| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215064 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Adelphi Nursing and Rehabilitation Center | 1801 Metzerott Road<br>Adelphi, MD 20783 |

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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on record reviews and interviews it was determined that the facility failed to notify the resident's health care Responsible Party (RP) of a change to the resident's plan of care. This was found evident in 3 (Resident #4, #50 and #69) of 70 residents reviewed during the survey.<br><br>The findings include:<br><br>1a) On [DATE] at 11:53 AM, the surveyor reviewed Resident #4's medical record. The review revealed that Resident #4 had a Guardian established in July of 2023.<br><br>On [DATE] at 6:55 AM, the surveyor reviewed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) form and the Notice of Medicare Non-Coverage (NOMNC) form that was given to Resident #4. Both of these forms are required to be provided after a resident is determined to no longer be eligible to receive Medicare Part A skilled services. The beneficiaries have the right and protections related to financial liability and the right to appeal a denial of Medicare service under the Medicare program. The providers are responsible for communicating these notices. Resident #4 signed the NOMNC form on [DATE] and it was documented that he/she refused to sign the SNF-ABN form on [DATE].<br><br>On [DATE] at 7:03 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that Resident #4's guardian, the representative that legally makes decisions on behalf of Resident #4, was not notified of the non coverage and liability notices. The NHA stated she would look into the issue.<br><br>On [DATE] at 7:31 AM, the surveyor interviewed the Social Service Director #13. During the interview SW #13 stated that she had reached out to Resident #4's guardian and she was okay with having Resident #4 sign the paper. The surveyor reviewed the concern that there was no documentation that the guardian was aware or acknowledged the notices.<br><br>1b) On [DATE] at 10:25 AM, the surveyor reviewed Resident #50's medical record. The review revealed that Resident #50 was admitted to the facility in late August of 2020. On further review it was discovered that Resident #50 was deemed unable to make a rational evaluation of the burdens and risks, and benefits of treatment or course of treatment by two providers. A temporary/90 day guardian was established for Resident #50 in October of 2020. Resident #50's guardian started the application for Long-Term Care Medicaid for Resident #50 to remain in a Long-Term Care nursing facility.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On further review Resident #50 had a psychoactive medication informed consent form that was marked as, I do desire to use the medication indicated above. On the consent line it was written Resident is unable to sign but consented to meds. The Unit Manager (UM) #16 signed the document as the person completing the form.<br><br>The surveyor reviewed the care plan sign in logs. Resident #50 had a care plan done on [DATE]. The area that designates the Resident's Representative or Responsible Party (RP) had the temporary guardian's name but it was documented he was unavailable. The next care plan meeting attendance log was dated, [DATE] and Resident #50 was designated to be his/her own Responsible Party (RP). An X was marked through the signature.<br><br>Next the surveyor reviewed the discharge planning psychosocial assessment completed on [DATE] by Social Worker Coordinator (SW) #9. The topic for discharge planning was marked extended care stay as stated by the Legal Representative. However, on [DATE] that same question was answered, extended care stay as stated by other. On the next line that asked to clarify other, facility was written.<br><br>On [DATE] at 11:20 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). The surveyor relayed the concern that Resident #50 was established to be unable to make decisions for himself/herself and at one time had a guardian yet some of the documentation was that Resident #50 was his/her own decision maker. The NHA stated she would look into the concern and follow-up.<br><br>On [DATE] at 2:30 PM, the surveyor conducted a follow-up interview with the NHA. During the interview the NHA explained that the guardian Resident #50's had when he/she was admitted had expired and that she was looking into who would be the guardian now. At the time of exit no additional documents were provided.<br><br>1c) On [DATE] at 7:16 AM, the surveyor reviewed Resident #69's medical record. The review revealed that Resident #60 had guardianship that was established in September of 2022.<br><br>On further review a progress note was written on [DATE] by Unit Manager (UM) #59 stated that Resident #69 declined to keep his/her appointment and that the Responsible Party (RP) was made aware. Further in the note it was noted that the Physician's Assistant (PA) from the vascular office spoke to the resident's daughter about the plan of care.<br><br>On [DATE] a note written by Provider #60 stated, I spoke with the Resident regarding prognosis and plan of care. No one else was mentioned as updated or to be updated.<br><br>Additionally, a note written on [DATE] by Provider #61 stated, I discussed the plan of care with nursing. It further documented, Discussed with: Responsible Party,; Staff.<br><br>On [DATE] at 1:19 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor relayed the concern that the facility was not consistent with identifying who the Responsible Party (PR) is and then updated that individual on all changes to the plan of care. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>44440<br><br>Based on interviews and record reviews it was determined that the facility failed to inform residents of their right to formulate advanced directives. This was found evident of 2 (Resident #160 & #121) out of 10 residents reviewed for advanced directives during the survey.<br><br>The findings include:<br><br>1a) On 1/29/25 at 1:05 PM, the surveyor reviewed Resident #160's medical record. The review revealed that on 1/10/25 Social Work Director (SW) #13 documented a discharge planning psychosocial assessment. SW #13 documented Resident #160 did not have Advanced Directives (AD)'s. The area below that stated, Patient was offered information on initiated Advanced Directives, was left blank.<br><br>On 2/7/25 at 7:40 AM, the surveyor conducted an interview with the Nursing Home Administration (NHA). During the interview the NHA confirmed there was no documentation to show that Resident #160 was offered information to formulate an Advanced Directives.<br><br>1b) On 1/31/25 at 8:04 AM, the surveyor reviewed Resident #121's medical record. The review revealed a discharge planning note written by Social Work Coordinator (SW) #9 on 10/23/24 documented Resident #121 had Advanced Directives. On further review a discharge planning note written by Social Work Director (SW) #13 on 11/10/24 documented that Resident # 121 did not have Advanced Directives.<br><br>On 2/6/25 at 12:27 PM, the surveyor conducted an interview with SW #9. During the interview SW#9 stated she had marked that Resident #121 had Advanced Directive in error and he/she did not have any.<br><br>On 2/7/25 at 7:40 AM, the surveyor conducted an interview with the Nursing Home Administration (NHA). During the interview the NHA confirmed there was no documentation to show that Resident #121 was offered information to formulate advanced directives. