STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215067	A. Building 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 Salisbury, MD 21804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 30440 Based on observation and interviews with facility staff it was determined the facility failed to ensure a resident's dignity was maintained for residents. This was found to be evident for 6 (Resident #210, #130, #56, #91, #152, and #179)) of 7 residents reviewed for dignity during the survey. Findings include: 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 on the hoyer. 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. 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. 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. 42782 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During observation rounds on 01/13/25 at 7:58 am while in Resident #56's room the surveyor observed a undated cloudy half full suction canister on the bedside table and dried tube feeding on the floor and IV pole holding the tube feeding pump. 3) On 01/13/25 at 7:59 am while speaking with Resident #152, the surveyor observed an empty urinal and a full urinal on the bedside table. 4) At 8:15 am the surveyor observed Resident #179 in bed with mucous secretions on the upper portion of their gown and the tracheostomy dressing was saturated with secretions. During an interview with Geriatric Nursing Assistant #30 he/she verbalized everyone knows his/her thing leaks mucous. 5) At 8:55 am on 01/13/25 while speaking to Resident #91 the surveyor observed a yellow stain and brown matter on the right side of the resident's fitted bed sheet. On 01/15/25 at 2:21 pm the surveyor made Director of Nursing #2 aware of the observations which compromised the residents' dignity. DON #2 verbalized if any of the staff goes into a residents' room the urinal should be emptied, cleaned out and given back to the resident. 42863 6) On 01.13.25 at 09:21 AM the surveyor observed Resident # 130 in bed with a foley catheter in place hanging on the left side of the bed, visible from the doorway. Resident #130's foley bag did not have a foley cover in place. During the surveyor's observation the assigned GNA # 53 was interviewed and asked what his/her responsibilities included related to caring for the Resident #130. GNA #53 stated that she/he was responsible for ensuring the foley catheter was emptied and looked at the uncovered foley catheter during the interview but did acknowledge that the foley catheter bag should be covered. On 1.13.25 at 1:45 PM the Resident #130 was observed with the foley catheter bag uncovered. On 01.14.25 at 10:30 AM the resident was observed without a foley bag cover over the metered foley bag. On 01.17.25 at 1:00 PM the resident was observed without a foley bag cover in place. On 01.17.25 at 1:30 PM the surveyor interviewed the director of nursing (DON) and informed her of this surveyor's observations of the uncovered foley bag. The DON stated that the expectation was that all foley catheter have a foley bag cover in place. This deficient practice was discussed during the exit interview on 01.17.25 as well

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30440 Based on observations and interviews it was determined that the facility staff failed to verify each resident on Unit 4 had their call bells readily available if assistance were needed and ensure a resident's needs were accommodated by scheduling a follow-up appointment in a timely manner. This was evident for 4 (Resident #119, #179, #210, and # 178) out of 5 residents reviewed for accommodation of needs during the survey. The findings include: 1. During observation rounds on 01/13/25 at 8:07 am the surveyor observed Resident #119 call bell on the floor. At 8:16 am while in Resident #179's room, the surveyor asked Geriatric Nursing Assistant (GNA) #31 where was the resident's call bell. GNA #31 verbalized the resident was unable to use their right arm and had minimal use of their left arm. GNA #31 proceeded to remove the call bell from behind the bed and place the call bell near the resident's left hand. While walking down the hall on Unit #4 on 01/13/25 at 8:38 am the surveyor entered room [ROOM NUMBER]. Resident #210 was in bed and the surveyor observed the call bell inside of the resident's slipper. The surveyor left the room to find a staff member. Registered Nurse #32 went to Resident #20 room, removed the call bell from their slipper and gave it to the resident. On 01/14/25 at 8:53 am the surveyor asked Geriatric Nursing Assistant #43 to describe their typical day on the unit caring for the residents. GNA#43 verbalized when they come into work, they check on the residents and make sure everyone is alright. Before vitals are taken the breakfast trays come and they must hand out the trays. If they are assigned a resident needing assistance with eating, they assist with the meal. If report is not given from the outgoing GNA, the Unit Manager is made aware. They check on the residents every few hours and they are supposed to make sure the resident's have their call bells. 42782 2. On 1/15/2025 at 8:54 AM, during a review of Resident #178's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] after being hospitalized . Further review revealed a Discharge Summary from the hospital which included orders to follow up with Orthopedic Surgery Service in two weeks. The Surveyor also identified a physician's order dated 12/04/2024 for an Ortho follow up. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the Director of Nursing on 1/15/2025 at 11:40AM, the Surveyor was informed that when a resident is admitted to the facility with a Discharge Summary including medical appointments, the admitting nurse is to review the Discharge Summary, highlight any appointments, and send it to the Unit Clerk. The Unit Clerk is then responsible for scheduling the appointment (unless it was already scheduled), arranging transportation, and contacting the resident representative or family to inquire if they plan to attend the appointment with the resident and/or provide their own transportation. If the appointment was already scheduled, the Unit Clerk should call to confirm that the appointment was scheduled. A record of resident appointment dates and times are kept by the Unit Clerk and that information should be documented in the specific resident's electronic medical record. The Surveyor asked the DON to provide documentation verifying Resident #178's scheduled orthopedic appointment, transportation arrangements, and contact with the family regarding any appointment arrangements during the admission period. On 1/17/2025 at 10:12AM, the DON informed the Surveyor that she was unable to provide documentation verifying Resident #178's scheduled orthopedic appointment, transportation arrangements, and contact with the family regarding any appointment arrangements during the admission period and confirmed the facility failed to schedule the resident's follow up appointment.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51490 Based on resident and staff interviews and record review, it was determined the facility failed to act promptly upon the recommendations of the resident council concerning issues of resident care and life in the facility. This was evident for 4 of 4 months of resident council meeting minutes reviewed. The findings include: On 1/15/25 at 2:15pm, an interview with 10 residents, including members of the resident council, was conducted. The residents voiced numerous concerns, many of which had also been identified by the surveyors. During an interview with the Life Enrichment Director (Staff #8) on 1/15/25 at 4:30 pm, copies of resident council minutes for November 2024, December 2024 and January 2025 were obtained. Minutes were requested for October 2024 but were not provided to the surveyor. Staff #8 stated that she sends council minutes and concerns to administration by using a Department Response Form. On 1/16/25 at 10:26 am during review of the Resident Council minutes provided by the facility, it was revealed that 20 issues were identified by the Resident Council in November 2024. These issues were with administration, nursing, EVS (Environmental Services) and dietary. 18 of the 20 issues were marked Still an issue. For December 2024, the same 20 issues were identified and all 20 were marked Still an issue. For January 2025, the same 20 issues were again identified, and all were again marked as Still an issue. On 1/16/25 at 4:45 pm, the DON and administrator were made aware of the findings during the review of resident council minutes and the earlier meeting.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50457 Based on medical record reviews and interviews, it was determined that facility staff failed to assess the resident for an advance directive and did not offer assistance with creating an advance directive. This deficient practice was evident for 6 (#98, #76, #133 #185, #107, #547) out of 6 residents reviewed during the survey. The findings include: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. On 1/13/25 at 10:57 AM, a review of Resident #98, #76, #133, #185, #107, #547's medical records revealed no evidence that the residents or their representatives were assessed for an advance directive, informed of their rights to have and advance directive, or provided with written material regarding an advance directive. On 1/13/25 and 01/14/25 the surveyor requested documentation from the Administrator #1 indicating that Resident #98, #76, #133, #185, #107, #547 or their representative were offered assistance with establishing advance directive. On 1/15/25 at 8:50 AM, the Administrator #1 provided the surveyor with a copy of the advance directive policy. The policy states that prior to or upon admission of a resident, the social director or designee inquires of the resident, his/her family members and/or his or her legal representative about the existence of any written advance directives. Additionally, if a resident does not have an advance directive, nursing staff must document in the medical record the offer to assist the resident and the resident's decision to accept or decline assistance. On 01/15/2025 at 8:56AM, the surveyor requested documentation from the Director of Social Services #13 indicating that an inquiry of an advance directive was completed at the time of admission and evidence that the resident and their representative were offered assistance creating an advance directive for Resident's #98, #76, #185, #107, #547. On 1/15/25 at 9:24 AM, the Director of Social Services #13 provided the surveyor with a copy of the Maryland Advance Directive: Planning for Future Care Decisions document. The Director of Social Services #13 acknowledged that the facility had no evidence that Resident #98, #76, #185, #107, #547 or their representative was offered assistance with creating an advance directive at the time of admission.