now owned by a different company she forwarded the request to Corporate as she had been instructed to do. Staff #22 stated she never heard anything else about the request. Interview with the Director of Nursing on 5/21/24 at 9:04 AM confirmed the facility staff failed to provide a copy of Resident #15's medical records as requested by the Resident in a timely manner.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to notify the resident representative and physician of a change in condition. This was evident during the review of a complaint for 1 of 3 residents (#4). The findings include: Review of the complaint #MD00169562 on 5/14/24 at 11:39 revealed concerns related to the notification of a significant weight loss that occurred with a family member that was residing in the facility. Review of the medical record for Resident #4 on 5/14/24 at 11:39 AM revealed medical diagnosis including congestive heart failure and atrial fibrillation. Further record review revealed an initial order to notify the physician for weight gain of 5 lbs or more related to the congestive heart failure. On 6/8/21 the resident physician ordered Metolazone, a diuretic, (used to treat conditions like high blood pressure, edema, and heart failure, help the body get rid of extra fluid and salt by making the kidneys remove water and salt through urine. This lowers the amount of fluid flowing through the veins and arteries) to be administered concurrently with already ordered Lasix, a diuretic. According to the physician progress note dated 6/22/21 the Metolazone was ordered as a 1-time dose related to the identified weight gain and shortness of breath documented on 6/7 with a weight gain from 221-225 lbs. A review of Resident #4's medication administration record (MAR) revealed that the Metolazone was administered from 6/7-6/14.Resident #4 was on weekly weights at the time related to the CHF. His/her weights went from 221 on 6/11/21 to 159 lbs. on 6/16/21 during the time of the Metolazone administration. The facility dietitian staff #3 was interviewed on 5/14/24 at 1:36 PM and again followed up with an interview on 5/15/24 at 8:17 AM. The physician order and for the Metolazone and the weight loss was reviewed.The provided physician note dated 6/22/21 regarding Resident #4's admission and care stated that the Metolazone was a 1x dose was reviewed. The physician note also only stated about the reported weight gain not the significant weight loss that had occurred prior to the 6/22/21 note. Staff #3 concurred at that time that the order for Metolazone stated 1 time dose. She stated that the Metolazone is usually ordered for 5-7 days but concurred that the physician note did state it was for a 1-time dose. She also reported that there were no further dietary notes she could locate after the initial screening assessment completed on 5/28/21. According to the progress notes and assessments there were no change in condition reports or documents around the time of 6/14/21 regarding the significant weight loss of 62 lbs. and notification to the family or the physician. This identified concern was reviewed with staff #3 on 5/15/24 at 8:17 AM. The DON was also notified of the identified concerns on 5/15/24 and again during exit on 5/21/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference F757

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and interview it was determined that the facility failed to have a process in place to ensure that allegations of abuse were reported to the State Agency within the required 2-hour time frame and to ensure that the final report was sent to the State Agency within 5 business days. This was evident for 3 of 3 allegations of abuse reviewed. The findings include: 1) On 5/20/24 at 11:45 AM a review of the facility's investigation file for the facility reported incident #MD00205616 revealed an initial report form that read a police officer had come to the facility on [DATE] at approximately 7:30 PM and reported that they suspected sexual assault due to the findings of the physician's exam at the hospital. Further review revealed an email confirmation for the report sent to the state agency (SA) which read it had not been sent until 5/13/24 at 1:15 AM, 5 hours and 45 minutes after the facility was made aware of the allegation. There was no evidence of when the final investigation report had been sent to the SA. On 5/20/24 at 2:10 PM reviewed the findings with the Director of Nursing who offered no rationale for the late reporting. Subsequently, the Regional Nurse #23 came in during the interview and was made aware of the late reporting. 