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51589<br><br>Based on observations and staff interviews, it was determined that the facility failed to provide maintenance services necessary to maintain a clean, comfortable, and homelike environment. This was observed in 1) 4 resident rooms (#125, #128, #201, and #204) of 68 rooms and 2) 19 (2nd floor room [ROOM NUMBER] to 233) rooms identified with poor interior wall paint integrity out of 29 residents' room reviewed.<br><br>The findings include:<br><br>1) On 1/29/2025 at 12:04 PM, surveyors observed room [ROOM NUMBER] which had numerous stains on the ceiling tiles. The packaged terminal air conditioning (PVAC) unit in room [ROOM NUMBER] was dirty and debris was noted to be collecting inside the unit underneath the vents. On 1/30/2025 at 12:04 PM, surveyors observed an open window in room [ROOM NUMBER] with a screen that had multiple tears and holes. At 12:03 PM, surveyors observed a hole in the ceiling of room [ROOM NUMBER] that had been patched with a piece of drywall, with stains surrounding the patched area. On 2/3/2025 at 2:20 PM, surveyors observed stains on ceiling tiles in room [ROOM NUMBER].<br><br>On 2/6/2025 at 12:34 PM, the facility ' s progress report was reviewed by surveyors that listed current and upcoming maintenance needs. room [ROOM NUMBER] ceiling was on the list to be repaired but there was no mention of Rooms #128, #201, and #204.<br><br>The Maintenance Director and Nursing Home Administrator were interviewed on 2/6/2025 at 1:20 PM. Surveyors addressed the environmental concerns with multiple resident rooms. The Maintenance Director verified that room [ROOM NUMBER] was on their maintenance list and would address concerns with Rooms #128, #201, and #204. The Maintenance Director stated that the facility building is older and has a problem with leaks from the roof. He also stated that Spring is when the facility will work on repairing broken window screens. The Nursing Home Administrator stated it is the facility's expectation that staff should be making the Maintenance Director aware of maintenance concerns.<br><br>45733<br><br>2) During a floor rounding of the facility on 1/31/25 at 10:58 AM, the surveyor noticed the interior wall paint peeling off in residents' rooms and in the hallway visibly. This was evident for 19 of the 2nd floor rooms numbered 200 to 233. Especially behind the bed broads and chairs. Per floor staff #15, it had been going for a while.<br><br>Interview, on 2/05/25 at 11:22 AM, the Unit Manager Staff #16 stated that there was an ongoing re-paint project of the interior wall plan for the whole building. However, she was not sure how long it could be done.<br><br>Interview with the Maintenance Director Staff #25 on 2/06/25 at 12:14 PM, he stated that there were many peeling paint requests from different floor staff and he was aware that paint peeling debris can be a health hazard issue as well. He was unable to come up with a completion date for re-paint at this time.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further interview, the Administrator reviewed the above findings and she agreed that this ongoing issue was a concern. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51713<br><br>Upon record review and facility staff interviews it was determined that the facility failed to code resident medication accurately on the Minimum Data Set (MDS) assessment. This was true for 1(Resident #61) of 32 residents reviewed during the annual survey.<br><br>The findings include:<br><br>Surveyors conducted a review of Resident #61's medical record on 1/30/25 at 10:43 AM. Review of the quarterly MDS dated [DATE] revealed that the resident received 1 injection of an insulin for 1 day.<br><br>Further record review revealed the Medication Administration Record (MAR) for the month of November 2024 showed that Trulicity was administered on 11/25/24 at 12:00 PM by injection.<br><br>On 1/30/2025 at 12:30 PM surveyors held an interview with the MDS Coordinator, Staff # 6. Staff #6 reviewed the MDS data and the November MAR with surveyors and determined that Trulicity was coded as an insulin in error. It should have been coded as a hypoglycemic. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>44440<br><br>Based on record review and interviews it was determined that the facility failed to develop a comprehensive person-centered care plan. This was found evident of 2 (Resident #5 & #160) of 5 residents reviewed for care planning.<br><br>The findings include:<br><br>1a) On 2/4/25 at 10:23 AM, the surveyor reviewed Resident #5's medical record. The review revealed that Resident #5 was readmitted to the facility in November of 2024. Further review of the hospital transfer records revealed that Resident #5 had a past surgical history that consisted of an ileostomy (a surgical procedure in which the ileum (small intestine) is diverted to an artificial opening in the abdominal wall). It also revealed that Resident #5 reported no longer producing any urine and was on hemodialysis (a treatment to filter wastes and water from your blood).<br><br>Next the surveyor reviewed Resident #5's care plan. A care plan was created on 10/30/24 that stated Resident #5 is incontinent of bladder and/or bowels related to medication use and impaired mobility.<br><br>On 2/5/25 at 7:01 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #5's care plan was not person centered and that Resident #5 was not incontinent of bladder or bowels. The DON confirmed that the care plan was inaccurate.<br><br>1b) On 1/29/25 at 11:40 AM, the surveyor conducted an interview with Resident #160. During the interview Resident #160 reported having a new pain in his/her left foot after returning from a treatment. The surveyor observed the nurse acknowledge the new complaint.<br><br>On 2/3/25 at 9:24 AM, the surveyor reviewed Resident #160's medical record. The review revealed a care plan initiated on 1/10/25 that stated, Resident #160 has a risk for pain related to. On further review an additional care plan was created on 1/10/25 that stated, Resident #160 is at risk for constipation related to.<br><br>On 2/3/25 at 11:20 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that the care plan was not complete, or resident centered. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on record review, and interview it was determined that the facility failed to invite a resident to participate in their care plan meeting and conduct care plan meetings after each resident's Minimum Data Set (MDS) assessment. This was found evident in 2 (Resident #134 & #90) out of 5 residents reviewed for care planning.<br><br>The findings include:<br><br>1) On 1/30/25 at 10:42 AM, the surveyor interviewed Resident #134. During the interview Resident #134 stated he/she had never been to a care plan meeting.<br><br>On 1/31/25 at 12:48 PM, the surveyor reviewed Resident #134's medical record. The review revealed that Resident #134 was admitted to the facility in late December of 2024 and had a Minimum Data Set (MDS) assessment dated [DATE]. In section C Cognitive Patterns the resident scored a 15 on his/her Brief Interview for Mental Status (BIMS), which indicated that Resident #134 was cognitively intact.<br><br>On further review the surveyor noted two care plan meeting logs. One dated 1/2/25 and another dated 1/9/25. Neither care plan meeting logged had Resident #134 attending. Also noted was an invitation to the care plan meeting that was held on 1/2/25. Resident #134's guardian was the only person invited to the meeting on the invitation.<br><br>On 2/3/25 at 10:05 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA confirmed that a residents should be able to participate in their care plan meeting. She further stated she would talk to the Social Worker and find out why the resident was not there.