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 21859 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. The findings include: 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. 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. 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. 50457 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. 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. 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. 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 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. The findings include: 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. 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. 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. 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. 30440 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. 48167 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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Also, Resident 150's bathroom had a dried, brown, strong, foul-smelling substance splattered on the wall, toilet and floor. 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 the facility on the weekend. 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. 21859 5) During an observation of the facility on 1/13/25 at 9 am the following was observed: 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. Room#119: The trashcan was overflowing with trash; floor was noted with trash and a dried substance. 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. The maintenance staff # 25 was made aware of the findings on 1/13/25 at 12:30pm. 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. On 1/15/25 at 4pm the Administrator was made aware of the resident concerns. 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. 50457 6) During the initial facility tour conducted on 1/13/25, the surveyor observed the following: 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. At 7:50 AM in room [ROOM NUMBER], observed a black substance on the toilet seat and clothes on the bathroom floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. At 8:19 AM, in room [ROOM NUMBER], observed a yellow and brown substance on the toilet seat. 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. At 8:33 AM, in room [ROOM NUMBER], observed a missing light bulb in the bathroom. 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. 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on record reviews and resident interviews conducted during the resident council meeting, it was determined the facility failed to ensure the residents have the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal and failed to promptly assist a resident in filing a grievance of missing personal property. This deficient practice was evident for 1 (#76) out of 1 resident reviewed during the annual survey. The findings included: 1) On 01/13/25 at 12:04 PM, during an interview with Resident #76, who was admitted [DATE], and their family member, they stated that the resident's jacket had gone missing during the week of Christmas. They reported the incident to a facility staff, but no one had followed up regarding the matter. On 01/14/25 at 03:15 PM, a review of Resident #76's personal property inventory record for December 2024 revealed that no personal property inventory had been completed. On 01/14/25 at 3:20 PM, during an interview with the Director of Nursing (DON) #2, she explained that a personal property inventory form is completed for residents upon admission. When asked about the process for addressing missing personal property, the DON #2 stated that nursing staff or herself would assist the resident in filing a grievance, and a staff member would follow up with the resident after completing the investigation. The surveyor informed the DON #2 of Resident #76's missing jacket and lack of follow-up regarding the matter. The DON #2 stated that she could not locate a grievance filed for the missing jacket and follow up with the resident and their family member. On 01/17/25 at 12:23 PM, the surveyor met with Resident #76 and their family member regarding the status of the missing persona property. Both the resident and family stated no facility staff had followed up with them about the missing property. 51490 2) On 1/15/25 at 2:15pm, an interview with 10 residents, including members of the resident council, was conducted. The residents voiced numerous concerns, many of which had also been identified by the surveyors. When the residents present at the meeting were questioned about the process of filing grievances, no resident in attendance was aware of the grievance process or where to find information to file a grievance. Multiple residents specifically expressed fear of reprisal if they were to file a grievance. Review of the resident council minutes on 1/15/25 at 3:30pm for October, November December 2024 and January 2025 revealed numerous concerns that are being documented each month as still an issue. During an interview with staff # 13 and staff #27 they both stated several residents have voiced several concerns during resident council meetings; however, the issues are not addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 1/15/25 at 4pm, when asked why the issues/grievances have not been addressed she stated they were addressed; however, was unable to produce any documentation. During an interview with the Activities Director, she validated the resident council meeting minutes were correct; however, was unable to produce any closed issues or grievances from the meetings.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 30440 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. Findings include: 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. 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. 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. 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 30440 Based on resident interviews and staff interviews it was determined that the facility failed to protect the residents from misappropriation of personal property and investigate resident's report of missing personal property. This was evident for 2 (resident #38 and #76) out of 4 residents reviewed during survey. The findings include: 1) On 01/13/25 at 11:26 AM, Resident #38 was interviewed. During the interview, Resident #38 stated that some of his/her clothing was missing after being laundered by the facility. On 01/13/25 at 12:45 PM, the Nursing Home Administrator staff #1 was interviewed. During the interview, he/she was made aware of Resident #38's grievance regarding his/her laundry missing. After surveyor intervention, the Nursing Home Administrator staff #1 stated that a Grievance Summaries would be completed. On 01/15/25 at 10:21 AM, Environmental Director staff #15 was interviewed. During the interview, Environmental Director staff #15 stated that he/she was not aware of the missing items and did not receive a Grievance Summaries regarding Resident #38's missing clothing. 50457 2) On 01/13/25 at 12:04 PM, during an interview with Resident #76, and their family member, they stated that the resident's jacket had gone missing during the week of Christmas. They reported the incident to a facility staff, but no one had followed up regarding the matter. On Tuesday 01/14/25 at 3:20 PM, the surveyor informed the DON #2 of Resident #76's report of missing personal property. On Friday 01/17/25 at 12:23 PM, the surveyor met with Resident #76 and their family member regarding the status of the missing personal property. Both the resident and family stated no facility staff had followed up with them about the missing property. The facility failed to protect the resident's personal property and investigate reports of missing property. Even after the surveyor informed the DON #2, no action was taken.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51490 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. The Findings include: 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. 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. 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42863 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. The findings include: 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. 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. 