| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215067 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bay Harbor Post Acute Healthcare Center | 200 Civic Avenue<br>Salisbury, MD 21804 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>21859<br><br>Based on medical record review and interview with facility staff and family, it was determined that the facility failed to notify the resident's responsible party (RP) when residents were had a change in condition/medical care. This was evident during a random observation for 2 of 2 residents (Resident #176 and #133) reviewed for notification during the survey.<br><br>The findings include:<br><br>1. During observation rounds on 1/15/24 at 6:15pm while standing in the hallway near resident #210's room. Resident #176 family member began questioning the nurse staff # 85 on the medication cart as to where Resident #176 was located since s/he was not in the room. The nurse staff # 85 stated to the family member I know where the resident is. Who are you? The family member stated I am one the residents' responsible parties. Staff #85 stated the resident was transferred to the hospital for complaints of chest pain. The family member replied I was never notified. Why? The nurse stated, I don't know why. The nurse may have called the other contact person. The family member contacted the other family member listed as the second contact person while standing in the hallway with the staff #85 and the surveyor. The family member verified she was also not notified of the resident's transfer.<br><br>Review of the medical record revealed a face sheet listing 2 Responsible party contacts persons located on the face sheet. Both were interviewed and neither family member was made aware of the transfer.<br><br>An interview was conducted on 1/16/25 at 10 am with the DON, she stated the evening nurse made her aware of the incident and she would be addressing it.<br><br>50457<br><br>2. On 01/13/25 at 5:38 PM, during an interview with family member #1, they expressed concerns about the discontinuation of a medication that the resident had been taking for a long time.<br><br>On 1/16/25 at 9:14 AM, during an interview with Resident #133's RP, they expressed concerns about Resident #133 medication being discontinued in February 2024. The RP explained that they became aware of the discontinuation when the resident's family member #1 asked the doctor questions about a certain medication, which they learned had been discontinued.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215067 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/17/2025 |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON) #2 on 01/16/25 a 4:11 PM, she explained the process for discontinuing a resident's medication. She stated that either the nurse or the provider can discontinue the medication. The nurse is responsible for documenting the discontinued medication and notifying the residents' RP or family.<br><br>Review of Physician Assistant (PA) #39's progress note on 01/17/25 at 8:54 AM, revealed that Resident #133's medication was discontinued on February 2024.<br><br>The DON #2 provided the surveyor with progress notes from the PA #39 dated 02/17/24 and 02/27/24 and acknowledged that the resident's family had not been notified about the discontinued medication. |

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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** 42782<br><br>Based on observations and staff interviews it was determined the facility failed to provide adequate lighting, housekeeping and maintenance services to keep the residents' environment clean and in good repair. This was evident in 3 of 4 unit units observed during tours of the facility and resident rooms during the survey.<br><br>The findings include:<br><br>1) During observation rounds on 01/13/25 at 7:50 am the surveyor entered the shower room located across from room [ROOM NUMBER], on the right side of the room in the corner was a white shower chair. Beneath the shower chair was a large amount of dried dark brown stool on the floor. Certified Nursing Assistant #29 confirmed the surveyor's findings and verbalized the shower room was used by the staff daily.<br><br>2) On 01/13/25 at 8:02 am the surveyor observed a cotton tipped swab on the left side of the commode in bathroom of room [ROOM NUMBER]. The cotton tipped swab remained in the same location when observed again by the surveyor later in the in the afternoon.<br><br>On 01/15/25 at 12:27 pm the the cotton tipped swab remained on the left side of the commode in the bathroom of room [ROOM NUMBER] as it was initially observed on 01/13/25.<br><br>On 01/15/25 at 4:05 pm the surveyor along with Regional Environmental Services Director #44 and District Manager Assistant #45 observed the cotton tipped swab located on the left side of the resident's commode in room [ROOM NUMBER]. The surveyor asked who is responsible for keeping the residents' rooms clean. Regional Environmental Services Director # 44 verbalized the house keepers pull the trash, clean the residents' horizontal surfaces, clean the bathrooms, and sweep & scrub the floors daily. They are responsible for wiping down the commode.<br><br>30440<br><br>3) During observation of resident #18's bathroom on 1/13/25 at 1:16 PM it was noted that a large area of the wall next to the toilet was in need of paint. When the bathroom door was opened, a very large visible area of the wall has spackling present. The resident stated to the surveyor, it really does need to be painted, this is my home now.<br><br>48167<br><br>4) On 01/13/25 at 8:15 AM, Resident #150 was interviewed. During the interview, Resident #150 stated that housekeeping did not clean his/her room on 01/11/25 and 01/12/25.<br><br>During observation rounds on 01/13/25 at 8:19 AM, Resident #150's room was found to have food and trash scattered throughout the floor and bedside table as well as an overflowing trash can with trash near the resident's bed.<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 | Also, Resident 150's bathroom had a dried, brown, strong, foul-smelling substance splattered on the wall, toilet and floor.<br><br>On 01/13/25 at 8:31 AM, Licensed Practical Nurse staff #9 was interviewed. During the interview, Licensed Practical Nurse staff #9 stated that housekeeping is supposed to clean resident rooms Monday through Friday and housekeeping was not at<br><br>the facility on the weekend.<br><br>On 01/17/25 at 11:52 AM, Environmental Director staff #15 was interviewed. During the interview, the Environmental Director staff #15 stated that Resident #150's room did not get cleaned on 01/11/25 and 01/12/25.<br><br>21859<br><br>5) During an observation of the facility on 1/13/25 at 9 am the following was observed:<br><br>room [ROOM NUMBER]: Smelled of a strong urine odor; large sticky spots were noted throughout the room floor; dirty towels were noted lying on the floor.<br><br>Room#119: The trashcan was overflowing with trash; floor was noted with trash and a dried substance.<br><br>The main dining room on the first floor was noted with tiles in the ceiling with dark brown spots, some ceiling tiles were loose. The wall columns were noted with a dark black substance.<br><br>The maintenance staff # 25 was made aware of the findings on 1/13/25 at 12:30pm.