2) On 5/17/24 at 10:28 AM a review of the facility's investigation file for the facility reported incident #MD00198055 revealed a self-report form for an allegation of abuse which occurred on 10/1/23, however the remainder of the content was for an allegation of abuse that occurred on 5/26/23. A concern form was completed by Registered Nurse (RN) Staff #24 on 5/26/23 at 11:14 AM that documented Resident #19 reported to him that last night (5/25/23) on night shift the resident was eating a pack of crackers, which were dry and started coughing. When the resident put on his/her call light for assistance and to ask for water, the aide came in and turned the light out and walked away without helping. The roommate Resident #37 was present and reported that s/he put on their call light and two aides responded and then Resident #19 and the original aide started yelling at each other. Resident #37 also reported that the night shift nurse came in and spoke to Resident #19 after the incident. Statements were obtained from both residents and Geriatric Nursing Assistant (GNA) staff #25. However, there was no evidence that the incident had been reported to the state agency (SA). On 5/17/24 at 11:01 AM the surveyor reviewed the investigation file with the Director of Nursing (DON) and requested evidence that the allegation of abuse on 5/26/23 was reported to the SA. She stated she would look into it. As of 5/17/24 at 1:44 PM, the DON had not reported back to the surveyor. The Nursing Home Administrator (NHA) was interviewed. She reported that they had investigated the incident dated 5/26/23 but had determined that the resident had everything that s/he needed, and the investigation was closed out. When asked about the reporting of the allegation of abuse, she stated she had not determined abuse had occurred and did not report it. Facilities were required to report all allegations of abuse within 2 hours of being informed of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) A review of the facility's investigation file for the self-reported incident #MD00198055 on 5/21/24 at 9:25 AM revealed a self-report form that noted that Resident #19 had reported that a GNA on night shift had thrown the resident's dirty gown on the floor and then threw it in his/her face and was rough while providing care. Further review revealed a statement by Licensed Practical Nurse (LPN) #28, which read she was made aware of the allegation of abuse from Resident #19 on 10/2/24, after the GNA #26 made her last rounds of care. However, the email confirmation noted that the facility failed to report the allegation of abuse until 10/9/23 at 3:59 PM, 7 days after learning of the allegation. Also, there was no evidence that the final investigation was submitted to the SA. This was reviewed with the DON on 5/21/24 at 10:00 AM and she confirmed she had been involved with the investigation but was not the DON at the time this occurred. She offered no rationale for the late reporting of the incident. The NHA was not available for interview. Cross Reference: F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40927 Based on record review and interview it was determined that the facility failed to conduct a thorough investigation of allegations of abuse. This was evident for 3 of 3 allegations of abuse reviewed. The findings include: 1) A review of Resident #19's medical record on 5/17/24 at 9:25 AM revealed a quarterly MDS (minimum data set) with an assessment reference date of 7/14/23 that documented the resident had no cognitive impairment and the resident required extensive assist of 2 staff to provide care. On 5/17/24 at 10:28 AM a review of the facility's investigation file that was supposed to be for the facility reported incident #MD00198055. The file had the self-report form for the incident that occurred on 10/1/23, however the remainder of the content was for an allegation of abuse that occurred on 5/26/23. Registered Nurse (RN) Staff #24 completed a concern form on 5/26/23 at 11:14 AM that documented Resident #19 reported to him that last night (5/25/23) on night shift the resident was eating a pack of crackers, which were dry and started coughing. When the resident put on his/her call light for assistance and to ask for water, the aide came in and turned the light off and walked away without helping. Also, it was documented that the resident's roommate, Resident #37, reported that s/he put the call light on, and two aides responded. While attending to Resident #37 the aide and Resident #19 were yelling at each other. A statement was obtained from Resident #19 and the roommate Resident #37. A statement was obtained from Geriatric Nursing Assistant (GNA) Staff #25. However, they failed to obtain statements from the other staff who were duty at the time and residents who were on Staff #25's assignment, On 5/17/24 at 11:01 AM the surveyor reviewed the investigation file with the Director of Nursing (DON) and requested evidence that the allegation of abuse on 5/26/23 was reported to the SA. As of 5/17/24 at 1:44 PM, the DON had not reported back to the surveyor. The Nursing Home Administrator (NHA) was interviewed. She reported that they had investigated the incident dated 5/26/23 but had determined that the resident had everything that s/he needed, and the investigation was closed out. Reviewed with the NHA that the resident and the resident's roommate were both reporting that the resident was coughing/choking and put his/her call light on to ask for assistance, Staff #25 came in the room and turned the call light off without tending to the needs of the resident. She stated that Staff #25 wrote in her statement that the resident had water at the bedside. When asked if she had investigated to see if that was true, she confirmed she had not. Staff #25's statement did not say that the resident had water at the bedside. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the facility's investigation file for MD00198055 on 5/21/24 at 9:25 AM revealed a self-report form that read the resident had reported that a GNA took the resident's dirty gown that had been on the floor and threw it in the resident's face. Also, the GNA was rough during care. The self-report form noted, Pending investigation. According to the statements given by Resident #19, the resident reported that on 10/1/23 s/he had not been changed during the day shift. When the GNA on evening shift (later identified as Staff #26) came in to change the resident she had turned the resident on his/her right side which caused pain. A statement was given by the resident's roommate Resident #37, who stated she had overheard the resident telling the GNA she was hurting him/her. However, they failed to conduct interviews with other staff who may have had knowledge of the incident and residents who the GNA had been assigned to that day. Regarding the lack of care on 10/1/23 dayshift, a statement was obtained from the dayshift GNA and she reported that she had not been assigned to the resident that day. The assignment sheet noted that the GNA had been assigned to the resident the room number was handwritten on the bottom. On 5/21/24 at 1:50 PM the facility had emailed the surveyor the GNA documentation for 10/1/23 - 10/30/23. A review of the GNA documentation for 10/1/23 dayshift revealed no one had signed off that they had provided care for the resident that day. On 5/21/24 at 10:00 AM an interview with the DON, who had been involved in the investigation revealed she had no rationale for not interviewing all the staff and not interviewing the residents. She confirmed she had not been aware that the resident preferred not to be turned on their right side before this complaint. She stated she thought that GNA Staff #26 was disciplined for not providing care to Resident #19 during the dayshift on 10/1/23, however there was not evidence of the discipline in the employee file. Cross Reference: F609 37586 3) On 5/16/24 at 10:26 AM a medical chart review and incident report were reviewed for abuse. Resident # 19 reported to staff member # 14 on 5/26/2023 that a GNA (Geriatric Nursing Assistant) who was caring for Resident # 19 threw a box of tissue at the resident. Resident #19 reported this happened a couple of months ago. Staff nurse #14 failed to report this information to the facility or DON until later. Staff #14 was interviewed on 5/16/24 at 11:25 AM. Staff # 14 was not able to identify the GNA responsible for this alleged incident, but stated she was an agency GNA and he/she never saw her/him again. When staff #14 reported this, DON (Director of Nursing) educated Staff # 14 on reporting an incident late and provided education on abuse and resident rights. Based on interview with the DON on 5/16/24 at 11:00 AM, the Director of Nursing revealed that she never filed a complaint with the agency the GNA worked for and chose not to find out who the agency GNA was, that was scheduled to take care of Resident # 19. Therefore there was no statement from the GNA. DON stated she would try to find out who the GNA was at the time of the incident but may be hard as this incident is over a year old. No further information was given.

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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. 34484 Based on medical record review and interview the facility staff failed to 1.) follow physician orders for a resident in a timely manner (Resident #15); and 2.) failed to administer care to a resident when in distress (Resident #30). This was evident for 2 of 36 residents reviewed during a complaint survey. The findings include: 1a) Review of Resident #15's medical record on 12/17/22 revealed the Resident was admitted to the facility for rehabilitation on 11/23/22 following a spinal surgery. Further review of Resident #15's medical record revealed the Resident went to a follow up infectious disease and orthopedic appointment on 12/8/22. Review of the Consultation Report dated 12/8/22 revealed the physician ordered the Resident to start Clindamycin 300 mg three times a day. Clindamycin is an antibiotic used to treat infections. Review of Resident #15's December 2022 Medication Administration Record revealed Clindamycin was not started until 12/10/22, 2 days after the consult. 1b) Further review of Resident #15's medical record revealed the Resident went a follow up infectious disease and orthopedic appointment on 1/17/23. Review of the Consultation Report dated 1/17/23 revealed the physician ordered blood work to be completed every 2 weeks and faxed to the Consultant physician. Review of Resident #15's medical record revealed the Resident's last lab work was completed on 1/23/23 and therefore the Resident should have had blood work on 2/6/23. Further review of Resident #15's medical record revealed the Resident did not have laboratory orders or blood work completed for 2/6/23. Interview with the Director of Nursing on 5/21/24 at 9:04 AM confirmed the facility staff did not start the Clindamycin until 2 days after the 12/8/22 consult and did not obtain blood work on 2/6/23 for Resident #15. 