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. This deficient practice was discussed with the administrator and DON on 01.17.25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50573 Based on medical record review and staff interview, it was determined that the facility staff failed to code a resident's status accurately on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #188) of 40 sampled residents reviewed during the survey. The findings include: The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. The Assessment Reference Date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process. On 01/13/25 at 2:52 PM, review of Resident #188's medical record revealed a progress note titled Wound Care Progress Note dated 1/3/25 which indicated the resident had a Deep Tissue Injury (DTI) on her/his sacrum. A Deep Tissue Injury (DTI) is a type of pressure sore where the tissue underneath the skin is severely damaged by pressure. The sacrum consists of the bottom or base of the spine, between the two hip bones. On 01/13/25 at 2:26 PM, further review of Resident #188's medical record revealed a skin and wound evaluation dated 1/3/25 which indicated the resident had a DTI noted on the sacrum. On 01/13/25 at 3:00 PM, review of Section M - Skin Conditions of Resident #188's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/25 failed to reveal the wound being coded/indicated. On 01/15/25 at 04:29 PM, an interview with MDS Coordinator (Staff #12) revealed that to complete sections of the MDS, staff would rely on the resident's medical record, including progress notes. She further indicated that for wounds, they use wound evaluation notes. On 01/15/25 at 04:29 PM, during the same interview with Staff #12, the surveyor reviewed the 1/3/25 ARD MDS concern with Staff #12 regarding the coding not accurately reflecting the resident status and she agreed it was inaccurate coding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48167 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. The findings include: 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. 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. 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. 42782 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. 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. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 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. The findings include: 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. 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. 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. 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. 48167 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. 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation, record review, and interview with staff, it was determined that the facility failed to provide nursing care within professional standards of practice. This was found to be evident for 5 (Resident #178, #297, #447, #150, and #158) out of 74 residents reviewed during the annual and complaint survey. The findings include: 1) On 1/15/2025 at 8:54 AM, during a review of Resident #178's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] after being hospitalized . Further review revealed a Discharge Summary from the hospital which included orders to follow up with Orthopedic Surgery Service in two weeks. The Surveyor also identified a physician's order dated 12/04/2024 for an Ortho follow up. During an interview conducted with the Director of Nursing on 1/15/2025 at 11:40AM, the Surveyor asked the DON to provide documentation verifying Resident #178's scheduled orthopedic appointment, transportation arrangements, and contact with the family regarding any appointment arrangements. On 1/17/2025 at 10:12AM, the DON informed the Surveyor that she was unable to provide documentation verifying Resident #178's scheduled orthopedic appointment, transportation arrangements, and contact with the family regarding any appointment arrangements during the admission period and confirmed the facility failed to schedule the resident's follow up appointment. 2) 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. 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 orders for PEG tube management at the facility. 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. 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 physician orders for PEG tube management for Resident #178. The DON confirmed that there were no orders in place while the resident was at the facility. 3) 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 from 7 am-3pm, 3pm-11pm, and 11pm-7am. 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, and 7/27/2024 on the 7 am-3pm shift. 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. 4) Controlled Drugs 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. On 1/17/2025 at 8:45 AM, during an interview conducted with Licensed Practical Nurse (LPN) #5, the Surveyor was informed that narcotic counts for controlled drugs must be done by the incoming nurse and the outgoing nurse at change of shift. The nurses would verify the controlled drug count was accurate and sign the count on the Controlled Drug Receipt/Record/Disposition (CDRRD) form in the narcotic count binder at the narcotic medication cart. LPN #5 continued, when administering a controlled drug, the nurse should complete the report the same time the medication was given to keep the count accurate. If the medication was not taken for any reason, 2 nurses must destroy the medication according to the facility policy. On 1/17/2025 at 12:20 PM, during an observation of the narcotic medication cart at nurses' station #8, the Surveyor discovered a narcotic count binder containing CDRRD forms, to be completed for each resident taking a controlled drug on station #8. The Surveyor also observed the narcotic lock box to compare the controlled drugs in the lock box to the CDRRD forms in the binder. The Surveyor reviewed the CDRRD form for Resident #150's Oxycodone 15 mg tablet in which a remaining count of 10 tablets was recorded and in the actual medication blister pack there were 9 tablets remaining with initials and a time by #10; Oxycontin CR 10 mg tablets in which the remaining count of 2 tablets was recorded and in the actual medication blister pack there was 1 tablet remaining with initials by the #2, and Amphet Combo ER 30 mg capsules in which a remaining count of 14 was recorded and in the actual medication blister pack there were 13 capsules remaining with initials by the #14. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Surveyor reviewed the CDRRD form for Resident # 447's Tramadol 50 mg tablets in which a remaining count of 21 tablets was recorded and in the actual medication blister pack there were 20 tablets remaining and with initials and a time by the #21 and BUT/APAP/CAF (Fioricet) 50/325/40 mg tablets in which a remaining count of 10 tablets was recorded and in the actual medication blister pack there were 9 tablets remaining with initials by the #10. During an interview with Registered Nurse (RN)#60 on 1/17/2025 at 12:30 PM, the Surveyor confirmed that Resident #150 was given Oxycodone 15 mg, Oxycontin CR 10 mg, and Amphet Combo ER 30 mg and that Resident #447 was given Tramadol 50 mg and BUT/APAP/CAF 50/325/40 mg because RN #60 recorded her initials on the blister pack to show that the medication was given that morning. The Surveyor expressed the concern that the CDRRD forms for Resident #150's Oxycodone 15 mg, Oxycontin CR 10 mg, and Amphet Combo ER 30 mg as well as Resident #447's Tramadol 50 mg and BUT/APAP/CAF 50/325/40 mg had no documentation to confirm the medication was given to the residents which made the narcotic counts for those medications inaccurate at the time. RN#60 stated that she signs the medication off on the blister packet with her initials and initials and date for PRN (as needed) medications. She updates the CDRRD form by the end of the shift. RN #60 was unable to confirm the facility's policy for recording of controlled drugs counts on the CDRRD form at the time administration. An interview conducted with the Director of Nursing (DON) on 1/17/2025 at 2:15 PM revealed that according to the facility's policy, the nurse administering controlled drugs should complete the CDRRD form at the time the medication is removed from the narcotic drawer and make sure the time, resident name, drug, dose is correct, signed off on the CDRRD form, and adjust the balance in the appropriate column of the form. The Surveyor made the DON aware of the concern, during observation of the narcotic lock box at station #8, and that RN#60 had not signed off on Resident #150's and Resident #447's CDRRD form at the time she administered their controlled drug. The DON stated she would make sure RN#60 is provided education to regarding Controlled Substance signage/Reconciliation. On 1/17/2025 at 4:45 PM, the DON provided the Surveyor with a copy of the Inservice sign-in sheet for Controlled Substance signage/Reconciliation with RN #60's signature. 5) On 1/17/2025 at 8:45 AM, During an interview with Licensed Practical Nurse (LPN) #5, the Surveyor was informed that when a resident is discharged or a controlled medication has been discontinued, 2 nurses must destroy the medication according to the facility policy and document on the Controlled Dangerous Substance Destruction Report each time. On 1/17/2025 at 8:49 AM, an observation of the narcotic lock box in the narcotic medication cart across nurses' station #1 revealed a discontinued controlled medication, Hydrocodone-Acetaminophen blister pack, for Resident #158. LPN #5 was made aware of the Surveyors' findings and stated she would remove the discontinued controlled medication and have a second nurse assist with discarding and destroying the controlled medication according to the facility's policy. 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 narcotic medication cart at nurses' station #1. The DON stated that 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/2025 at 12:20 PM, an observation of the narcotic lock box in the narcotic medication cart at nurses' station #8 revealed a discontinued controlled medication, Amphetamine-Dextroamphet ER blister pack for Resident #150. Registered Nurse (RN) #60 was made aware of the Surveyors findings and stated that she would discard of them according to facility's policy. 