<br><br>On 2/3/25 at 10:30 AM, the surveyor conducted an interview with the Social Work Coordinator (SW) #9. During the interview SW #9 stated she conducted the care plan meeting on 1/2/25 for Resident #134. She further stated she normally invites the residents and their representatives to care plan meetings. The surveyor asked why Resident #134 was not part of the care plan meeting on 1/2/25 or why he/she had no written invitation to attend. SW #9 stated she spoke with Resident #134 multiple times and he/she stated he/she did not want to attend. SW #9 stated she did not have a note in the medical record that he/she was invited and/or declined and confirmed she missed documenting that. SW #9 was not able to explain why the Unit Manager #59 also did not invite Resident #134 to the additional care plan meeting held on 2/9/25. No where in the medical record explained why Resident #134 was not present at the 2/9/25 care plan meeting.<br><br>2) On 1/30/25 at 10:12 AM, the surveyor interviewed Resident #90. During the interview Resident #90 stated he/she had not had a care plan meeting but was that he/she was supposed to have one today.<br><br>On 2/4/25 at 12:50 AM, the surveyor reviewed Resident # 90's medical records. The review revealed that Resident # 90 was admitted to the facility in fall of 2022. The surveyor reviewed Resident #90's Minimum Data Set (MDS) assessment for 2024. Resident #90 had a MDS assessment completed on 3/19/24, 6/19/24, 9/17/24 and 12/18/24.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On further review it was noted that there was no documentation that any care plan meetings were conducted after the MDS assessment for 2024. In 2025 there was only one invitation to a care plan meeting that was scheduled on 1/22/25. There was, however, no care plan meeting logs to indicate that the care plan meeting was conducted.<br><br>The surveyor next reviewed Resident #90's progress notes. The Unit Manager (UM) #24 documented Resident #90's care conference was scheduled for 1/22/25 at 10:30 AM. Further review of the progress notes reveal that Resident #90 was off the unit during this time.<br><br>On 2/5/25 at 8:03 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview with the NHA the surveyor reviewed the concern that there was no documentation to indicate that Resident #90 had care plan meetings after his/her MDS assessments. The surveyor also reviewed the concern that Resident #90 was not able to attend the care plan meeting scheduled on 1/22/25 at 10:30 AM and there was no indication as to who attended the care plan meeting. The NHA stated she would look into the issue and follow-up.<br><br>On 2/5/25 at 12:13 PM, the surveyor conducted a follow-up interview with the NHA. She confirmed the care plan meeting for Resident #90 did not happen on 1/22/25. The surveyor was provided with documentation that Resident #90 had a care plan meeting on 2/4/25. The surveyor reviewed the concern that Resident 90 had multiple MDS assessments and there was no documentation until yesterday that he/she had a care plan meeting after any of the MDS assessments for 2024. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent residents. This was found evident in 1 (Resident #134) out of 2 residents reviewed for Activity of Daily Living (ADL) cares.<br><br>The findings include:<br><br>On 1/30/25 at 10:44 AM, the surveyor interviewed Resident #134. During the interview Resident 134 stated that he/she only received bed baths and was not offered the chance to take a shower.<br><br>On 1/31/25 at 12:48 PM, the surveyor reviewed Resident #134's medical record. The review revealed that Resident #134 was admitted to the facility in late December of 2024 and had a Minimum Data Set (MDS) assessment dated [DATE]. In section C Cognitive Patterns Resident scored a 15 on his/her Brief Interview for Mental Status (BIMS) which indicated that Resident #134 was cognitively intact. On further review it was noted that Resident #134 had an order, written on 1/24/24, that stated, validate shower schedule twice a week on Monday and Thursday on the evening shift.<br><br>On 2/3/25 at 11 AM, the surveyor reviewed Resident #134's shower point of care documentation provided by the Nursing Home Administrator (NHA) for January of 2025. On review of Task documentation, a shower was first documented as given on 1/13/25, and then again on 1/15/25 and 1/18/25.<br><br>On 2/3/25 at 11:23 AM, the surveyor conducted an interview with the NHA. During the interview the surveyor reviewed the concern that only 3 showers were documented in the point of care documentation for showers for Resident #134. The NHA stated she would obtain shower sheets that are completed when a shower is done.<br><br>The NHA returned with shower sheets for Resident 134. On 12/26/24 a bed bath was documented as completed with no indication as to why a shower was not given. The next shower sheet was dated 1/27/25 and it was documented that Resident #134 refused. The last shower sheet given was dated 1/30/25 and again Resident #134 was documented as refusing. Additionally, documentation provided by the NHA was a nurse progress note dated 1/17/25 that documented Resident #134 refused a shower.<br><br>The surveyor next reviewed Resident #134's Treatment Administration Record (TAR) for January 2025. On 1/2/25,1/6/25, 1/9/25, 1/13/25, 1/16/25, 1/16/25, 1/20/25, 1/23/25, 1/27/25 and 1/30/25 showers were documented as given with a check mark. These dates were every Monday and Thursday in January. No refusals were documented, however, even on the days of 1/27/25 and 1/30/25, where it was checked that Resident #134's received a shower the shower sheets that were provided documented Resident #134 refused a shower. No shower sheets were provided for the other marked days a shower was given.<br><br>The surveyor reviewed the concern with the NHA that the resident reported he/she was not given showers as well as multiple areas in Resident #134's medical record that indicated that Resident #134 was not being offered or provided showers as ordered in his/her plan of care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215064 | A. Building<br>B. Wing | 02/11/2025 |

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| Adelphi Nursing and Rehabilitation Center | 1801 Metzerott Road<br>Adelphi, MD 20783 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>44440<br><br>Based on observations, interviews and record review, it was determined that the facility failed to provide treatments according to a resident's plan of care. This was found evident of 4 (Resident #134, #34, #121, & #69) out of 5 residents reviewed for skin care.<br><br>The findings include:<br><br>1a) On 1/30/25 at 10:46 AM, the surveyor interviewed Resident #134. During the interview Resident #134 stated he/she believed that his/her wounds were not being treated as often as they were supposed to be done.<br><br>On 1/31/24 at 12:48 AM, the surveyor reviewed Resident #134's medical record. The review revealed that on 12/26/24 wound Nurse Practitioner (NP) #53 wrote a progress note related to Resident #134's initial wound assessment. The note stated that Resident #134 had a history of a chronic right foot wound. The note further stated that Resident #134 was seen for bilateral (both) lower extremity severe dryness and venous stasis. NP #53 identified two wounds 1. Right leg and 2. Left foot. Both wounds were recommended to have the same treatment; cleanse with soap and water, pat dry, apply AD ointment to the wound, leave open to air and change: twice per day.<br><br>The note further stated for preventive measure Resident #134 should have emollient (a substance that helps soothe, soften, and increase moisture levels) applied twice a day and for intermittent leg elevation to help with the edema (swelling).