37586 2) On 5/14/24, at 9 AM, a medical record review was conducted for Resident # 30 and revealed that on 1/28/24 the resident was in bed cutting his/her toenails, when they accidentally cut their left big toe. The toe was bleeding and according to resident, he/she tried several times to call nursing staff using the call bell but no one came to help them. Resident #30 called the receptionist # 13 to let her know he/she was calling 911 and that they needed help. EMS was called on 1/28/24 at 10:06 AM and responded. EMS found resident sitting on the bed with a towel wrapped around his/her foot. EMS reported a large amount of blood. The resident also stated he/she was on eliquis, which is a blood thinner. EMS applied pressure to the wound and got the cut to stop bleeding. The resident refused to go to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Receptionist staff # 13 was interviewed on 5/14/24 at 10 AM. Staff # 13 did not remember incident and cannot say whether or not she contacted unit manager or DON to get resident help. During an interview with the Director of Nursing on 5/14/24, at 11 AM she stated to the surveyor, she was unaware this happened until EMS spoke to her on 1/28/24. At that time she started an investigation.EMS did state he spoke with the DON (Director of Nursing) about the incident and the DON was unaware this happened.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 34484 Based on medical record review and interview, the facility staff failed to provide siderails as ordered by the consulting physician (Resident #15). This was evident for 1 of 36 residents reviewed during a complaint survey. The findings include: Review of Resident #15's medical record on 5/17/24 revealed the Resident was admitted to the facility following a spinal surgery for rehabilitation. Review of the hospital's Occupational Therapy (OT) note on 11/21/22 prior to discharge, the OT note stated the Resident was practicing rolling using bed rail. Further review of the Resident's medical record revealed the Resident went to a follow up orthopedic appointment on 12/8/22. Review of the Consultation Report dated 12/8/22 stated, Please apply bed rails so patient can work on pulling up or rolling. Interview with the Director of Rehabilitation (DOR) on 5/20/24 at 11:40 AM, the DOR stated the facility does not use siderails and thinks the facility gave the Resident a trapeze. Asked if the facility had any evidence of placing a trapeze and stated it would have been in old TELs system for maintenance but he doesn't have access to anymore. Further review of Resident's medical record revealed no evidence in therapy notes, orders or care plans of a trapeze put in place. There is also no evidence in the medical record of notification to the Consulting physician that the facility does not use bed rails to see if an alternative equipment would be acceptable. During interview with Resident #15's representative on 5/21/24 at 10:12 AM, he/she stated a trapeze or siderails was never put in place for the Resident. Interview with the Director of Nursing on 5/21/24 at 9:04 AM confirmed the facility staff did not install siderails for Resident #15 per the physician's orthopedic consult report.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30428 Based on medical record review and interview it was determined that the facility failed to prevent a known wandering resident from leaving the facility. This was evident for 1 of 6 (#18) residents reviewed for elopements. This failure resulted in an Immediate Jeopardy for Resident #18. After the elopement incident the facility developed, initiated and completed a plan of correction to prevent further elopements. Therefore, this deficiency will be cited as a past non-compliance. The date of correction was 5/27/2023. The findings include: Review on 5/16/24 at 9:59 AM of the facility reported incident MD00192701 revealed that on 5/19/23, Resident #18 eloped at approximately 9:15 AM. Record review on 5/16/24 at 10:10 AM revealed Resident #18 had a diagnosis of Parkinson's disease of which s/he had been refusing medication, delirium, and dementia with behavioral disturbances. A wander guard was placed on Resident #18 upon admission. Further review of the facility report revealed that Resident #18 was able to leave the facility undetected, and was found by police 5 hours later at a hotel approximately 14 miles away. The facility report further noted that upon the resident return to the facility, his/her wander guard bracelet, that was located on the resident's wrist prior to the elopement was checked for functioning and it was working, even alarmed upon reentry to the facility, however, it did not alarm when s/he left the facility. A new wander guard was placed on Resident #18's ankle, the care plan was updated, and staff education was completed related to elopement procedures. Additionally, the facility report and nursing progress notes stated that on readmission, Resident #18 refused any assessment, became aggressive, and combative, and was sent to the hospital for further treatment and evaluation. According to the facility report and investigation, the receptionist, staff #16 stated that she thought Resident #18 was a visitor and opened the door for him/her to leave with other visitors. Further, according to the incident report, when Staff #16 was interviewed about Resident #18 and the incident, she stated that she was unaware of the elopement binder that had the resident's picture and information in there. Review on 5/17/24 at 9:44 AM revealed that upon hire, staff #16 was educated on the facility elopement procedures, including the elopement binder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was interviewed on 5/17/24 at 8:22 AM and she provided the survey team with training, education, and interventions that were completed related to the elopement for Resident #18. The changes and intervention implementations completed by 5/27/23 after the occurrence on 5/19/23 included: Staff re-education on the elopement process and procedures and education related to the elopement binder at the front desk. Additionally, there are daily checks completed on the exit doors. According to the TELS (an electronic communication with maintenance and work order tracking) logbook documentation provided on 8:20 AM at 5/17/24, the operation of the door monitors and patient wandering systems are checked daily and all noted as pass. Based on the above actions taken by the facility and verified by the surveyor on-site, it was determined that the facility had corrected the deficient practice by 5/27/23, prior to the start of the survey.

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	215054	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towson Rehabilitation and Healthcare Center	509 East Joppa Road Towson, MD 21286

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 30428 Based on medical record review and interview with facility staff, it was determined that the facility staff failed to appropriately order and administer a medication. This was evident for 1 of 36 (#4) residents reviewed during a complaint survey. The findings include: Review of the complaint #MD00169562 on 5/14/24 at 11:39 revealed concerns related to the notification of a significant weight loss that occurred with a family member that was residing in the facility. Review of the medical record for Resident #4 revealed medical diagnosis including congestive heart failure and atrial fibrillation. Further record review revealed an initial order to notify the physician for weight gain of 5 lbs or more related to the congestive heart failure. On 6/8/21 the resident physician ordered Metolazone, a diuretic, (used to treat conditions like high blood pressure, edema, and heart failure, help the body get rid of extra fluid and salt by making the kidneys remove water and salt through urine. This lowers the amount of fluid flowing through the veins and arteries) to be administered concurrently with already ordered Lasix, a diuretic. According to the physician progress note dated 6/22/21 the Metolazone was ordered as a 1-time dose related to the identified weight gain and shortness of breath documented on 6/7 with a weight gain from 221-225 lbs. A review of Resident #4's medication administration record (MAR) revealed that the Metolazone was administered from 6/7-6/14. Resident #4 was on weekly weights at the time related to the CHF diagnosis. His/her weights went from 221 on 6/11/21 to 159 lbs. on 6/16/21 during the time of the Metolazone administration. The facility dietitian staff #3 was interviewed on 5/14/24 at 1:36 PM and again followed up with an interview on 5/15/24 at 8:17 AM. The physician order and for the Metolazone and the weight loss was reviewed. The provided physician note dated 6/22/21 regarding Resident #4's admission and care stated that the Metolazone was a 1x dose was reviewed. Staff #3 concurred at that time that the order for Metolazone stated 1 time dose. She stated that the Metolazone is usually ordered for 5-7 days but concurred that the physician note did state it was for a 1-time dose. The concern that the Metolazone was administered for 7 days instead of the ordered 1 day with a result of a significant weight loss was reviewed at this time with staff #3. The facility DON was also notified on 5/15/24 and again during exit on 5/21/24. Cross reference F580