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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 42863 Based on clinical record review, staff interviews, and observations it was determined that the facility failed to offer alternative equipment for a resident whose electric wheelchair was broken in order to maintain the resident's mobility and opportunities to be out of bed and failed to provide basic activities of daily needs to a resident. This was evident for 2 (Resident #130 and # 116) out of 4 residents reviewed for activities of daily living during the survey. The findings include: 1. Resident #130 was diagnosed as a C5-C-7 quadriplegic as a result of a Motor Vehicle Accident several years ago who has limited mobility of his/her hands. On 01.13.25 at 09:20 AM the surveyor returned to resident #130's room. The resident stated that staffing was not sufficient. The resident 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 he's/her wheelchair had not been repaired for over six months. The resident also stated that he/she would prefer to get out of bed once per day to a chair but that he/she has not been provided this opportunity. The resident was not able to state the status regarding the repair or replacement of the broken electric wheelchair. 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's electric wheelchair was not working however she did not comment on whether the resident had been out of bed to a chair routinely within a specific time period. On 01.17.25 at 11:40 AM the surveyor spoke with the DON regarding resident #130's broken wheelchair. The DON stated that she was aware that the electric wheelchair was broken but did not know whether the equipment would be repaired or replaced. The DON did not provide any documentation related to the use of alternative equipment for the resident to use to be out of bed on a routine basis while the repair or replacement of resident #130's electric wheelchair was completed. The DON stated the nurse practitioner (NP) # 69 had been in touch with a company that is able to assess whether a resident's chair will be covered under Medicare to be repaired or replaced. The DON stated that the nurse practitioner # 69 had submitted an order for an in-person assessment of the resident and wheelchair with the company during the month of October 2024. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01.17.25 at 1:45 PM the surveyor reviewed the electric wheelchair related documentation that the DON had provided. The documents faxed to the company on October 22, 2024 included a statement . it is expected that a powered wheelchair will allow increased independence with facility mobility, increasing his quality of life. The surveyor did not locate or receive documentation that the in -person assessment of resident #130 occurred prior the exit conference on 01.17.25. The script provided to the surveyor for the new electric wheelchair was dated 01.15.25. The facility failed to provide documentation that the resident was able to be out of bed on a daily or routine basis between the months of August 2024 through and including January 16, 2025. The deficient practice was discussed with DON prior to the exit conference on 01.17.25. 42782 2. On 01/13/25 at 4:25 pm during observation rounds the surveyor asked Resident #116 how often they are receiving a shower. Resident #116 verbalized not receiving showers; they get washed up. On 01/14/25 at 3:45 pm a review of Resident #116's Task section in the electronic medical record (EMR) revealed there was no documentation to verify the resident was receiving showers. On 01/14/25 at 4:23 pm during an interview with Assistant Director of Nursing (ADON) #3 the surveyor asked if Resident #116 was receiving showers. ADON #3 verbalized the staff are supposed to follow the shower list and each resident is supposed to receive a shower at least twice a week. The resident was scheduled to have a shower on Tuesday and Fridays during the 3 pm-11 pm shift. ADON #3 checked to see if the resident was receiving showers. There was no documentation to verify the resident was receiving showers. There were no notes to verify the resident refused any showers. ADON #3 verbalized the staff needs a better system to document whether a shower was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863 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. The findings include: 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. 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. 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. 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. 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm 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. 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: October 2024: ADL Care Oral Care: 10/20/24 ,10/29/24, 10/30/24- day shift-no documentation Personal hygiene: 10/20/24,10/29/24, 10/30/24-no documentation Shower/bath: 10/20, 10/29/24, 10/30/024-no documentation, Toileting, transfer: Oct. 1-19th: marked N/A, 20th, 29th, 30th had no documentation, Transfer wheelchair: Oct. 1 through 5th marked as N/A, 20th, 29th, 30th had no documentation, noted. November: Personal Hygiene: Nov. 12, 13, 28, 29th day shift: no documentation Wheelchair/Transfer: [DATE] through 14, 8, 9, 10, 14, 15, 16, 18, 19, 20, 21, 24, 25, 26, 27, 30 were marked N/A. Toilet/hygiene: Nov. 8, 9, 11, 16, 21, marked N/A; Nov. 12, 13, 28, 29 had no documentation. 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. December 2024 Oral hygiene: No documentation on Dec. 7, 8, 10, 29, 30, 31 Personal hygiene: No documentation on Dec. 7, 8, 10, 29, 30, 31. (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 30440 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. Findings include: An observation was made on 1/13/25 at 1:01 PM and resident # 24 was lying in bed asleep. No activities were observed. 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. 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. 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. 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 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. The findings include: 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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. 48167 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. 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. 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: - Dakins (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) apply to Sacral Decubitus topically two times a day for Wound treatment - Pack wound with 1/4 iodoform ribbon moistened with Dakins leaving tail for removal - Apply barrier crm. to periwound tissue - Cover with 2x2/4x4 and Abd to keep surface dry - If outer dressing becomes moist or saturated then change outer dressing. 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. 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. 42782 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. 50573 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). 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. 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. Gabapentin can treat nerve pain, which can be caused by different conditions. Lidocaine skin patches are used to relieve nerve pain. The medication prevents pain by blocking the signals at the nerve endings in the skin. Tizanidine is used to help relax certain muscles in your body. It relieves spasms, cramping, and tightness of the muscles caused by medical problems. 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. 6) On 01/13/25 at 02:52, review of Resident #188's medical record revealed she/he was receiving comfort care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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. 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. Methadone is a long-acting opioid (pain) medication used to replace the shorter-acting opioids. 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. 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). 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. 50457 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. 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. 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30440 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. Findings include: 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. 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. 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. 51490 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. 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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. During a follow up observation on 1/16/25 at 10am the wires were secured along the baseboard with staples.