<br><br>Next the surveyor reviewed Resident #134's January Treatment Administration record (TAR). An order was written on 12/26/24 for Resident #134 to have his/her left and right lower extremity washed with soap and water, patted dry and A&D ointment applied daily with the instructions to leave open to air. This was documented as completed 1/1/25-1/31/25, however, this treatment was done once per day even though the wound care recommendation by NP #53 stated this treatment should be done twice per day. On further review on 1/7/25 an order was placed for Resident #134 to have Aquaphor external ointment (Emollient) to be applied to both lower legs two times per day for xerosis cutis (a condition characterized by excessive dryness, tightness, and scaling of the skin) This was 11 days after NP #53 had recommended the treatment.<br><br>On 2/3/25 at 2:30 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that Resident #134 was not receiving the treatments that the wound NP was recommending.<br><br>1b) On 1/29/25 at 12:23 PM, the surveyor observed Resident #34's legs and noted multiple scabbed areas and dry flaky skin. No dressing were noted on Resident #34's legs<br><br>Again on 2/5/25 at 1:38 PM, the surveyor noted no dressings applied to Resident #34's legs.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/6/25 at 7:18 AM, the surveyor reviewed Resident #34's medical record. The review revealed that on 1/27/25 a wound Nurse Practitioner (NP) #53 wrote a progress note for Resident #34. A new treatment was recommended and stated, apply clobetasol ointment (a topical corticosteroid medication used to treat various skin conditions) twice a day Monday- Friday to all blisters and open wounds, except on weekends. It further stated coat legs with a thick layer of Vaseline and then cover with gauze and ACE/kerlix wrap.<br><br>On further review Resident #34 had two skin care plans written. One titled skin impairment to bilateral (both) legs and feet and the other that stated Resident #34 had chronic wounds and ulcers to the bilateral legs, feet and that the resident was at risk for worsening wound(s), or the development of additional wounds related to chronic health conditions, dry fragile skin, and immobility.<br><br>The surveyor next reviewed Resident #34's Treatment Administration Record (TAR) for January 2025 and February 2025. Clobetasol ointment was applied twice a day every day from January 27th through February 5th. There was no break on the weekend and no Vaseline or ACE/Kerlix wraps documented as completed.<br><br>On 2/3/25 at 2:30 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that Resident #34 was not receiving the treatments that the wound NP was recommending.<br><br>1c) On 1/31/25 at 8:33 AM, the surveyor observed Resident #121 in bed and observed that Resident #121 had a dry left lower leg that had lines that appeared to thick cracked skin.<br><br>On 2/7/25 at 8:18 AM, the surveyor reviewed Resident #121's medical record. The review revealed that on 12/6/24 a wound Nurse Practitioner (NP) #53 wrote a progress note for Resident #121. NP #53 wrote, Resident was noted to have dry skin to lower extremities, and feet. NP #53 recommended the use of emollient (a substance that helps soothe, soften, and increase moisture levels) daily, oral hydration and podiatry evaluation for management of nails.<br><br>On further review Resident #121 had a skin care plan written that stated, Resident #121 had a skin impairment related to itching.<br><br>Next the surveyor reviewed Resident #121's Treatment Administration Record (TAR) for December 2024. There was no documentation that Resident #121 received the recommended treatment for his/her identified skin needs.<br><br>On 2/3/25 at 2:30 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that Resident #121 was not receiving the treatments that the wound NP was recommending.<br><br>1d) 1/30/25 at 9:42 AM, the surveyor observed Resident #69's lower legs and noted that they were both dry and flaky and were both in protective boots.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/10/25 at 9:14 AM, the surveyor reviewed Resident #69's medical record. The review revealed that on 1/23/25 a wound Nurse Practitioner (NP) #53 wrote a progress note for Resident #69. The note described that Resident #69 had a history of wounds to the left lower extremity and foot. NP #53 documented that Resident #69 had dry, flaky intact skin. She further noted that Resident #69's bilateral (both) lower extremities had edema (swelling). NP #53 wrote that Resident #69 was at moderate to high risk for skin breakdown and recommended use of emollient (a substance that helps soothe, soften, and increase moisture levels) daily. She further recommended intermittent leg elevation.<br><br>On further review Resident #69 had a care plan titled skin impairment and stated Resident #69 was at risk due to impaired mobility and incontinence.<br><br>On 2/10/25 at 1:19 PM, the surveyor reviewed Resident #69's December 2024 and January 2025 Treatment Administration Recorded (TAR). The TARs revealed no documentation that the treatments recommended by the wound NP#53 were written to be done or completed.<br><br>On 2/3/25 at 2:30 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that Resident #69 was not receiving the treatments that the wound NP was recommending. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>44440<br><br>Based on interviews, and record review, and facility policy, it was determined that the facility failed to provide respiratory care consistent with professional standards for oxygen administration. This was found evident of 2 (Resident #108 & #5) out of 4 residents reviewed for respiratory care during the survey.<br><br>The findings include:<br><br>Pulse oximeter - a device that uses a light source to analyze the light that passes through a finger and can determine the percentage of oxygen saturation in the red blood cells, referred to as a pulse ox.<br><br>Nasal cannula- a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels.<br><br>1a) On 1/30/25 at 10:38 AM, the surveyor observed Resident #108 being pushed in a recliner chair by Geriatric Nursing Assistant (GNA) #22 through the Terrace level hallway. Resident #22 had a nasal cannula (NC) in his/her nose but the NC was not hooked up to any supplemental oxygen. The surveyor observed Unit Manager (UM) #24 assist GNA #22 push Resident #108 to the elevator.<br><br>On 1/30/25 at 10:47 AM, the surveyor observed GNA #22 return to the Terrace level and noticed that GNA #22 was pushing Resident #108's oxygen concentrator (an oxygen concentrator is a device that produces high levels of oxygen from room air by removing nitrogen, providing an alternative to using compressed gas cylinders also known as oxygen tanks) through the hallway to the elevator. When the surveyor asked if Resident #108 needed to be on oxygen GNA #22 stated, yes and that was why she had came back so she could bring the concentrator up to Resident #108 who was currently in dialysis.<br><br>On 2/5/25 at 11:46 AM, the surveyor reviewed Resident #108's orders. Oxygen was ordered on 12/6/24 through 2/3/25 as oxygen at 2 liters per minute via nasal cannula and to monitor every shift. On 2/3/25 the same 2 liters per minute was ordered, however, the monitoring was changed to every night shift for monitoring.<br><br>On further review a note written by Licensed Practical Nurse (LPN) #51 on 2/1/25 stated, Resident #108 was assisted into bed and remains on continuous oxygen for shortness of breath. Additionally a note written on 1/27/25 by Nurse Practitioner (NP) #61 wrote, Resident #108 continues on supplemental oxygen at a goal of oxygen saturations above 92%<br><br>The surveyor next reviewed Resident #108's care plan titled, Respiratory. It stated Resident #108 had a risk for respiratory complications secondary to supplemental oxygen requirements. One of the interventions was to administer oxygen as ordered.