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on review of pertinent facility documents and interview with facility staff, it was determined that the facility failed to have an updated annual facility assessment. The findings include: Review of the facility assessment for the [AGE] year that would be reflective of 2023 on 5/21/24 at 11:40 AM during the extended survey revealed paperwork only for the year 2020-2021. This was brought to the attention of the facility corporate nurse and corporate operations representative at 11:45 AM. There were signed reviews in the front of the facility assessment binder showing the current Nursing Home Administrator and the facility governing body representative. The Corporate Operations representative stated that he has signed as the governing body representative. The signature page was not dated and a concurrent review of the facility assessment binder with this surveyor and the Corporate Operations representative and the corporate nurse failed to reveal any other documents with dates for the 2023 or [AGE] year.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 34484 Based on medical record review and interview, the facility staff failed to follow up with outside resources for the care of residents (Resident #15 and #14). This was evident for 2 of 36 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #15's medical record on 12/17/22 revealed the Resident was admitted to the facility for rehabilitation on 11/23/22 following a spinal surgery. Review of the hospital discharge summary dated 11/23/22, stated Duration of antibiotics-gave name of facility to follow up with and contact information. Possible stop date is now 12/2/22, but Infectious Disease will need to re-evaluate the labs and patient status prior to stopping. Further review of Resident #15's medical record revealed the Resident went to an Infectious Disease follow up appointment on 12/8/22. Review of the 12/8/22 Consultation Report stated to discontinue the IV antibiotic and start a by the mouth antibiotic Clindamycin 300 mg three times a day. Review of the Resident's Medication Administration Record (MAR) for December 2022 revealed the Resident did not receive the IV antibiotic on 12/4, 12/5, 12/6 and 12/7/22. The Resident did receive the IV antibiotic on 12/8/22. The facility staff failed to consult with the Infectious Disease physician prior to stopping the IV antibiotic on 12/4/22. Further review of Resident #15's medical record revealed the Resident went to an Infectious Disease follow up appointment on 1/17/23. Review of the 1/17/23 Consultation Report stated to Continue Clindamycin 300 mg three times a day until fused. Review of Resident #15's January 2023 MAR revealed the facility staff stopped administering Clindamycin to the Resident on 1/20/23. Further review of the medical record revealed no evidence the facility staff consulted with the outside facility before stopping Clindamycin on 1/20/23. Interview with the Director of Nursing on 5/21/24 at 9:04 AM confirmed the facility staff failed to follow up with the Resident's Infectious Disease physician at an outside facility for antibiotic orders per Resident #15's hospital discharge summary and outpatient Consultation Reports. 30428 2). Review of the medical record for Resident #14 revealed diagnosis including unspecified dementia and adult failure to thrive. On admission Resident #14 was also noted with a 'dark/black' area on his/her right heel. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions for the treatment of the area were ordered. Weekly assessments were completed, and the area was noted to increase in size. On 11/16/22 Resident #14's physician ordered for a podiatry consult and wound consult. A review on 5/20/24 revealed physician orders for those consultants. However, those orders were never implemented according to the progress notes and medication administration and treatment administration record. The facility DON was interviewed on 5/21/24 at 9:50 AM. She stated that she had contacted the facility podiatrist and there was no record that he had seen the resident, in addition there was no wound consult completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to constantly document activities of daily living (ADL) care provided to a dependent resident. This was evident during the review of 1 of 36 residents (#32) related to complaints of lack of ADL care. The findings include: Review of reported complaints for Resident #32's on 10:16 AM at 5/14/24 revealed concerns related to being left in bed and soiled with urine and stool for hours. A review of Resident #32's medical record at 10:22 AM revealed a minimum data set (MDS) Kardex documenting that s/he was frequently incontinent of bowel and bladder. The geriatric nursing assistant (GNA) documentation for toileting and bowel and bladder was requested to the facility and received on 5/16/24 at 7:47 AM. Review of this documentation revealed multiple shifts where GNA staff failed to document that care was provided for toileting for this dependent resident, specifically on 3/13/24, which was identified in the complaint as a day of concern. However, a review of the nursing progress notes, and medication administration record revealed that there was care provided and a staff member that was interactive with Resident #32 throughout the day. Interview with a unit supervisor, staff #1 on 5/14/24 at 11:00 AM revealed that he frequently tours the units and does rounds and ensures that all staff are checking on their patients. He further stated that if there is a need he will assist or provide care to residents as needed. The concerns that staff failed to document on multiple days for the month of March that ADL care was provided to Resident #32, a dependent resident, was reviewed with the facility interim Director of Nursing throughout the survey and again during exit on 5/21/24.