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50457 Based on medical record reviews, and interviews, it was determined that facility staff failed to monitor and address the nutritional needs of a resident who had a known significant weight loss. This deficient practice was evident for 1 (#107) of 1 resident reviewed during the survey. The findings include: On 01/13/2025 at 3:11PM, during a review of Resident #107's medical records, the surveyor identified that the resident's weight on 12/8/24, was 194 lbs, and on 1/6/25, it had decreased to 175 lbs, reflecting a weight loss of 9.79%. Review of Resident #107's treatment record for September 2024 to December 2024 revealed an order for monthly weights. On 12/08/24 a new order was written for Resident #107 to be weighed weekly, times four weeks, then monthly starting 12/08/24. There was no documentation to verify Resident #107 was weighed weekly. On 1/15/25 at 2:04 PM, a review of the Registered Dietician (RD) #21 progress notes for 11/13/2024, regarding weight changes reveals that Resident #107 weight had decreased by 20.6 lbs (9.3%) over the past two months. A review of the RD #21 progress notes for 1/13/2025, regarding weight changes revealed that Resident #107 weight has decreased by 19 lbs over the past month. No interventions were ordered until 1/13/25. Further review of residents' medical records revealed weights from September 2024 to January 2025: 9/17/2024 11:50 215.6 Lbs Standing 10/1/2024 07:46 208.8 Lbs Standing 11/4/2024 07:04 201.8 Lbs Standing 12/8/2024 18:21 194.0 Lbs Standing 1/6/2025 10:42 175.0 Lbs Standing 1/12/2025 14:40 175.0 Lbs Standing 1/15/2025 10:36 165.0 Lbs Standing (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RD #21 on 1/15/25 at 2:23 PM, she explained that she believed the residents' recent move to a different unit within the past month could have contributed to the residents' weight loss. RD #21 further explained that she chose not to intervene between September 2024 and January 2025 since the resident had a history of weight fluctuations. When it was pointed out that the residents' weight did not fluctuate but steadily decreased, the RD #21 acknowledged the continued weight loss and agreed that no other interventions had been put in place to address the weight until 1/13/25. RD #21 explained that she sent monthly emails to the Director of Nursing, and Unit Nurse Managers to inform them of the residents' weight changes. On 1/15/24 at 2:54 PM, a review of an emails sent by the RD #21 to medical staff on 11/13/24 revealed Resident #107 had 20.6 lb weight lost. On 1/10/25 an email was sent to medical staff explaining that monthly weights were missing. On 1/13/25 an email was sent to the medical staff of Resident #107's 19 lb weigh loss. There were no emails sent in October or December 2024 concerning the resident's weight. During an interview with the DON #2 on 1/15/25 at 4:21 PM, the surveyor asked about the process for addressing a significant weight change in a resident. The DON #2 explained that residents identified with significant weight loss are ordered weekly weights for four weeks, than monthly. Additionally, the residents' medical provider and family are notified. When it was pointed out that Resident #107's medical provider and family were not informed of the significant weight loss, the DON was not able to provide a reason why notification was not done. On 1/17/25 at 10:37 AM, during an interview with Physician Assistant (PA) #39 regarding Resident #107 weight loss, she stated that she expects nursing and dietary staff to inform her of any changes in a resident's condition. The surveyor inquired about Resident #107's weight loss from September 2024 to January 2025. The PA #39 explained that she was not aware of the weight concern until the previous week during an interdisciplinary meeting. The surveyor reminded the PA #39 that she had seen the resident between September 2024 to January 2025, but no interventions were ordered. The PA #39 explained that she had minimal interaction with the resident and again stated that she was unaware of the weight change.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 50573 Based on observation, record review and interview with facility staff, it was determined that the facility failed to obtain informed consent prior to the initiation of bed rails. This was evident for 5 (Resident #48, #107, #160, #167, and #188) of 5 residents reviewed for physical restraints. The findings include: Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. The facility should obtain a signed consent form before the use of bedrails. 1) On 01/13/25 at 11:59 AM, during the initial phase of the survey, the surveyor observed Resident #48 in bed with two 1/4 bed rails up on either side of the top end of the bed. On 01/16/25 at 11:00 AM, review of the document provided titled MQS: Admission/Readmission Evaluation Packet Section 2: Bed Rail Evaluation for Resident #48 failed to reveal alternatives attempted nor consent obtained prior to initiation and/or use of bed rails. 2) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #160 in bed with two 1/4 bed rails up on either side of the top end of the bed. On 01/16/25 at 11:00 AM, review of the document provided titled MQS: Admission/Readmission Evaluation Packet Section 2: Bed Rail Evaluation for Resident #160 failed to reveal alternatives attempted nor consent obtained prior to initiation and/or use of bed rails. 3) On 01/13/25 at 8:48 AM, during the initial phase of the survey, the surveyor observed Resident #167 in bed with two 1/4 bed rails up on either side of the top end of the bed. On 01/16/25 at 11:00 AM, review of the document provided titled MQS: Admission/Readmission Evaluation Packet Section 2: Bed Rail Evaluation for Resident #167 failed to reveal alternatives attempted nor consent obtained prior to initiation and/or use of bed rails. 4) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #188 in bed with two 1/4 bed rails up on either side of the top end of the bed. On 01/16/25 at 11:00 AM, review of the document provided titled MQS: Admission/Readmission Evaluation Packet Section 2: Bed Rail Evaluation for Resident #188 failed to reveal alternatives attempted nor consent obtained prior to initiation and/or use of bed rails. 5) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #107 in bed with two 1/4 bed rails up on either side of the top end of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 1:15 PM, review of the facility's policy titled, Bed Safety and Bed Rails indicated that the use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, and informed consent. On 01/16/25 at 11:00 AM, review of the document provided titled MQS: Admission/Readmission Evaluation Packet Section 2: Bed Rail Evaluation for Resident #107 failed to reveal alternatives attempted nor consent obtained prior to initiation and/or use of bed rails. On 01/16/25 at 1:40 PM, an interview with the Director of Nursing (Staff #2) revealed that she did not have consent nor alternatives attempted prior to initiation and/or use of bed rails for Resident #48, #107, #160, #167, and #188.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 50457 Based on record reviews and interviews, it was determined that the facility staff failed to ensure that the physician provided supervision of a resident with significant weight loss. This deficient practice was evident for 1 (#107) resident reviewed during the survey. The findings include: On 01/13/2025 at 3:11PM, during a review of Resident #107's medical records, the surveyor identified that the resident's weight on 9/17/2024, was 215.6 lbs, and on 1/12/25, it had dropped to 175 lbs. Further review of residents weight on 01/15/24 revealed a weight of 165 lbs. A review of the RD #21 progress notes for 1/13/2025, regarding weight changes reveals that Resident #107's weight had decreased by 19 lbs over the past month. No interventions were ordered until 1/13/25. During an interview with the Director of Nursing (DON) #2 on 1/15/25 at 4:21 PM, the surveyor asked why Resident #107's medical provider was not informed of the significant weight loss, the DON #2 was not able to provide an explanation why notification was not done. On 01/16/25 at 3:33 PM, the surveyor reviewed progress notes from Physician Assistant (PA) #39, Nurse Practitioner (NP) #69, and NP #84 for 01/7/25, 12/16/24, 11/26/24, 10/10/24, 10/9/24 however there was no mention of weight concerns until 01/07/25. No interventions were added to address weight concerns until 1/13/25. On 1/17/25 at 10:37 AM, during an interview with Physician Assistant (PA) #39 regarding Resident #107's weight loss, she stated that she expects nursing and dietary staff to inform her of any changes in a resident's condition. The surveyor inquired about Resident #107's weight loss from September 2024 to January 2025. The PA #39 explained that she was not aware of the weight concern until the previous week during an interdisciplinary meeting.

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F 0725 Level of Harm - Minimal harm or potential for actual harm 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. 50457 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. The findings include: 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. 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. 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. 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. 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. 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. 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. 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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on record review and interviews it was determined that the facility leadership staff failed to ensure certified nursing assistants completed a state approved geriatric nursing assistant training program within four months of employment. This deficient practice was evident in 7 (#29, #61, #73, #74, #75, #76, #77) actively employed certified nursing assistants. The findings include: On [DATE] at 4:30 pm a review of Certified Nursing Assistant (CNA) #29's employee record revealed the CNA completed their CNA training on [DATE]. Their CNA certificate was issued by the Maryland Board of Nursing on [DATE]. According to the employee's record the CNA had been working at the facility past the four-month allotted timeframe to obtain their Geriatric Nursing Assistant (GNA) certification. On [DATE] at 8:38 am Administrator #1 verbalized the Nurse Aide Candidate Handbook the facility used under the [former owner's] policy indicated CNA's had 12 months to obtain a GNA certification. They were not aware of the four-month time frame for a CNA to obtain their GNA certification to work in long term care. The surveyor requested a list of all the GNA and CNA who are employed at the facility. Review of the list of CNAs revealed there were five other CNA's (#61, #73, #74, #75, & #76), who have been working at the facility longer than the four-month allotted window to obtain their GNA certificate. In addition, CNA #77 certification expired on [DATE]. The surveyor called CNA #77; they verbalized their last day working at the facility was [DATE]. On [DATE] at 1:03 pm Human Resources (HR)Director #38 confirmed that CNA #77 last worked in the facility on [DATE] during the day shift. At 2:40 pm the surveyor asked who was responsible for verifying the staff had updated licenses and certificates. HR Director #38 verbalized when the clinical staff are hired, they are put in the system by corporate. Every month he/she, the scheduling coordinator, and Director of Nursing (DON) #2 receives an email with a list upcoming expiring licenses & certifications. They missed it and were under the assumption CNA #77 certificate was still active.