<br><br>On 2/6/25 at 8 AM, the surveyor reviewed the facility's Respiratory Care & Oxygen Equipment policy. Two types of oxygen therapy were described. Continuous and as needed oxygen therapy. In the safety guidelines, the first statement says, oxygen support is not to be initiated or adjusted without a provider's order.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/6/25 at 11:19 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the observations of a resident, who was ordered to be on continuous oxygen, being transported without oxygen to dialysis. The NHA agreed that residents who have an order for continuous oxygen therapy should not be taken off for transport convenience.<br><br>1b) On 1/29/25 at 11:55 AM, the surveyor observed Resident #5 lying in bed with a nasal cannula in his/her nose, however the tube was not hooked up to any supplemental oxygen. Resident #5 then stated that he/she was supposed to be hooked back up to oxygen and he/she believed that the concentrator must have been left in dialysis.<br><br>On 1/29/25 at 11:57 AM the surveyor observed Geriatric Nursing Assistant (GNA) #23 walk into Resident #5s room. The surveyor asked GNA #23 if Resident #5 was supposed to be on oxygen. GNA #23 stated that the concentrator is normally brought back with him/her and that she would go to dialysis to get it. The surveyor next observed the GNA return with Resident #5's concentrator and connected the nasal cannula to the oxygen concentrator.<br><br>On 2/4/25 at 10:29 AM, the surveyor reviewed Resident #5's orders. An order was written on 11/21/24 for oxygen therapy, continuous oxygen at 2 liters per minute via nasal cannula for Chronic Obstructive Pulmonary Disease (COPD).<br><br>On 2/6/25 at 8 AM, the surveyor reviewed the facility's Respiratory Care & Oxygen Equipment policy. Two types of oxygen therapy were described. Continuous and as needed oxygen therapy. In the safety guidelines, the first statement says, oxygen support is not to be initiated or adjusted without a provider's order.<br><br>On 2/6/25 at 11:19 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the observation of a resident who was ordered to be on continuous oxygen being transported without oxygen to dialysis. The NHA agreed that residents who have an order for continuous oxygen therapy should not be taken off for transport convenience. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>51589<br><br>Based on record review and staff interviews, it was determined that the facility failed to ensure nursing staff were competent in medication administration. This was found to be evident in 21 (LPN 19, LPN 33, LPN 34, LPN 35, RN 36, LPN 37, LPN 38, LPN 39, RN 40, LPN 41, LPN 42, LPN 43, RN 44, LPN 45, LPN 46, LPN 47, RN 48, RN 49, LPN 50, LPN 51, LPN 52) of 59 licensed nursing staff employees reviewed for medication administration record (MAR) documentation during the recertification survey.<br><br>The findings include:<br><br>A MAR is a document used in healthcare settings to track and record the medications given to patients, including details like dosage, time, and the person administering the medication. It is important because it ensures accurate medication administration, helps prevent errors, and provides a legal record of treatment. It also supports continuity of care by informing healthcare providers of a patient's medication history.<br><br>A Controlled Substance Log Book is a record used in healthcare settings to track the use, distribution, and administration of controlled substances, which are drugs that have a higher potential for abuse or addiction. It is important because it helps prevent misuse, theft, and diversion of these substances, ensures compliance with legal and regulatory requirements, and provides an accurate and traceable record of their handling for accountability and safety.<br><br>PRN medication stands for pro re nata, which is a Latin term meaning as needed or as the situation arises. It refers to medication that is taken only when necessary, rather than on a regular schedule.<br><br>During an observation on 2/4/2025 at 9:58 AM of the controlled substance log book on the facility's first floor medication cart, surveyors identified a discrepancy between PRN narcotic medication being signed out of the controlled substance log but not being documented in the MAR.<br><br>On 2/6/2025 at 1:43 PM, surveyors addressed concerns about the PRN medication documentation with the Director of Nursing (DON). The DON stated that it is the facility's expectation that medications given to residents are documented in the MAR and that she would provide a list of licensed facility nurses who failed to document PRN medication administration in the MAR for Residents #4, #11, #53 identified by surveyors for having discrepancies between controlled substance log book and MAR. The DON stated they would provide an immediate In-service with licensed nursing staff on documentation of PRN medication.<br><br>The facility ' s policy for medication administration was reviewed by surveyors on 2/7/2025 at 11:29 AM. Under Section IV Subsection 7 it stated, After administration, return to cart, replace medications container (if multi-dose and doses remain), and document administration in the MAR or TAR and the controlled substance sign out record, if necessary.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/10/2025 at 10:55 AM, the Quality Assurance/Staff Development (QA/SD) Registered Nurse (RN) was interviewed by surveyors. During the interview, the QA/SD RN stated that he observes nurses passing medications monthly or more frequently if necessary to make sure they are competent in medication administration. At 12:47 PM, surveyors spoke with both the DON and QA/SD RN and addressed concern about PRN narcotics not being documented in the MAR and overall staff competency. They stated the facility will change how they address medication competencies in regard to this issue. The QA/SD RN presented previous competencies for nursing staff which surveyors reviewed.<br><br>On 2/10/2025 at 1:22 PM, the QA/SD Registered Nurse provided surveyors with the In-service/Training competency form on PRN narcotics with signatures from facility nursing staff that were identified who did not document PRN narcotics in the MAR.<br><br>Cross Reference Ftag 0755. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>51589<br><br>Based on record review and interviews, it was determined that facility staff failed to appropriately document pro re nata (PRN) narcotic medication in the facility's medication administration record (MAR). This was found to be evident in 3 (Residents #4, #11, #53) of 3 residents reviewed for PRN medication administration during the recertification survey.<br><br>The findings include:<br><br>PRN medication stands for pro re nata, which is a Latin term meaning as needed or as the situation arises. It refers to medication that is taken only when necessary, rather than on a regular schedule.<br><br>A MAR is a document used in healthcare settings to track and record the medications given to patients, including details like dosage, time, and the person administering the medication. It is important because it ensures accurate medication administration, helps prevent errors, and provides a legal record of treatment. It also supports continuity of care by informing healthcare providers of a patient's medication history.<br><br>A Controlled Substance Log Book is a record used in healthcare settings to track the use, distribution, and administration of controlled substances, which are drugs that have a higher potential for abuse or addiction. It is important because it helps prevent misuse, theft, and diversion of these substances, ensures compliance with legal and regulatory requirements, and provides an accurate and traceable record of their handling for accountability and safety.