<br><br>On 1/15/25 at 2:15pm, an interview with 10 residents, including members of the resident council, all residents voiced numerous concerns regarding the wall columns that were noted with a dark black substance. The residents reported that these concerns were reported to the administrative staff over the last 4 months with no response. The residents stated they are concerned the black substance may be mold.<br><br>On 1/15/25 at 4pm the Administrator was made aware of the resident concerns.<br><br>On 1/ 16/25 at 12 noon during a follow-up interview with the Administrator, she stated the first floor main dining room was being shut down for renovation.<br><br>50457<br><br>6) During the initial facility tour conducted on 1/13/25, the surveyor observed the following:<br><br>At 7:50 AM in room [ROOM NUMBER], observed a missing light bulb in the bathroom, a dirty toilet seat, and a specimen tub on the floor next to Resident B's bed.<br><br>At 7:50 AM in room [ROOM NUMBER], observed a black substance on the toilet seat and clothes on the bathroom floor.<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 | At 8:07 AM in room [ROOM NUMBER], observed a foley catheter bag touching the floor, the call bell device on the floor, dentures sitting on the bedside table, and a bathroom with one broken light bulb.<br><br>At 8:09 AM observation of room [ROOM NUMBER] revealed the toilet seat had a black substance around the toilet seat rim, the room smelled of urine, and the bathroom had one broken light bulb.<br><br>At 8:09 AM, in room [ROOM NUMBER], observed a large, dried puddle of a yellow substance on the floor directly in front of the toilet inside the bathroom.<br><br>At 8:19 AM, in room [ROOM NUMBER], observed a yellow and brown substance on the toilet seat.<br><br>At 8:19 AM, room [ROOM NUMBER] observed a missing light bulb in the bathroom, crumbs on the floor, a sticky floor, and a strong smell of urine in the room.<br><br>At 8:33 AM, in room [ROOM NUMBER], observed a missing light bulb in the bathroom.<br><br>On 01/13/25 at 9:00 AM, following the conclusion of the facility tour, the surveyor informed Administrator #1, Director of Nursing #2, and Infection Preventionist #4 of the observations. The Administrator #1 responded that she was unaware of the missing lightbulbs in the resident's bathroom.<br><br>On 1/15/25 at 4:05 PM, during an interview with Environmental Services #44, the surveyor asked who was responsible for keeping the resident's rooms clean. The Environmental Services #44 explained that housekeepers are responsible for removing trash cleaning residents room, wiping down surfaces, cleaning bathrooms, and sweeping and scrubbing the floors daily. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>30440<br><br>Based on administrative review and interviews with facility staff it was determined the facility failed to prevent a resident from experiencing verbal abuse by an employee. This was found to be evident for 1 (Resident # 24) of 6 residents reviewed for abuse during the survey.<br><br>Findings include:<br><br>Intake MD00205342 was reviewed on 1/17/25 at 11:00 AM for allegations of abuse. According to the facility's investigation, GNA (Staff #56) was overheard by a Nurse (RN # 57) stating that she would hurt Resident # 24.<br><br>Review on 1/17/25 of a written witness statement by the RN (#57) dated 5/3/24, revealed that while she was sitting at the nurse station, a GNA (#56) went to move Resident # 24 out of the way and the resident became verbally and physically aggressive. The Nurse heard the GNA say, Imma [sic] leave you alone because I know what you are and your mental isn't right, because other than that I would [expletive] you up.<br><br>Further review of a signed written statement by the GNA (#56) revealed that she said the following to Resident # 24; Today is not my day, I would beat you up because [resident] full forced punched me in my stomach three times and then went to trip me.<br><br>During an interview with the Administrator (#1) on 1/17/25 at 11:25 AM she stated that GNA # 56 was suspended pending the investigation and then terminated and RN # 57 no longer worked at the facility. She went on to say that anytime abuse is substantiated, employment is immediately terminated. The Administrator was asked if the Board of Nursing was notified of the investigation results, and she stated no. She further stated that the Board of Nursing should have been notified. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>51490<br><br>Based on review of the facility reported incidents and interviews, it was determined that the facility failed to report an injury of unknown origin in a timely manner to the state agency. This was found to be evident for 1(Resident #154) of 6 residents reviewed for abuse during the survey.<br><br>The Findings include:<br><br>During review of the facility reported incident MD00205829 on 1/17/25 at 8:58 am, it was found that an injury of unknown origin was reported to LPN (Licensed Practical Nurse) #14 by Resident #154 on 5/18/24 at 4:20pm.<br><br>The Self Report Form from the facility was submitted to the State Agency on 5/19/24 with no time indicated by the DON (Director of Nursing). The report was received by the State Agency on 5/20/24 at 12:34pm.<br><br>During an interview with the DON and the Administrator on 1/17/25 at 10:30 am, both were unable to indicate why the alleged incident and injury of unknown origin was not reported within the 2 hour requirement. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>42863<br><br>Based on medical record review, facility investigation report review, and staff interview it was determined that the facility failed to retain documentation related to the delayed reporting of a resident fall. This was evident for 1 out of 4 (#124) residents reviewed for falls during the survey.<br><br>The findings include:<br><br>On 01.15.25 the surveyor reviewed the facility report related to Resident # 124 that was submitted to OHCQ on 06.23.24. On 06.03.24 the resident complained of pain to the right hip and leg. The resident was treated for the pain, the medical director, nurse practitioner, and the resident representative were notified as well on 06.3.2024. On 06.03.24 resident #124 was admitted to the hospital and found to have a fracture of the right femur. The surveyor's review of the final facility reported submitted by the facility revealed the resident had fallen on 06.01.24, the LPN #24 did not document the completion of the assessment of Resident #124 or document that the fall had occurred at 10 PM on 06.01.24. The DON failed to retain documentation that the LPN #24 failed to report the falls that occurred on 06.01.24 related to Resident #124's falls on 06.01.24.<br><br>On 01.16.25 at 09:13 AM the DON stated that she did not type up LPN #24's statement in which she/he admitted to the Resident #124's fall that occurred on 06.01.24. The DON stated that there was no nursing assessment performed by LPN #24 on 06.01.24 after the resident slid from the wheelchair or when the resident fell from the bed on 06.01.24 in the evening around 10 PM. Additionally, the DON stated that she did not report LPN #24 to the Maryland Board of Nursing. Also, DON could not provide a copy of the disciplinary action form that resulted in LPN#24's termination from the facility on 06.26.24. The DON stated that she failed to retain the documentation related to the resident's fall on 06.01.24 that was directly related to the facility report submitted to OHCQ on 06.03.24.