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 42863 Based on observation and interviews, it was determined that the facility failed to post the required staffing data on the whiteboard and/or on the daily staffing board. The facility also failed to post the daily staffing schedule in a prominent place, readily accessible visually to visitors and residents. This was evident on three out of three nursing units. The findings include: On 01.13.25 at 08:45 AM the surveyor observed that on unit 7 the census board reflected the staffing assignment for Sunday, 01.12.25. Also, on unit 7 the daily staffing schedule was lying on the top of the counter and was not visible for visitors or residents. Additionally, at approximately 09:00 AM on unit 8 the daily staffing schedule was not posted so that visitors and residents could easily visualize the information. On 01.14.25 at 08:39 AM while performing an observation tour on Unit 2 and 3 surveyor observed the assignment board did not have written information regarding which clinical staff were assigned to each resident. There was no assignment sheet displayed that informed the residents or visitors which clinical staff were assigned to which resident. On 01.15.25 at 2:16 PM during an interview with LPN Unit Manager #30 she verbalized that the assignment board should be completed by the charge nurse. The assignment board was completed that morning and the ratio for the nurses and geriatric nursing assistants (GNA's) were added. The assignment is placed in the (GNA) assignment book. LPN # 30 stated that nursing staff would write their name on the sheet in the book. The surveyor informed LPN #30 that the assignment sheet is to be displayed and easily visible on the unit so that residents and visitors can view the information. LPN #30 verbalized that she was not aware of the regulation. On 01.17.25 at 3:13 PM the surveyor spoke with the DON regarding the correct process for the posting of the shift assignments, hours per clinical staff and residents assigned to clinical nursing staff information. The DON stated the charge nurse, the GNA or the unit manager could post the staffing information. The surveyor provided the DON with three examples of the staffing posting deficiencies during the survey.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49148 Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure that an account of all controlled drugs was complete and accurate and failed to provide the correct dosage of medication for a resident. This was found to be evident for 2 out of 2 narcotic lock boxes located in the narcotic medication carts and for 1 (Resident # 158) of 3 medication administration records reviewed for accuracy during the facility's survey. The findings include: Controlled Drugs 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. 1. On 1/17/2025 at 8:45 AM, during an interview conducted with Licensed Practical Nurse (LPN) #5, the Surveyor was informed that narcotic counts for controlled drugs must be done by the incoming nurse and the outgoing nurse at change of shift. The nurses would verify the controlled drug count was accurate and sign the count on the Controlled Drug Receipt/Record/Disposition (CDRRD) form in the narcotic count binder at the narcotic medication cart. LPN #5 continued, when administering a controlled drug, the nurse should complete the report the same time the medication was given to keep the count accurate. If the medication was not taken for any reason, 2 nurses must destroy the medication according to the facility policy. On 1/17/2025 at 12:20 PM, during an observation of the narcotic medication cart at nurses' station #8, the Surveyor discovered a narcotic count binder containing CDRRD forms, to be completed for each resident taking a controlled drug on station #8. The Surveyor also observed the narcotic lock box to compare the controlled drugs in the lock box to the CDRRD forms in the binder. The Surveyor reviewed the CDRRD form for Resident #150's Oxycodone 15 mg tablet in which a remaining count of 10 tablets was recorded and in the actual medication blister pack there were 9 tablets remaining with initials and a time by #10; Oxycontin CR 10 mg tablets in which the remaining count of 2 tablets was recorded and in the actual medication blister pack there was 1 tablet remaining with initials by the #2, and Amphet Combo ER 30 mg capsules in which a remaining count of 14 was recorded and in the actual medication blister pack there were 13 capsules remaining with initials by the #14. The Surveyor reviewed the CDRRD form for Resident # 447's Tramadol 50 mg tablets in which a remaining count of 21 tablets was recorded and in the actual medication blister pack there were 20 tablets remaining and with initials and a time by the #21 and BUT/APAP/CAF (Fioricet) 50/325/40 mg tablets in which a remaining count of 10 tablets was recorded and in the actual medication blister pack there were 9 tablets remaining with initials by the #10. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN)#60 on 1/17/2025 at 12:30 PM, the Surveyor confirmed that Resident #150 was given Oxycodone 15 mg, Oxycontin CR 10 mg, and Amphet Combo ER 30 mg and that Resident #447 was given Tramadol 50 mg and BUT/APAP/CAF 50/325/40 mg because RN #60 recorded her initials on the blister pack to show that the medication was given that morning. The Surveyor expressed the concern that the CDRRD forms for Resident #150's Oxycodone 15 mg, Oxycontin CR 10 mg, and Amphet Combo ER 30 mg as well as Resident #447's Tramadol 50 mg and BUT/APAP/CAF 50/325/40 mg had no documentation to confirm the medication was given to the residents which made the narcotic counts for those medications inaccurate at the time. RN#60 stated that she signs the medication off on the blister packet with her initials and initials and date for PRN (as needed) medications. She updates the CDRRD form by the end of the shift. RN #60 was unable to confirm the facility's policy for recording of controlled drugs counts on the CDRRD form at the time administration. An interview conducted with the Director of Nursing (DON) on 1/17/2025 at 2:15 PM revealed that according to the facility's policy, the nurse administering controlled drugs should complete the CDRRD form at the time the medication is removed from the narcotic drawer and make sure the time, resident name, drug, dose is correct, signed off on the CDRRD form, and adjust the balance in the appropriate column of the form. The Surveyor made the DON aware of the concern, during observation of the narcotic lock box at station #8, RN#60 had not signed off on Resident #150's and Resident #447's CDRRD form at the time she administered their controlled drug. The DON stated she would make sure RN#60 is provided education to regarding Controlled Substance signage/Reconciliation. On 1/17/2025 at 4:45 PM, the DON provided the Surveyor with a copy of the Inservice sign-in sheet for Controlled Substance signage/Reconciliation with RN #60's signature. 42782 2. On 01/16/25 at 12:44 pm during the morning medication pass with Certified Medication Aide (CMA) #11 he/she showed the surveyor the medication packet of Pioglitazone 30 mg. The physician order was Pioglitazone 45 mg by mouth (PO) daily (QD). The CMA clicked on the order in PointClickCare where another order for Pioglitazone 30 mg PO QD. The surveyor reviewed the medication administration record (MAR) and there was not a visible order for Pioglitazone 30 mg PO QD. The surveyor made Director of Nursing (DON) #2 aware at 12:05 pm. The surveyor called the pharmacy twice and was unable to speak with anyone at the pharmacy. The surveyor asked DON #2 to provide the pharmacy with their phone number to discuss the medication order and the dose being provided. On 01/17/25 at 8:34 am the surveyor made DON #2 aware the surveyor was unable to reach the pharmacy and they did not receive a telephone call from the pharmacist. On 01/17/25 1:59 pm the surveyor reported calling the pharmacy again. DON #2 verbalized Assistant Director of Nursing #3 reached out to the pharmacist and provided the surveyor's contact information.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 51490 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. The findings include: 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. 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. A pharmacy review for this resident was performed on 1/8/25 and the review was documented as No Irregularities. 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. 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. 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. 48167 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. 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. 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42863 49148 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. The findings include: 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. 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. 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. 