<br><br>On 2/4/2025 at 8:56 AM, a record review of Resident #53's medical chart revealed they were on 10 milligrams of oxycodone every 6 hours as needed for pain. Further review of the resident's MAR for January 2025 revealed multiple dates of no documented oxycodone administration. At 9:11 AM, Registered Nurse (RN) #18 was interviewed by surveyors. She stated that it is the facility's expectation that all medications administered to residents are documented in the MAR. At 9:58 AM, surveyors reviewed the controlled substance sign out log for Resident #53 for January 2025. The review revealed that staff had signed out PRN narcotic medication for Resident #53 on the controlled substance sign out log but had not documented the administration in the resident's MAR. This occurred 30 times in the month of January 2025.<br><br>On 2/6/2025 at 11:31 AM, surveyors interviewed RN #31. They stated that residents are assessed for pain when they request narcotics, then the resident's orders are checked, and the MAR is checked to see when the last dose was given. The medication is then pulled from the medication cart and signed out in the narcotic log, and it is the facility's expectation that the medication is documented in the MAR. RN #31 stated she had not noticed any discrepancies between narcotic log and MAR documentation. Surveyors requested copies of the controlled substance sign out log for Residents #4 and #11.<br><br>(continued on next page) |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/6/2025 at 12:35 PM, surveyors compared the controlled substance sign out log versus the MAR for both Residents #4 and #11 for the month of January in 2025. It revealed that on multiple dates in January, staff documented the controlled substances in the sign-out log book for both residents but failed to record the medication administration in the residents' MAR.<br><br>On 2/6/2025 at 1:43 PM, surveyors addressed concerns about PRN narcotic medication documentation with the Director of Nursing (DON). The DON stated that it is the facility ' s expectation that medications administered to residents are documented in the MAR, and that they would make a list of the nurses who failed to do this for Resident's #53, #4, and #11.<br><br>The facility's policy for medication administration was reviewed by surveyors on 2/7/2025 at 11:29 AM. Under Section IV Subsection 7 it stated, After administration, return to cart, replace medications container (if multi-dose and doses remain), and document administration in the MAR and the controlled substance sign out record, if necessary.<br><br>The DON was interviewed on 2/10/2025 at 10:27 AM and provided surveyors with a list of facility nurses who pulled PRN narcotics for Residents #53, #4, and #11 and did not document in the MAR. The DON stated that she would be providing an in-service to educate these nurses about following facility policies. She also stated that she interviewed those nurses, and they stated they administered the PRN narcotic medications but did not document in the MAR.<br><br>On 2/10/2025 at 1:22 PM, the Quality Assurance/Staff Development RN provided surveyors with the In-service/Training competency on PRN narcotics with signatures from facility nursing staff that were identified who did not document PRN narcotics in the MAR. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215064 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Adelphi Nursing and Rehabilitation Center | 1801 Metzerott Road<br>Adelphi, MD 20783 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>51713<br><br>Based on observations of the facility's kitchen, and staff interviews, it was determined that the facility failed to store items properly to maintain the integrity of specific food items and utensils under sanitary conditions. This was evident for one of three observations during kitchen tours on the annual survey.<br><br>The findings include:<br><br>During the follow-up visit to the Kitchen on 2/6/25 at 11:15 AM, the surveyors observed the following:<br><br>- An undetermined delivery date and expiration date for nine 100 oz cans of green peas, which showed production date of 8/23<br><br>- One opened bag of 16oz cornstarch<br><br>- One 25lb bag of uncooked parboiled rice, unsealed, and without a label<br><br>- One unsealed 10lb bag of Orzo pasta<br><br>- An opened bulk sugar container (observed kitchen manager closing lid upon entrance of dry storage room).<br><br>The kitchen manager accompanied surveyors during further observations which revealed seven stacked dish racks containing 112 cleaned red cereal bowls faced up. The kitchen manager confirmed that the cereal bowls were to be placed faced down to prevent water nesting.<br><br>Wet nesting is when wet dishes are stacked on top of each other, preventing them from drying. This can lead to bacteria growth, which can affect food quality.<br><br>Also, during the kitchen tour on 2/6/25 surveyors and the kitchen manager observed debris, dark colored spots, and dead insects on multiple kitchen windowsills. The windowsills were located near the triple sink dish wash area, the ice machine, and storage of clean kitchen utensils. The kitchen manager confirmed that he would schedule cleaning to be done by housekeeping staff.<br><br>On 2/6/25 at 1:30PM surveyors conducted tours of the terrace nourishment room. Surveyors observed:<br><br>In refrigerator<br><br>- No thermometer<br><br>- One gallon bottle with unknown liquid dated 1/30/25<br><br>- 16oz bottle of French dressing dated 2/2/25<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - 64oz bottle of prune juice date 2/2/25<br><br>- 12oz can of Canada dry ginger ale opened no date label<br><br>- 56 oz bottle of sunny D opened no date label<br><br>In freezer<br><br>- Four 16oz Styrofoam cups with frozen liquid no date label<br><br>On 2/6/25 at 2:15 PM surveyors and the Maintenance Director conducted a tour of the second-floor nourishment room which revealed the ice machine (for residence use) had black substance on the dispensing flap and rusty edges around the storage bin. The maintenance director confirmed that he would have the ice machine serviced right away. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on interviews and record review it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices. This was found evident in 2 records of (Resident #5 & #165) out of 70 residents reviewed during the survey.<br><br>The findings include:<br><br>1a) On 2/4/25 at 10:23 AM, the surveyor reviewed Resident #5's medical record. The review revealed that Resident #5 was readmitted to the facility in November of 2024. Further review of the hospital transfer records revealed that Resident #5 had a past surgical history that consisted of an ileostomy (a surgical procedure in which the ileum (small intestine) is diverted to an artificial opening in the abdominal wall). It also, revealed that Resident #5 reported no longer producing any urine and was on hemodialysis (a treatment to filter wastes and water from your blood).<br><br>Next the surveyor reviewed Resident #5's care plan. A care plan was created on 10/30/24 that stated Resident #5 was incontinent of bladder and/or bowels related to medication use and impaired mobility.<br><br>On further review a note written by wound Nurse Practitioner (NP) #53 on 11/4/24 documented in physical exam section Resident #5 had fecal incontinence in the gastrointestinal section and urinary incontinence in the genitourinary system. Further in the note NP #53 documented Resident #5 was incontinent of urine and stool and was at an increased risk of skin breakdown. She further stated that she recommended ongoing interventions and protocol for incontinence management.