<br><br>On 01.16.25 at 3:11 PM the surveyor received a phone call from GNA #23. GNA #23 stated on the evening shift of 06.01.24 that she/he is unable to remember the nurse's name however, he/she reported the fall observations related to Resident #124 to LPN #24. GNA #23 stated that the resident fell in the hallway twice on evening shift of 06.01.24.<br><br>This deficient practice was discussed with the administrator and DON on 01.17.25. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>48167<br><br>Based on resident interviews, staff interviews, and record reviews, it was determined that the facility failed to implement a comprehensive, person-centered care plan regarding activity needs for residents, a resident with weight loss and a resident with communication deficit. This was evident for 3 (#150, 116 & #179) of 5 residents reviewed for careplans during the survey.<br><br>The findings include:<br><br>1. On 01/13/25 at 8:15 AM, Resident #150 was interviewed. During the interview, Resident #150 pointed out and stated to the surveyor that he/she had an August 2024, activities calendar posted on his/her room wall; therefore, he/she does not know what daily activities are being held at the facility. Also, Resident #150 did not have a Main Events calendar posted on his/her room wall; therefore, he/she was not aware of the facility's special events.<br><br>On 01/15/25 at 8:34 AM, Resident #150's medical record was reviewed. The medical record review revealed that Resident #150's care plan stated that he/she should be provided with a monthly activity calendar and should be invited to special activities.<br><br>On 01/15/25 at 8:56 AM, the Life Enrichment Director staff #8 was interviewed. During the interview, the Life Enrichment Director staff #8 stated that the facility does not post daily, activities calendars in resident rooms. The Life Enrichment Director staff #8 also stated that the Main Events calendar, which shows monthly special events, should be posted in resident rooms.<br><br>42782<br><br>2. On 01/15/25 at 9:33 am a review of Resident #116's care plans revealed there was not a patient specific care plan for nutrition or weight loss although the resident was receiving a nutritional supplement and had a suspected weight loss.<br><br>On 01/15/25 at 10:03 am during an interview with Registered Dietician # 21 he/she verbalized the resident would have had a weight loss care plan but, the weight was not confirmed. RD #21 confirmed they ordered Resident #116 to receive a nutritional supplement, and their meal intake was being monitored but the interventions were not included in the care plan.<br><br>On 01/17/25 at 1:50 pm a review of Resident #179's care plans revealed the resident did not have a patient specific care plan for communication and respiratory care. The respiratory care plan did not include basic information about the tracheostomy tube and how the staff should care for the artificial airway.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 01/17/25 at 2:17 pm during an interview with Director of Nursing (DON) #2 the surveyor asked how the staff communicates with Resident #179. DON #2 verbalized the resident communicates by gestures and eye movements. Their spouse is the main person who lets the staff know what the resident needs as Resident #179 nods or shakes their head side to side when asked questions. However the care plan was not specific to the resident's communication and the respiratory care plan was not updated to reflect the current orders. |

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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** 42782<br><br>Based on record review and interview it was determined that the facility staff failed to have a care plan meeting with the interdisciplinary care team and failed to provide residents with a quarterly care plan meeting prepared and revised by the entire interdisciplinary team after the quarterly review assessment. This deficient practice was evidenced in 2 ( Resident #116 and Resident #150) of two records reviewed for care plan meetings during the survey.<br><br>The findings include:<br><br>1. On 01/13/25 at 4:18 pm during an interview with Resident #116 the surveyor asked if they were participating in care plan meetings. The resident did not recall having care plan meetings.<br><br>On 01/15/25 at 8:35 am a review of the resident's electronic medical record revealed there was no documentation to verify the resident had a multidisciplinary care plan meeting prior to 12/24/24. The resident was admitted to the facility on [DATE]. There was documentation of a navigation guide meeting on 11/01/24. There was no documentation to verify the multidisciplinary team meet with the resident within the first seven days of admission to inform them about their anticipated plan of care.<br><br>On 01/15/25 at 2:56 pm the surveyor received a copy of the Initial Navigation Guide Meeting note. There was not a interdisciplinary care conference attendance record to verify the interdisciplinary team was involved in the meeting.<br><br>On 01/15/25 at 3:02 pm during an interview with Director of Social Services (DSS) #13 the surveyor asked what the process is when a care plan meeting is held. DSS #13 verbalized the residents are invited to attend the meeting either in writing or in person. They introduce themselves update the MOLST form, review goals, address any concerns, and review if the Advance Directive is current. The facility does not have a discipline assessment.<br><br>48167<br><br>2. On 01/15/25 at 10:01 AM, the Director of Social Services #13 was interviewed. During the interview, the Director of Social Services #13 stated that he/she sent emails to the interdisciplinary team inviting them to attend Resident #150's care plan meetings; however, they don't attend.<br><br>On 01/15/25 at 10:10 AM, Resident #150's medical record was reviewed. The medical record review revealed that Resident #150's quarterly Interdisciplinary Care Conference Attendance Record dated 12/19/24, showed that only the Director of Nursing, MDS Coordinator, Social Service, and Occupational Therapy attended Resident #150's care plan meeting. |

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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** 42863<br><br>Based on staff interviews, observations, administrative records reviews,and medical record reviews it was determined that the facility failed to document that a dependent resident consistently received activities of daily care such as showering and bathing or assistance with meals. This was evident for 1 out of 4 residents (#130) reviewed during the survey.<br><br>The findings include:<br><br>Resident #130 was diagnosed as a C5-C-7 quadriplegic as a result of a Motor Vehicle Accident several years ago who had limited mobility of his hands.<br><br>On 01.13.25 at 09:05 AM during an observation tour of the clinical unit 8, the surveyor observed resident #130 in bed with a foley catheter, no foley bag cover was present. The resident had an over the bed table in front him/her with both his/her hands on the table. The surveyor observed that the there was a dirty hand splint lying on the table in front of the resident's hand. While the surveyor was speaking with the resident, GNA #53 entered the resident's room with a breakfast tray. GNA #53 placed the breakfast tray on the resident's bedside table and proceeded to walk towards the door. The surveyor asked to speak with the GNA and inquired whether he/she would be assisting the resident with the meal. GNA#53 responded that he/she would ask the resident. The resident responded yes when the GNA returned to the bedside.