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50573 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that residents were served meals according to their menu ticket. This was evident for 6 (Resident #136, #97, #176, #600, #193, #83, #599) of 6 residents randomly observed during meals, and 1 of 1 meal tray line observed during the survey. The findings include: 1a) On 01/14/25 at 09:13 AM, the surveyor randomly observed Resident #136 in her/his room eating breakfast. The surveyor observed Resident #136's meal ticket which indicated extra gravy or sauce on the side, hot cereal, orange juice, and coffee or hot tea. Resident #136's meal tray failed to include extra gravy or sauce on the side, hot cereal, orange juice, and coffee or hot tea. On 01/14/25 at 09:14 AM, an interview with Certified Nursing Assistant (CNA, Staff #29), who was in the room at the time of the observation revealed that she agreed that the listed items above were not on the resident's tray. CNA #29 also indicated that the kitchen did not have any orange juice and that by the time she passes out the trays to all of the residents, the coffee tray was gone, and that staff relies on the kitchen for coffee because they did not have a way of making it on the unit. 1b) On 01/14/25 at 09:15 AM, the surveyor randomly observed Resident #97 in her/his room eating breakfast. The surveyor observed Resident #97's meal ticket which indicated hot cereal, orange juice, and coffee or hot tea. Certified Nursing Assistant (CNA, Staff #29), who was in the room at the time of the observation agreed that the listed items above were not on the resident's tray. CNA #29 indicated that the kitchen did not have orange juice this morning and that they only had cranberry juice. 1c) On 01/15/25 at 08:52 AM, the surveyor randomly observed Resident #176 in her/his room eating breakfast. The surveyor observed Resident #176's meal ticket which indicated orange juice, hot cereal, and hot coffee. Resident #176's tray failed to reveal orange juice, hot cereal, nor hot coffee. On 01/15/25 at 08:53 AM, an interview with Resident #176 revealed that staff do not bring him/her coffee. On 01/15/25 at 08:55 AM, an interview with Certified Nursing Assistant (CNA, Staff #61) revealed that the kitchen ran out of orange juice. 1d) On 01/15/25 at 08:57 AM, the surveyor randomly observed Resident #600 eating breakfast in his/her room. The surveyor observed Resident #600's meal ticket which indicated orange juice, hot cereal, and coffee or hot tea. Resident #600's meal tray failed to reveal orange juice, hot cereal, and coffee or hot tea. 1e) On 01/15/25 at 09:02 AM, the surveyor observed Resident #193 in his/her room eating breakfast. The surveyor observed Resident #193's meal ticket which indicated orange juice, hot cereal, and coffee or hot tea. Resident #193's meal tray failed to reveal orange juice, hot cereal, and coffee or hot tea. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1f) On 01/15/25 at 09:04 AM, the surveyor observed Resident #83 in his/her room eating breakfast. Resident #83's meal ticket indicated orange juice and hot cereal. Resident #83's meal tray failed to reveal orange juice and hot cereal. 1g) On 01/15/25 at 12:09 PM, the surveyor observed Resident #599 in his/her room eating lunch. The surveyor observed Resident #599's meal ticket which indicated baked apple slices. Resident #599's meal tray had a cup of apple sauce, but failed to reveal baked apple slices. 2) On 01/15/25 at 12:36 PM, during a lunch tray line observation in the kitchen, the Director of Operations (Staff #58) indicated that they ran out of the Au Gratin Potatoes, which was the regular starch on lunch meal tickets. The residents with trays following were provided mashed potatoes instead which was not what the regular meal ticket indicated. On 01/15/25 at 01:01 PM, during the same lunch tray line observation, Dietary Aide (Staff #62) indicated that they had ran out of the regular dessert, which was an apple cake slice. The residents with trays following were provided baked apple slices which was not what the regular meal ticket indicated. On 01/15/25 at 01:16 PM, during the same lunch tray line observation, Director of Operations (Staff #58) indicated that the kitchen was out of the regular entree, which was meatloaf. The residents with trays after were provided with baked fish which was not what the regular meal ticket indicated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50573 Based on resident interview and surveyor observation it was determined the facility failed to provide palatable food with an appetizing temperature. This was evident for 1 out of 1 observation of a kitchen tray line and test tray. The findings include: On 01/15/25 at 11:23 AM, the surveyor observed the start of the lunch tray line in the kitchen. Staff were placing plates with food onto hot plates which were then placed into the tray carts for unit delivery. Hot plates are used to keep prepared food warm by serving it on a heated plate, ensuring that the meal stays at an appealing serving temperature for residents, especially those who may take longer to eat, preventing the food from cooling down too quickly when served on a cold plate. On 01/15/25 at 01:02 PM, Director of Operations (Staff #58) indicated that they had run out of hot plates at the time during the tray line. There were approximately 16 resident plates left to be made and sent to the unit. Staff #58 continued to place the following 16 plates on trays without a hot plate underneath onto the cart for unit delivery. On 01/15/25 at 01:21 PM, the surveyor requested a test tray, which was then the last tray made during the lunch tray line. The temperature of the fish entree was 138.1 degrees fahrenheit and the side of mashed potatoes were at a temperature of 144 degrees fahrenheit. The temperatures above, taken by Staff #58 with the surveyor present, were the temperatures just prior to placing the food onto the tray (without a hot plate underneath) and then onto the cart for unit delivery. On 01/15/25 at 01:42 PM, the same plate for the test tray temperatures were taken by Staff #58 with the surveyor present. The temperatures were taken after the last tray on the cart had been delivered to the prospective resident on the prospective unit. The entree was 124.8 degrees fahrenheit and the side of mashed potatoes was 114.1 degrees fahrenheit. On 01/15/25 at 01:45 PM, two surveyors tested the entree and side, which failed to be a palatable taste and at an appetizing temperature. The coffee which was also on the tray was room temperature at taste by the surveyor.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 51490 Based on an interview with resident council members, it was determined the facility staff failed to ensure that suitable, nourishing alternative meals and snacks were provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This was evident for 10 out of 10 residents present at the resident council meeting with the surveyor. The findings includes: On 1/15/25 at 2:15pm, a meeting with 10 residents for the resident council interview was held in the main dining hall. At this time, numerous resident complaints were voiced. All residents in attendance agreed that often there are no snacks at bedtime. The residents stated that bedtime snacks are brought to the unit not labeled and often not delivered to the rooms, there is typically only one choice of snack and no consideration of personal preferences. One resident stated they required special dietary considerations and that those considerations were never met by the evening snacks. Review of the resident council minutes on 1/15/25 at 3:30 pm for October, November December 2024 and January 2025 revealed numerous concerns which included snacks at bedtime. The issue was documented each month as still an issue. On 1/15/25 between 15pm and 5:30 pm the Surveyor interviewed staff # 26 and staff #70 on unit one, staff # 49 on unit 2, staff # 30 on unit 4, staff # 71 on unit 7, staff # 72 on unit 8, and staff # 62 from the dietary department. Each staff member validated that snacks are sent to the units unlabeled. During an interview on 1/16/25 at 11pm with the Senior Director of Operations for food services (staff # 59), he stated bedtime snacks are sent to each unit in bulk and unlabeled. When asked how resident personal preferences and special dietary considerations are addressed, he stated this process works in all the facilities he has overseen.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 50573 Based on observation and interview, it was determined that the facility failed to ensure that the facility's kitchen had an eating assistive device for a resident. This was evident for 1 (Resident #23) of 223 resident meal tickets observed during the kitchen meal tray line. The findings include: On 01/15/25 at 11:45 AM, during the lunch tray line observation, Director of Operations (Staff #58) indicated that they did not have the scoop plate that was indicated on the meal ticket for Resident #23. A scoop plate is an assistive device that helps people eat independently by making it easier to push food onto a spoon or fork because of curved rim features. On 01/15/25 at 11:45 AM, an interview with Staff #58 revealed that physical therapy would have to order more because the kitchen had no scoop plates. On 01/15/25 at 11:46 AM, an observation during the same tray line revealed Resident #23's food prepared on a regular plate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 3) On [DATE] at approximately 9:25 AM, the Surveyor observed the Medication room at nursing station #1. There were 2 small black refrigerators sitting one on top of the other in the medication room. The inside of the bottom refrigerator door and interior shelves were dirty, covered with multiple areas of brown dried food stains and sticky cream-colored stains. The Surveyor observed a clear cup of cream-colored pudding covered with plastic wrap and labeled ,d+[DATE]. 