<br><br>On 2/5/25 at 7:01 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern the Resident #5's medical record had multiple areas of inaccuracy. The DON confirmed that the area that described incontinence for Resident #5 were inaccurate.<br><br>42828<br><br>1b) Review of a complaint MD00198820 on 2/3/25 at 9 AM revealed, an allegation that Resident #165 complained of pain in her/his right wrist, to her/his nurse while residing at the facility on 10/20/23.<br><br>Review into Resident #165's medical record showed the resident was admitted to the facility on [DATE] for rehabilitation following a hospital stay due to altered mental status and colostomy care.<br><br>A colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. A colostomy bag, also called a stoma bag or ostomy bag, is a small, waterproof pouch used to collect waste from the body.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Additional review of the medical record revealed a change in condition note written by licensed practical nurse (LPN) #14 on 10/20/23. LPN #14 noted that Resident #165 complained of pain in her/his right wrist upon assessment. Review of the medical record showed an order from the doctor to give Tylenol 500mg two tabs every 8 hours by mouth as needed for pain and an order to do a STAT (immediate) X- Ray to the wrist to rule out a fracture. LPN#14 also noted, Tylenol administered.<br><br>Resident #165's medication administration record (MAR) was reviewed on 2/3/25 at 12:14 PM. The documentation on the as needed 500 mg Tylenol order did not have any days noted as Tylenol given to Resident #165 for the month of October 2023.<br><br>The surveyor reviewed the medical record for evidence of the October 20, 2023 X-ray results of the resident's right wrist. There were no X- ray results of the X-ray of the right wrist found.<br><br>An interview held with the Director of Nursing (DON) was held on 2/5/25 at 7 AM. The surveyors requested documentation showing Resident #165 ' s X-ray results of the right wrist and reviewed the lack of documentation on the MAR for the as needed dose of Tylenol given to Resident #165 on 10/20/23 for right wrist pain.<br><br>2/7/25 at 1 PM the DON submitted a hard copy of the Resident #165's X-ray of her/his right wrist. At which time the DON confirmed that the X-ray results were not in the resident's medical chart and that she had to request them from the imaging facility on 2/7/25. The DON and the surveyor also reviewed the resident's medication administration record which did not reveal any Tylenol given to the resident on 10/20/23. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>45733<br><br>Based on observation, record review and interview, it was determined that the facility staff failed to maintain an infection prevention/control program i.e. standard of care of an enteral feeding tube. This was evident for 1 (Resident #17) out of 2 residents reviewed for feeding tubes during the annual survey.<br><br>The findings include:<br><br>Observation, on 1/30/25 at 7:59 AM, found that Resident # 17's tube feeding water flash bag was dated 1/29/25 still hanging on a pole. 2 Jevity unopened bottles were sitting on a draw table unlabeled.<br><br>Record review, on 2/03/25 at 11:54 AM, indicated that tube feed order was through a tube feed pump for Jevity 1.5 via the Percutaneous Endoscopic Gastrostomy (PEG) tube five times a day and cleanse PEG tube site with soap and water, cover with split gauze dry dressing and dated every day shift.<br><br>A Percutaneous Endoscopic Gastrostomy (PEG) tube is inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food, to the patient. Giving food through a PEG tube is a type of enteral nutrition.<br><br>During a bedside observation of Resident #17's PEG tube site dressing change, on 2/03/25 at 1:06 PM, revealed that nursing Staff #15 found no split gauze cover the PEG's insertion site from the day before. She started cleaning the external fixation plate and intended to cover it with a new split gauze. After the surveyor's intervention, an old Xeroform strip was discovered under the PEG's external fixation plate. Noted the xeroform stripe had already turned black with an odor, nursing Staff #15 was unable to explain why the Xeroform was present and how long it was left there (it was not part of the order). Unit Manager Staff #16 was notified and she examined the old xeroform strip which she agreed that nursing staff omitted to remove it.<br><br>A PEG tube fixation plate is a device that holds a PEG tube in place against the skin.<br><br>Xeroform is a non-adherent gauze that minimizes pain during dressing changes and promotes healing. Impregnated with medical-grade petroleum, Xeroform allows the wound to stay moist and warm so cells can heal more quickly. The gauze also reduces the amount of air that reaches the wound.<br><br>During an interview, on 2/03/25 at 1:38 PM, the Administrator and the Preventive Infectionist, Staff #4, agreed with the above findings that the tube feeding water flash bag had a wrong date and PEG's tube site found an old Xeroform strip which were not meeting the infection prevention/facility's standard of care. |

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|---|---|
| F 0907<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough space and equipment to meet each resident's needs<br><br>44440<br><br>Based on observations and interviews it was determined that the facility failed to maintain all patient care equipment in safe operating condition. This was found evident on 2 random observations on the Terrace level.<br><br>The findings include:<br><br>On 1/30/25 at 10:38 AM, the surveyor observed Resident #108 being pushed in a recliner chair by Geriatric Nursing Assistant (GNA) #22 through the Terrace level hallway. The surveyor observed the chair was not steering straight and the reclining setting was not able to be maintained. It was noted that the head of the chair would lose the reclining position abruptly and the foot of the recliner would fall synchronously. The surveyor observed Unit Manager (UM) #24 assist GNA #22 to push Resident #108 to the elevator. UM #24 asked GNA #22 why she wasn't using the other chair and GNA #22 stated, they are all like this.<br><br>On 2/6/25 at 11:03 AM, the surveyor again observed Resident #108 in a reclining chair being transported down the hallway. When the GNA stopped at the nursing station, the surveyor observed the head of the chair come up and the feet drop abruptly.<br><br>On 2/6/25 at 11:10 AM, the surveyor asks the Unit Manager (UM) #24 if the chair was supposed to work like that. UM #24 acknowledged that the chair was not working correctly. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>44440<br><br>Based on observations and interviews it was determined that the facility failed to ensure that a resident's bed mattress properly fit the bed frame and that annual inspections were performed. This was found evident of 1 Resident (Resident #108) out of 160 beds.<br><br>The findings include:<br><br>On 2/5/25 at 1:30 PM, the surveyor observed that Resident #108's call light was on. Next the surveyor conducted an interview with Resident #108. During the interview Resident #108 stated he/she was calling to follow-up from his/her earlier call where he/she reported the bed was not working. The surveyor observed that the mattress on Resident #108's bed was hanging over the bed frame on both sides of the bed. It appeared that the mattress was too big for the bed frame. The sheets were noted to be pulling the corners of the mattress up and the mattress was not able to lay flat.