<br><br>On 01.13.25 at 09:15 AM the surveyor observed GNA #53 walking out of resident #130's room with an empty tray. The surveyor asked if the resident had eaten the whole meal and GNA #53 replied yes. The surveyor asked GNA #53 why she had not set up the resident' s tray and assisted with the meal automatically. GNA#53 responded that she does not offer assistance unless the residents ask for assistance. The surveyor asked GNA #53 whether he/she was aware of the resident's limited range of motion with his/her hands and the GNA responded yes.<br><br>On 01.13.25 at 09:20 AM the surveyor returned to resident #130's room. Resident #130 stated that the facility staffing was not sufficient. Resident #130 stated that he/she had to ask for assistance and may wait a long time for the staff to return to his/her room. Also, the resident stated that he/she had not been out of bed for six months and that his/her wheelchair had not been repaired for over six months.<br><br>On 01.14.25 at 12:45 PM the surveyor reviewed the complaint, MD00205707 related to resident #130 which focused on the following issues: the resident was not provided total assistance with his/her activities of daily living, the room was dirty, and the resident was admitted to the hospital in May 2024 with a diagnosis of urinary tract infection and stage two decubitus ulcers on the sacral area.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215067 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/17/2025 |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01.16.25 at 1:00 PM the surveyor interviewed the DON regarding the concerns voiced by resident #130 regarding not being showered or gotten out bed for six months. The surveyor requested copies of the task forms related to activities of daily living for the months of August 2024 through January 2025. The DON stated that she was aware that the resident #130's electric wheel chair was not working however she did not comment on whether the resident had been out of bed or showered on a routine basis. The DON stated that the nurse practitioner # 69 had submitted an order for an in-person assessment of the resident and wheelchair with the medical equipment company in October 2024. The surveyor did not locate or receive documentation that the in -person assessment of resident #130 by medical equipment company occurred prior to the exit conference on 01.17.25 related to the electric wheelchair. The The nurse practitioner's pharmacy script provided to the surveyor for the new electric wheelchair was dated 01.15.25.<br><br>On 01.17.25 at 12:30 PM the surveyor received the copies of task forms related to personal hygiene and showers/bathing for the months of August 1, 2024 through and including January 16, 2024. The review of the task documentation utilized by the geriatric nursing staff (GNA) to document personal care provided to the resident is listed:<br><br>October 2024: ADL Care<br><br>Oral Care: 10/20/24 ,10/29/24, 10/30/24- day shift-no documentation<br><br>Personal hygiene: 10/20/24,10/29/24, 10/30/24-no documentation<br><br>Shower/bath: 10/20, 10/29/24, 10/30/024-no documentation,<br><br>Toileting, transfer: Oct. 1-19th: marked N/A, 20th, 29th, 30th had no documentation,<br><br>Transfer wheelchair: Oct. 1 through 5th marked as N/A, 20th, 29th, 30th had no documentation, noted.<br><br>November:<br><br>Personal Hygiene: Nov. 12, 13, 28, 29th day shift: no documentation<br><br>Wheelchair/Transfer: [DATE] through 14, 8, 9, 10, 14, 15, 16, 18, 19, 20, 21, 24, 25, 26, 27, 30 were marked N/A.<br><br>Toilet/hygiene: Nov. 8, 9, 11, 16, 21, marked N/A; Nov. 12, 13, 28, 29 had no documentation.<br><br>Transfer: Day shift: Nov. 1, 4, 5 marked marked maximum assist, there was no documentation for Nov. 12, 13, 28, 29, and N/A was marked on Nov. 2 through 11 and Nov. 14, 15, 16, 17, 20, 21, 24, 25, 26 ,27, 30.<br><br>December 2024<br><br>Oral hygiene: No documentation on Dec. 7, 8, 10, 29, 30, 31<br><br>Personal hygiene: No documentation on Dec. 7, 8, 10, 29, 30, 31.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Shower/bath: No documentation on Dec. 7, 8, 10, 28, 29, 30, 31.<br><br>Wheelchair/Transfers: No documentation on Dec. 7, 8, 10, 29 and N/A marked for Dec. 1, 2, 3, 4, 5, 6, 14, 15, 19, 23, 25, 27, 28th.<br><br>January 2025<br><br>Personal hygiene: No documentation on Jan. 1 through 7th, 11, 12, 13, 14, 16th.<br><br>Shower/Bathe: No documentation on Jan. 1 through 5, 7, 11, 12, 13, 14, 16.<br><br>Toileting/hygiene: No documentation on Jan. 1 through 5th, 7, 11, 12, 13, 15<br><br>Transfers: No documentation on Jan. 1, 2, 3, 4, 5, 7, 11, 12, 13, 14, and 16.<br><br>These deficient practices were discussed with the DON on January 17, 2025 prior to the exit conference. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>30440<br><br>Based on observations and interviews with facility staff it was determined the facility failed to ensure that one-on-one activities were provided for a resident. This was found to be evident for 1 (Resident #24) of 3 residents reviewed for activities during the facility's survey.<br><br>Findings include:<br><br>An observation was made on 1/13/25 at 1:01 PM and resident # 24 was lying in bed asleep. No activities were observed.<br><br>Observation on 1/15/25 at 9:00 AM resident # 24 was observed sitting up in the bed with his/her legs noted to the side of the bed. No activities observed. While remaining on the unit from 9:00 AM-9:40 AM on the same date, the resident remained in the room when observed multiple times, sitting with legs to the side of the bed. No activity staff were observed entering the resident room and no one-one activities were observed.<br><br>During an interview with the Life Enrichment Director (LED), Staff # 8 on 1/15/25 at 10:45 AM, she stated that anyone that does not come out for activities and is determined not to be active on their own, in their room will receive one-one activities two- three times per week.<br><br>Staff # 8 was asked to provide documentation of the one-one activities provided to resident # 24 for November and December 2024. She stated that activity staff document all activities into a computer program called Life Loop. She explained that this program allows the family to view as well. Staff # 8 opened their computer to show the program to the survey team and the screen displayed resident # 24 activity. There was (1) one-one activity noted on December 18, 2024 and Staff # 8 stated and confirmed that no other documentation was available for the resident. When asked to display November 2024 activities for resident # 24, she stated that she could not pull it up on the computer because staff had not documenting it and it looks like it was not being done. She was made aware that the surveyor did not observe one-one activities on the above-mentioned dates, and she stated she will make sure that staff provide and document all one-one activities for residents.<br><br>The Administration team was made aware of all identified concerns at the time of exit on 1/17/25 at 5:30 PM. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148<br><br>Based on record review and interview with staff, it was determined that the facility failed to ensure that physician's orders were implemented and completed, ensure a residents' weight was monitored and ensure professional standards of nursing practice were followed when administering medications to residents. This practice was noted for 7 ( Resident #178, #297 #150, #116, #193, #188, #107) out of 74 residents reviewed during the survey.<br><br>The findings include:<br><br>1) A percutaneous endoscopic gastrostomy (PEG) tube is a feeding tube that is surgically inserted into the stomach through the abdomen. It allows a person to receive nutrition, fluids, and medicine when they can't consume enough through their mouth.<br><br>On 1/15/2025 at 9:00 AM, a review of Resident #178's electronic medical record revealed that the resident was admitted to the facility on [DATE] with a PEG tube in place. Further review failed to reveal any physician's order for PEG tube management at the facility.<br><br>On 1/15/2025 at 11:48 AM, an interview with the DON revealed that a resident with a PEG tube should have at least a flush, dressing (if needed), and a cleanse and care order. The Surveyor requested documentation of Resident #178's PEG tube care orders.<br><br>During an interview with the DON on 1/17/2025 at 10:12AM, the Surveyor was informed that the facility was unable to provide documentation of a physician order for PEG tube management for Resident #178. The DON confirmed that there were no orders in place while the resident was at the facility.<br><br>Vital signs reflect essential body functions, including your heartbeat (pulse), breathing rate (respirations), oxygen saturation, temperature, and blood pressure and are monitored to check your level of physical functioning.<br><br>2) On 1/15/2025 at 12:37 PM, a review of Resident #297's electronic medical record revealed a physician's order on 7/25/2024, which stated, Vital signs on Admission and then every shift for 7 days after admission. An additional review of the electronic medical record revealed that Resident #297 was admitted to the facility the evening of 7/25/2024. Nursing staff work 8 hour shifts 7 am-3pm, 3pm-11pm, and 11pm-7am.<br><br>On 1/15/2025 at 12:45 PM, the Surveyor reviewed Resident #297's vital signs under the Vital Signs tab in the electronic medical record. There was documentation of the resident's blood pressure, pulse, respirations, temperature, and oxygen saturation on 7/26/2024 at 12:30 AM, 7/27/2024 between 1:52 AM and 2:11 AM, and 7/27/2024 at 9:36 PM; blood pressure, pulse, respirations, and temperature were documented on 7/27/2024 at 12:40AM; and only blood pressure was documented on 7/26/2024 at 9:13 AM. The medication administration record and the treatment administration record were reviewed for July 2024 and the vital sign documentation matched the documentation under the Vital Signs tab in the resident's electronic medical record. There was no complete vital sign documentation for 7/26/2024 on the 7 am-3pm shift and 3pm-11pm shift, or on 7/27/2024 on the 7 am-3pm shift.<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 | During an interview conducted with the Director of Nursing (DON) on 1/16/2025 at approximately 8:40AM, the Surveyor was informed that physician's orders are to be reviewed and implemented by the nursing staff. The nurses sign off on the order to acknowledge they have reviewed them. Vital signs should be implemented as ordered.<br><br>48167<br><br>3) On 01/13/25 at 08:15 AM, Resident #150 was interviewed. During the interview, Resident #150 stated that he/she has a wound on his/her sacrum and was supposed to have dressing changes completed twice daily. Resident #150 also stated that the nurses do not always change his/her dressing as ordered.<br><br>On 01/15/25 at 10:37 AM, Resident #150's medical record was reviewed and revealed that Resident #150 had physician orders, dated 01/11/25, in place that state to cleanse the sacral wound with wound cleaner, pat dry, skin prep to peri wound, pack at 12 o'clock tunneling and wound bed with Dakin's 0.125% moist 1/4 inch packing strip BID (twice a day) and PRN (as needed) every day and evening shift and as needed, and consult Wound Care services as needed.<br><br>On 01/15/25 at 11:01 AM, Resident #150's medical record was reviewed. The medical record review revealed that Resident #150's wound care treatment was ordered on 01/11/25 at 9:00 AM, which stated the following:<br><br>- Dakins (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) apply to Sacral Decubitus topically two times a day for Wound treatment<br><br>- Pack wound with 1/4 iodoform ribbon moistened with Dakins leaving tail for removal<br><br>- Apply barrier crm. to periwound tissue<br><br>- Cover with 2x2/4x4 and Abd to keep surface dry<br><br>- If outer dressing becomes moist or saturated then change outer dressing.<br><br>Further review of Resident #150's medical record, January 2025 Treatment Administration Record, revealed that wound care was not documented as completed on 01/13/25 during the evening shift.<br><br>On 01/16/25 at 2:26 PM, the Director of Nursing staff #2 was interviewed. During the interview, the Director of Nursing staff #2 stated that it was not documented that Resident #150 had wound care completed on the evening of 01/13/25, and that there were not any notes indicating why wound care was not completed on the evening of 01/13/25.<br><br>42782<br><br>4) A review of Resident #116's electronic medical record (EMR) on 01/15/25 9:06 am revealed the resident's weight on admission (10/30/24) was 110.9 lbs. On 01/13/25 the resident's weight was 86 lbs. Resident #116 had a 22.45% weight loss in less than 3 months. As of 12/10/24 the resident had a 12.89% weight loss. The resident did not have a care plan for weight loss.<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 01/15/25 9:27 am during an interview with Registered Dietician #21 the survey asked was they aware the resident had a significant weight loss and if so, what interventions were put in place to help prevent further weight loss. RD #21 verbalized having to refer to their notes to see if they were notified of the weight change as they rely on staff when a resident has weight loss, but they can also run reports to see if a weight change occurred. At 9:51 am RD#21 verbalized the resident went to the hospital on 12/02/24 and returned on 12/10/24. On 12/12/24 they requested a reweigh to confirm the change. The Unit Manager never put the order into PointClickCare. The clinical team was emailed to let them know it needed to be done. RD #21 advised a reassessment on 12/16/24 identified the risk for malnutrition and started on Two Cal HN 120 ml twice a day. Meal intakes are recorded in PCC and Resident #116's intake fluctuated and the drinks were doing good. Meal intake was monitored; the resident was not consuming much of her meals.<br><br>On 01/15/25 10:27 am the surveyor received a copy of the email dated 12/12/24 at 11:10 am sent by RD #21 to the clinical staff requesting Resident #116 along with other residents to be reweighed. Director of Nursing #2 and Assistant Director of Nursing #3 were included as recipients of the email.<br><br>On 01/15/25 at 11:33 am during an interview with DON#2 the surveyor asked why resident #116's reweight was not done as requested by RD #21. DON #2 verbalized typically when they get a request it is discussed during the clinical meeting, but it was overlooked.