<br><br>On 2/5/25 at 1:31 AM, a Geriatric Nursing Assistant (GNA) came to the room and asked what Resident # 108 needed. After Resident #108 explained his/her request the GNA stated she would follow-up with Resident #108's nurse who was already aware of the bed not working.<br><br>On 2/5/25 at 1:40 PM, Registered Nurse RN #21 walked into Resident #108's room and stated she had called maintenance to come to fix the bed but would make a follow-up phone call. The surveyor asked the nurse if repairs or requests were entered into a system or if calling was the way to notify maintenance. RN #21 stated she was unaware of how to use the computer system to request a repair and would call maintenance to let them know.<br><br>On 2/5/25 at 1:57 PM, the surveyor observed two maintenance staff, Staff #62 and Staff #63, enter into Resident #108's room. The surveyor observed Staff #62 reconnect a wire under Resident #108's bed and the head of the bed motor began to work properly.<br><br>On 2/5/25 at 2 PM the surveyor conducted an interview with Staff #63 and asked if Resident #108's mattress was the right size for Resident #108's bed frame. Staff #63 stated it appeared that the mattress was too big for the bed frame and would follow-up with the maintenance department.<br><br>On 2/6/25 at 10:56 AM, the surveyor conducted a follow-up interview with Resident #108. During the interview Resident #108 confirmed that the mattress had been switched out and that the new mattress fit the bed appropriately.<br><br>On 2/6/25 at 1:22 PM, the surveyor conducted an interview with Director of Maintenance Staff #25. During the interview Staff #25 stated he was not sure where the mattress came from that was on Resident #108's bed frame. Staff #25 stated the facility has regular beds and bariatric beds and that mattress was for neither of them. The surveyor asked if regular annual inspection of the beds were completed. Staff #25 stated he would look to see what was done on a regular schedule and that a computer software the facility utilized scheduled preventive maintenance and inspections.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/7/25 at 6:34 AM, the surveyor reviewed an example of a bed audit tool the Nursing Home Administered (NHA) provided. However, no audits that the facility performed accompanied the audit tool.<br><br>On 2/7/25 at 6:34 AM, the surveyor conducted an interview with the NHA. During the interview the surveyor asked if the facility could provide documentation that the facility performed bed audits. The NHA stated she would have to follow-up with maintenance.<br><br>At the time of exit no documentation that bed audits were performed was provided to the surveyor. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on observation and interviews it was determined that the facility failed to keep a sanitary environment in the common hallway. This was found in one random observation on the East Wing.<br><br>The findings include:<br><br>On 2/5/25 at 6:42 AM, the surveyor observed three garbage bags full of garbage placed in the hallway of the East wing. No staff were present.<br><br>On 2/5/25 at 6:45 AM, the surveyor observed Geriatric Nursing Assistant (GNA) #56 walk out of room [ROOM NUMBER] with a garbage bag in her hand. The surveyor asked GNA #56 why there were garbage bags left outside of resident rooms in the hallway. GNA #56 stated after she was done completing her rounds she had placed the garbage outside the door. At this time the surveyor observed two staff members come to the hallway and pick up the garbage and state they were taking the garbage to the dirty utility room.<br><br>On 2/5/25 at 7:01 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that garbage should not be left outside a resident's room and when a resident's garbage is emptied it should be taken to the dirty utility room. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440<br><br>Based on record review and interviews it was determined that the facility failed to have an effective pest control program. This was found evident on 2 observations (Resident 121's room and the elevator) and during one of three observations during kitchen tours on the annual survey.<br><br>The findings include:<br><br>1a) On 1/31/25 at 8:26 AM, the surveyor interviewed Resident #121 in his/her room on the Terrace level. During the interview Resident #121 stated he/she could not see very well but could feel things crawling on him/her at times. During the interview the surveyor observed a bug crawling on the floor and another bug crawling on the wall next to Resident #121's bed.<br><br>Next the surveyor notified Unit Manager (UM) #24 of the observations. UM #24 stated she would address the issue.<br><br>On 2/4/25 at 11:41 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the meeting the surveyor confirmed that the NHA was aware of the observation of bugs in Resident #121's room. She stated that a pest management company came out that same day. The surveyor asked for the pest management records<br><br>On 2/5/25 at 9:24 AM, the surveyor reviewed the pest management records. The review revealed that on 1/31/25 a pest management company came and treated several rooms including Resident 121's room for roaches and general insects. They also inspected room [ROOM NUMBER]-117 on the first floor.<br><br>On further review of the pest management records, a report identified the need for treatment in room [ROOM NUMBER]-117 in September of 2024. A note from the pest management company stated the room was very filled with fruit flies noted from trash that contained food. It further stated the room was treated for roaches in the closet. The note then stated roaches were noted in clothes and could not be treated by company but that the facility should bag the clothes carefully and put them into the drier right away to kill the roaches.<br><br>On further review that same room was specifically written as treated on 10/13/24 and 1/2/25.<br><br>The surveyor next reviewed Resident #121's room census. It was noted that Resident #121 resided in that room starting in October of 2023 and transferred to Terrace level at the end of December 2024.<br><br>On 2/5/25 at 12:13 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that roaches were noted in the room where Resident #121 resided and after Resident #121's room change there was no preventative treatment or evaluation to Resident #121's new room and currently bugs were noted in that room.<br><br>On 2/5/25 at 2:06 PM, the surveyor entered one of the elevators on the 2nd floor. Upon entering, the surveyor noticed a bug crawling on the wall of the elevator. At this time the surveyor exited the elevator and asked that the Director of Nursing come and note what was seen. The DON was able to confirm the bug crawling in the elevator. The bug was similar to the bug seen in Resident #121's room.<br><br>(continued on next page) |

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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 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 51713<br><br>1b) During the kitchen tour on 02/06/25 at 11:15 AM surveyors and the kitchen manager observed debris, dark colored spots, and dead insects on multiple kitchen windowsills. The windowsills were located near the triple sink dish wash area, the ice machine, and storage of clean kitchen utensils. The kitchen manager confirmed that he would schedule cleaning to be done by housekeeping staff.<br><br>On 2/6/25 at 12:37 PM an interview was performed with the Nursing Home Administrator (NHA). The NHA stated that housekeeping is expected to go to kitchen once a month from 8pm-12am, to keep kitchen cleanliness and confirmed housekeeping was currently in the process of cleaning the windows. |