<br><br>50573<br><br>5) It is a standard of nursing practice to document administered medications immediately after administration. Failing to do this raises the potential to result in medication errors (such as a resident receiving a dose twice, or two doses of a medication being given too close in time).<br><br>On 01/13/25 at 09:53 AM, an interview with Resident #193 revealed that her/his pain is not managed because their pain medication was not administered on time.<br><br>On 01/15/25 at 03:53 PM, review of Resident #193's medication administration audit provided by the Director of Nursing (DON, Staff #2) revealed in the months of December 2024 and January 2025, there was a pattern of multiple staff documenting multiple medications hours late, including those that reduce pain such as Gabapentin, Lidocaine Patch, Tizanidine, and Oxycontin Extended Release.<br><br>Gabapentin can treat nerve pain, which can be caused by different conditions.<br><br>Lidocaine skin patches are used to relieve nerve pain. The medication prevents pain by blocking the signals at the nerve endings in the skin.<br><br>Tizanidine is used to help relax certain muscles in your body. It relieves spasms, cramping, and tightness of the muscles caused by medical problems.<br><br>Oxycontin, also known as oxycodone is used to relieve pain severe enough to require opioid treatment and when other pain medicines do not work. It blocks pain signals to the brain.<br><br>6) On 01/13/25 at 02:52, review of Resident #188's medical record revealed she/he was receiving comfort care.<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 | Comfort care means providing medical care focused on making a person nearing the end of their life as comfortable as possible by managing pain and other symptoms, rather than trying to cure an illness. It can look different from person to person.<br><br>On 01/16/25 at 11:13 AM, the Director of Nursing (DON #1) provided the surveyor with a face sheet that included active orders and highlighted the orders specific to Resident #188's comfort care. Some of the highlighted medications indicated the resident was receiving Methadone and Salonpas Pain Relief Patch.<br><br>Methadone is a long-acting opioid (pain) medication used to replace the shorter-acting opioids.<br><br>Salonpas Pain Relief Patch is an anti-inflammatory medicine, spread across an ultra-thin and highly stretchable piece of cloth, that when applied directly to the skin enables the anti-inflammatory medicine to be delivered directly to the site of pain.<br><br>On 01/16/25 at 03:50 PM, review of the medication administration audit for Resident #188 in the month January 2025 revealed a pattern of multiple staff documenting multiple medications hours late, including those specific to the resident's comfort care (Methadone and Salonpas Pain Relief Patch).<br><br>On 01/16/25 at 04:07 PM, an interview with the DON regarding late medication administration for Resident #193 and #188 revealed that the expectation was that nursing staff administer medication within the time frame of an hour before, up to an hour after a medication is scheduled.<br><br>50457<br><br>7) On 01/13/2025 at 3:11PM, review of Resident #107's order summary and treatment record for December 2024 revealed an order weight on admission, then weekly weight times four weeks, then monthly weights every Sunday. Review of Resident #107s weight summary revealed there was no documentation indicating Resident #107 received weekly weights as ordered.<br><br>On 01/16/25 at 10:42 AM, during an interview with the Licensed Practical Nurse (LPN) #14, when asked about the process for obtaining and completing weekly weights for residents, the LPN #14 explained that a weekly weight sheet is printed and placed on a clipboard at the nurse's station. The geriatric nursing assistants (GNA's) are responsible for obtaining the weights for the residents listed on the sheet. The nurse or unit manager then enters the resident's weighs into the electronic medical records.<br><br>During an interview with the Nurse Unit Manager #26 on 01/16/25 at 12:12 PM, when asked who is responsible for obtaining weights for residents with weekly weight orders, she explained that she prints a list. The GNA's check the list and gather the weights for the residents they are assigned. The GNA's inform the nurse of the resident weight and the nurse enters the information into the electronic medical record. When asked why Resident #107's weekly weighs were not complete as ordered in December 2024, the Nurse Unit Manager #26 stated that she did not have an explanation for the oversight. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>30440<br><br>Based on observation and interviews with facility staff it was determined the facility staff failed to use appropriate safety measures while transferring a resident with a Hoyer lift and keep a resident environment safe. This was found to be evident for 2 (Resident # 210 and # 154) of 6 residents reviewed for accidents during the survey.<br><br>Findings include:<br><br>1. On 1/15/25 at 5:45 PM while touring the units, a family member who was visiting with resident # 210 requested assistance of staff to transfer the resident to bed. A nurse who was on the unit summoned a GNA (#48) to the resident room. Approximately five minutes later another GNA #54 and the assigned GNA (#55) arrived to assist. GNA #48 brought the Hoyer lift to the resident room and the other 2 GNA's placed the apron drape underneath the resident. The resident agreed to allow the surveyors to observe the transfer. At this time, the three GNA's attached the apron drape that was underneath the resident to the lift and proceeded to lift the resident. They were unable to lift the resident as the battery was not working. GNA # 48 removed the battery and went to get another battery. The battery was replaced three times and after the third time, the Maintenance Director (MD # 25) was called to the unit. The MD arrived approximately five minutes later and replaced the battery and the GNA's proceeded to transfer the resident with the resident grab bar in the up position. The Hoyer lift stopped working in the middle of the transfer and GNA # 48 went to another unit to get a battery. GNA # 48 returned approximately 5 minutes later, and the battery was changed. The three GNA's resumed the transfer, with resident # 210 observed bumping against the raised grab bar several times. The resident was noted to have a large wet area to his/her bottom. The assigned GNA, (#55) remained in the room to provide incontinent care and stated to the surveyor that she arrived at the facility at approximately 4:30 PM and made rounds on her other residents.<br><br>An interview was conducted with GNA # 54 on 1/15/25 at 6:15 PM and she was asked if the resident grab bar is to be in the up position when transferring a resident, she stated no. She went on to say that the grab bar is to be down during a transfer, but after the Hoyer lift battery was replaced multiple times, she forgot to put the grab bar down.<br><br>All identified concerns were discussed with the Administrator following the observation and at the time of exit on 1/17/25 at 5:30 PM.<br><br>51490<br><br>2. During observations on 1/13/25 at 8:20 am, a large tangle of wires was found in front of Resident #154's bed.<br><br>During a record review of the resident's care plan on 01/15/25 at 11:15 am, the following assessment was found: I am at risk for falls. The intervention listed for the resident stated, Create a safe environment, floors clear of clutter<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with staff # 63 on 1/15/25 at 8:45am she stated the resident was moved to the room a few days ago and the wires should not be there.<br><br>During a follow up observation on 1/16/25 at 10am the wires were secured along the baseboard with staples. |

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|---|---|---|---|
| | 215067 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bay Harbor Post Acute Healthcare Center | 200 Civic Avenue<br>Salisbury, MD 21804 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>50457<br><br>Based on observations, interviews, and record reviews, it was determined that facility staff failed to ensure adequate nursing staff to properly monitor residents. This deficient practice was evident for 1 (#133) out of 1 resident reviewed during the survey.<br><br>The findings include:<br><br>On 1/13/24 at 5:38 PM, review of complaint MD00204568 dated 4/2024 revealed, Resident #133 family member alleged the resident was being neglected by staff due to staffing issues.<br><br>On 1/14/25 at 4:19 PM, during an interview with Resident #133's family member, they report concerns about multiple falls Resident #133 had on station 7. The family member also mentioned that on 7/28/24 at 11:49 AM, they received a voicemail message regarding another fall the resident had. When they returned the call and asked the nurse who was working on station 7, the nurse replied that no nurse was working on unit 7.<br><br>On 01/15/25 at 8:41 AM, during an interview with geriatric nursing assistant (GNA) #19, they explained that stations 1, 2, 3, and 7 generally have one nurse assigned, while stations 4 and 8 have two nurses. GNA #19 stated that stations 1, 4, and 7 typically have three GNA's, and stations 2, 3, and 8 usually have four GNA's.<br><br>On 01/15/25 at 9:57 AM, during an interview with Station 7 Nurse Manager (NM) #26, regarding Resident # 133's fall in April 2024, and July 2024, the NM #26 stated she did not recall the incident in April 2024. She explained that in July 2024 while Resident #133 was in the dining room, she witnessed the resident attempt to stand. NM #26 tried to grab the resident but was unable to reach the resident in time.<br><br>On 01/15/25 at 11:01 AM, during an interview with the DON #2 regarding Resident #133's falls, the DON #2 explained that the resident was generally placed in the dining area to maximize supervision. The surveyor requested DON #2 to provide the nursing and GNA staffing for all nursing stations on 7/28/24.<br><br>A review of the facility's staffing levels for each station on 7/28/24 during the 7:00 AM to 3:30 PM shift, revealed that all stations were staffed with a nurse except for station 7.<br><br>During an interview with the DON #2 on 1/15/25 at 12:11 PM regarding staffing on station 7, she was asked why no nurse was working on Sunday 7/28/24 during the 7:00 AM to 3:30 PM shift. The DON #2 stated that she was not sure, but would provide proof that a nurse had been floated to station 7. The DON stated that NM #26 is usually the nurse assigned to station 7 but was floated to station 1 on that day.<br><br>On 1/17/25 at 10:23 AM, the DON #2 followed up with the surveyor and acknowledged that there was no nurse assigned to station 7 at the time Resident #133 fell . |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>51490<br><br>Based on medical record review and interview, it was determined the facility failed to ensure the pharmacist reports irregularities to the attending physician (Resident #133), and ensure that the Medication Regimen Review (MMR) of Residents #107 and # 150 was conducted at least once a month by a licensed pharmacist. This was evident for 3 of 7 residents reviewed.<br><br>The findings include:<br><br>Medication Regimen Review (MRR) or Drug Regimen Review (DRR), is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities.<br><br>1. A review of the medical record conducted on 1/15/25 at 10:58 pm for Resident #133, revealed a physician order from 8/26/23 for Phenobarbital 32.4 mg read as follows: Phenobarbital 32.4 tablet by mouth one time a day for seizures. The mg is missing from the order and could result in the administration of over 32 tablets.<br><br>A pharmacy review for this resident was performed on 1/8/25 and the review was documented as No Irregularities.<br><br>2. Review of Resident 107's medical record on 1/15/25 at 11:46am, failed to reveal an MMR for the months of September, October, November, and December 2024.<br><br>On 1/15/25 at 4:15pm, the DON (Director of Nursing) was given a request for the MRR's for the last 3 months for Resident #107.<br><br>On 1/16/25 at 3:37 pm, the DON informed the surveyor that the MRR for the last 3 months for Resident #107 could not be located. At this time, she verbalized understanding of the requirement for monthly MRR to be conducted for each resident.<br><br>48167<br><br>3. On 01/15/25 at 9:37 AM, Resident #150's medical record was reviewed. The medical record review revealed that pharmacy did not complete Resident #150's monthly, drug regimen reviews in September 2024, October 2024 and December 2024.<br><br>On 01/16/25 at 3:38 PM, the Director of Nursing staff #2 was interviewed. During the interview, the Director of Nursing staff #2 stated that pharmacy did not complete the resident's December 2024, October 2024 and September 2024 monthly drug regimen reviews.<br><br>All concerns were discussed with the Administration team on 1/17/25 at 5:30 PM at the time of exit. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>42863<br><br>49148<br><br>Based on observation, record review, and interviews with staff, it was determined that the facility failed to ensure that all medications and biologicals were stored and labeled properly. This was evident for 3 out of 3 medication carts reviewed during the medication storage facility task completed during the survey.<br><br>The findings include:<br><br>Controlled Medications are substances that have an accepted medical use, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence.<br><br>On 1/17/2025 at 8:30 AM, during an observation of a medication cart across from nurses' station #1, the Surveyor identified house stock medication bottles of Melatonin 10 mg, Melatonin 5 mg, Melatonin 3 mg, Aspirin chewable 81 mg, acetaminophen 325 mg, and Vitamin D 25 mcg which were all opened and not labeled with the date the bottle was opened. Licensed Practical Nurse (LPN #5 was made aware of the Surveyors findings and stated she would discard the medication according to the facility policy. LPN #5 informed the Surveyor that once a new house stock medication is opened, it should be labeled with the date opened.<br><br>On 1/17/2025 at 8:49 AM, during an observation of the another narcotic medication cart across nurses' station #1, the Surveyor also identified house stock medication bottles of Melatonin 10 mg, Melatonin 5 mg, Melatonin 3 mg, Aspirin chewable 81 mg, and Vitamin D 25 mcg which were all opened and not labeled with the date the bottle was opened. Further observation in the narcotic lock box, revealed a discontinued controlled medication, Hydrocodone-Acetaminophen blister pack, for Resident #158 in the medication cart. LPN #5 was made aware of the Surveyors findings and stated she would discard the house stock medication and have a second nurse assist with discarding and destroying the controlled medication according to the facility's policy.<br><br>On 1/17/2025 at 11:30 AM, during an interview conducted with the Director of Nursing (DON), the Surveyor informed the DON of their findings during observation of the medication carts at nurses' station #1. The DON stated that when house stock medications are opened, they should be labeled at that time with the date. Upon resident discharge or discontinuation of a controlled medication, 2 nurses must destroy that medication and document on the Destruction Report immediately. According to the facility policy, disposal of controlled substances must take place immediately after discontinuation of use by the resident.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/17/2025 at 12:20 PM, during an observation of the narcotic medication cart at nurses' station #8, the Surveyor identified house stock medication bottles of Vitamin B-12 1000 mcg x 2, Multivitamins, Allergy relief 10 mg, Vitamin C 500 mg, Renavit Dietary supplements, Thiamine Vitamin B 1 100 mg, and Ferrous Sulfate 325 mg which were all opened and not labeled with the date the bottle was opened. Further observation in the narcotic lock box revealed a discontinued controlled medication, Amphetamine-Dextroamphet ER blister pack for Resident #150 in the medication cart. Registered Nurse (RN) #60 was made aware of the Surveyors findings and stated that she would discard of them according to facility's policy.<br><br>On 1/17/2025 at 2:15 PM, the DON was made aware of the Surveyors findings for the narcotic medication cart at nurses' station #8. |

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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>30440<br><br>Based on medical record review and interviews with facility staff it was determined the facility failed to ensure that residents' records are accurate, complete and protected. This was found to be evident for 3 (Resident # 41 and # 105) of 40 sampled residents reviewed during the facility's survey.<br><br>Findings include:<br><br>1. Review of resident # 41's medical record on 1/14/25 at 11:45 AM revealed the Preadmission Screening and Resident Review (PASARR) form that was completed on 11/10/22 did not have section (A)- Exempted Hospital Discharge filled out. The rest of the form was completed.<br><br>2. Review of resident # 105's medical record on 1/14/25 at 11:20 AM revealed the PASARR form that was completed on 11/18/21 did not have section (A)- Exempted Hospital Discharge filled out. The rest of the form was completed.<br><br>An interview was conducted with the Director of Social Services staff # 13 on 1/15/25 at 1:50 PM and she was asked to review the PASARR form for the resident that did not have the top part completed. She stated that the first section (A)- Exempted Hospital Discharge is supposed to be completed before completing the remainder of the form. Staff # 13 stated that the form is usually completed at the time of admission and was not reviewed again. She stated that moving forward she will make sure that the information is reviewed for completion.<br><br>51490<br><br>3. On 01/17/25 at 11:34 am during an interview with the family member of Resident #25, s/he stated that when requesting a record of medications given to his/her family member, a medication list for a different resident in the facility was given to them. This family member then provided a photo of the document in question which was reviewed showing it was indeed for the wrong resident. The document was printed out by RN #500.<br><br>During review of the resident roster on 1/17/25 at 1:35 pm, it was revealed that the medication list given to the resident's family member was for a different resident in the facility.<br><br>During an interview with the DON and the Administrator on 1/17/25 at 1:30pm , both stated they had no knowledge of the incident.<br><br>The Administration was made aware of all identified concerns at the time of exit on 1/17/25 at 5:30 PM. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 50573<br><br>Based on observation and interview, it was determined that the facility failed to keep a sanitary environment. This was evident for 3 of 4 units observed.<br><br>The findings include:<br><br>1. On 01/13/25 at 07:48 AM, an observation of Unit 2 & 3 revealed linen on the floor outside of the bathroom next to room [ROOM NUMBER].<br><br>On 01/13/25 at 11:20 AM, an observation of Unit 2 & 3 revealed linen on the floor beside the dresser in Resident #56's room.<br><br>On 01/15/25 at 12:32 PM, an observation in Resident #116's room revealed the resident's clothing and linen on the floor. The Director of Nursing (DON, Staff #2) confirmed the surveyor's observation.<br><br>On 01/15/25 at 02:35 PM, an interview with Unit 2 & 3 Manager (Staff #30) revealed that the expectation is for staff to place soiled/dirty linen in resident room linen carts or the linen room upon completion of care or when identified.<br><br>2. On 01/13/25 at 08:37 AM, the surveyor observed a large vertical, rectangle- like area of missing wall paper on the unit 2 hallway across from room [ROOM NUMBER].<br><br>3. On 01/13/25 at 12:01 PM, the surveyor observed a metal box missing its bottom left corner. The metal box was high up on the wall directly behind the nurses station of the unit 2 hallway, if one is looking from the nurses station out onto the hallway in front. The missing corner exposed rough edges on the metal box.<br><br>On 01/16/25 at 03:10 PM, an interview with Director of Maintenance (Staff #23) revealed that the facility uses an online platform called 'TELS' for staff to report maintenance concerns. He indicated that it was the expectation for staff to report maintenance concerns as they identify them. The surveyor asked the Director of Maintenance and the Nursing Home Administrator (NHA), who was also present during the interview if there were any maintenance concerns on Unit 2 which included missing wallpaper and/or at the nurses station. During the same interview, the NHA indicated that the facility was in the process of renovating part of the building (not currently unit 2), and that it was impossible for them to address wallpaper concerns as they did not have the same wallpaper that the previous building owners used.<br><br>On 01/16/25 at 03:17 PM, the surveyor walked with the Director of Maintenance and NHA to unit 2 to identify the concerns.<br><br>On 01/16/25 at 03:24 PM, an interview with the NHA revealed that there are only a certain amount of hours in a day and that their list of maintenance concerns throughout the building is long and impossible to address all in a timely manner.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 21859<br><br>4. During an observation of the facility on 1/13/25 at 9 am the following was observed:<br><br>Station #1-clean utility room: The sink located in the clean utility room was noted with a dark black substance around the faucet, a dirty trash can was located just inside the door of the room, a dirty isolation cart was lying sideways on top of the clean equipment located on a metal cart inside the room.<br><br>The DON accompanied this surveyor to the clean utility room on 1/13/25 at 10 am where the findings were verified and removed and cleaned by the DON.<br><br>On 1/15/25 at 4pm the Administrator was made aware of the resident concerns. |