4) On [DATE] at approximately 9:50 AM, the Surveyor observed the Clean Utility room. There was a Standard size refrigerator located in the corner of the room. Licensed Practical Nurse (LPN) #5 informed the Surveyor that was where resident stored personal foods. The Surveyor observed a [DATE] temperature log with no freezer or refrigerator temperature documentation. Inside the refrigerator, on the top shelf, there was an opened and unlabeled 8 oz pack of [NAME] bologna, 32 oz Wawa hazelnut non-dairy creamer, 64 oz Thick It Clear Advantage water, and a pack of 24 slices [NAME] white cheese singles with an expiration date of [DATE]. On the second shelf, there was an opened and unlabeled white container of food with a clear lid, a brown Red Lobster bag containing food, a container of food for Resident #158 labeled ,d+[DATE]. On the door, there was a 236mL carton of whole milk which expired [DATE], an opened an unlabeled 46 oz Sysco Imperial Thickened lemon flavored water, and 46 oz Thickened Apple Juice which expired [DATE]. On [DATE] at approximately 10:30 AM, the Surveyor confirmed the Medication Room and Clean Utility Room refrigerator findings with LPN #5 and the Director of Nursing (DON). The Surveyor was informed that resident's food should be labeled with the resident's name and the date the food was brought in and should be discarded after 3 days. LPN #5 stated she would clean and discard any expired, opened and unlabeled foods from the Medication Room refrigerator and the Clean Utility Room refrigerator. 50573 Based on observations and staff interviews, it was determined that the kitchen failed to ensure food items are stored to maintain the integrity of the specific items and equipment temperature logs were maintained for monitoring and food was stored in accordance with professional standards for food service and safety. This failure has the potential to affect all residents. The findings include: 1) On [DATE] at 07:40 AM, an initial observation of the kitchen refrigerator revealed eggs unlabeled with a date of ,d+[DATE], lunch meat unlabeled with a date of ,d+[DATE], an unlabeled and undated raw meat on the bottom shelf which had crumbled wrapping exposing the food, an opened bag of sausage patties which were undated, a bag of opened, undated tater tots, cooked chicken unlabeled and undated, parmesan cheese with an unidentifiable label, a stack of yellow cheese in a tin pan unlabeled and undated, an unlabeled and undated opened bag of hot dogs, cooked cookies in individual bags unlabeled and undated, 2 bags of iceberg lettuce which were opened and undated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 07:53 AM, the surveyor observed tropical fruit with a date of [DATE]. The Assistant Manager (Staff #52) present at the time of observation indicated that [DATE] was the open date. The surveyor asked if that was able to be confirmed and she indicated that it was an assumption. On [DATE] at 07:57 AM, an observation of the dry storage room revealed approximately 8 prepped cereal bowls labeled rc that were undated. On [DATE] at 07:58 AM, an interview with the Assistant Manager (Staff #52), revealed that the expectation is for staff to label food with the name of the food, the date it was prepped, and a date of when the food should be thrown out. 2) On [DATE] at 08:10 AM, an observation of the kitchen freezer located in the basement revealed a temperature log which failed to reveal documentation that temperatures were taken since [DATE]. Assistant Manager (Staff #52) present at the time of the observation confirmed the finding. On [DATE] at 08:13 AM, review of the paper log on top of the dishwasher during observation revealed records of shifts logging temperatures of the dishwasher but failed to reveal any documentation for [DATE] morning/afternoon shift and documentation since the evening of [DATE] that indicated the temperatures were recorded. Staff #52 present at the time of the observation confirmed the finding. On [DATE] at 08:14 AM, an interview with Assistant Manager (Staff #52) revealed that the expectation is for staff to record temperatures on equipment logs each shift.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30440 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. Findings include: 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. 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. 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. 51490 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. 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. 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. 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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 30440 Based on review of the facility documentation and staff interviews it was determined the facility failed to ensure that the Quality Assurance Committee met on a quarterly basis for the past year. This was found to be evident during the facility's survey. Findings include: On 1/17/25 at 2:00 PM the survey team requested documentation of the facility's Quality Assurance attendance sheets for January 2024 through December 2024. The documents provided by the facility consisted of information dated July 2024 through November 2024. At that time an interview was conducted with the Administrator (Staff#1) who stated that she was the designated person for the Quality Assurance Program. She stated that the facility obtained new ownership effective June 26, 2024. She went on to say that the current owners did not maintain documentation of the previous attendance sheets at the time of obtaining ownership and could not provide the attendance sheets for January 2024, February 2024, March 20024, April 2024, and May 2024. She was made aware that the facility is responsible for maintaining all facility documentation under the provider's number. All concerns were discussed with the Administration team at the time of exit on 1/17/25 at 5:30 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48167 3. On 01/13/25 at 8:12 AM, Licensed Practical Nurse staff #9 was interviewed. During the interview, Licensed Practical Nurse staff #9 stated that Resident #447 was on droplet precautions for respiratory syncytial virus. Also, Licensed Practical Nurse staff #9 stated that the facility's policy and procedure is that residents diagnosed with respiratory syncytial virus should have droplet precaution signage on the outside of his/her room door. During observation rounds on 01/13/25 at 8:23 AM, Resident #447's room was found to not have droplet precaution signage posted on the outside of his/her room. On 01/17/25 at 11:28 AM, Resident's #447's medical record was reviewed. The medical record review revealed that Resident #447 was diagnosed with respiratory syncytial virus on 1/9/25. 42782 Based on observations and interviews it was determined that the facility staff failed to maintain infection control practices and provide the appropriate signage outside the resident's room indicating the use of specific personal protective equipment. This deficient practice was discovered during observations and tours involving a shower room, resident rooms (Resident #211 and Resident # 447) conducted during the facility's survey. The findings include: 1. On 01/13/25 at 7:52 am the surveyor walked into the shower room across from room [ROOM NUMBER] on Unit 2 and 3. There was a large white shower chair in the right corner of the room. There was a large amount of stool on the floor under the shower chair. Certified Nursing Assistant (CNA) # 29 confirmed the surveyor's findings. The CNA reported the shower room is used every day. The CNA verbalized completing the class in May. On 01/15/25 at 4:07 pm interview with Regional Environmental Services Director #44 who verbalized the nurses must clean up bodily fluids first and the cleaning staff would come and sanitize the area. They did not receive a report about the shower needing to be cleaned. 2. During the continuation of observation rounds at 8:50 am the surveyor observed Resident #211 incentive spirometer on the floor near the back of the bed and the oxygen tubing hanging off the side of the bed near the floor. Physical Therapy Assistant #34 confirmed the surveyor's observations. On 01/15/25 at 2:26 pm during an interview with Licensed Practical Nurse Unit Manager #30 he/she typically round on the unit between 7:00 am - 7:30 am. They check on all the residents and receive report from the nurses and aides. He/she tries to check the shower room routinely. Some residents use the shower independently.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 48167 Based facility record reviews and staff interviews, it was determined that the facility failed to provide documentation indicating that facility staff members received screening, education, offering, of the current COVID-19 vaccination. This was evident for 5 staff members (Geriatric Nursing Assistants #64, 65, 66, 67 and 68) out of 5 staff members reviewed during the survey. The findings include: On 01/17/25 at 1:17 PM, Geriatric Nursing Assistant's #64, #65, #66, #67 and #68 facility records were reviewed. The facility record review revealed that Geriatric Nursing Assistants #64, #65, #66, #67 and #68 did not have documentation in their personnel records indicating that they received screening, education, offering, of the current COVID-19 vaccination. On 01/17/25 at 1:44 PM, the Infection Preventionist staff #4 was interviewed. During the interview, the Infection Preventionist staff #4 stated that he/she did not have documentation indicating that the 5 Geriatric Nursing Assistants received screening, education, offering, and current COVID-19 vaccination.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50573 Based on observation, record review and staff interview, it was determined the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. This was evident for 5 (Resident #48, #107, #160, #167, and #188) of 5 residents reviewed for accidents. The findings include: Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. 1) On 01/13/25 at 11:59 AM, during the initial phase of the survey, the surveyor observed Resident #48 in bed with two 1/4 bed rails up on either side of the top end of the bed. 2) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #107 in bed with two 1/4 bed rails up on either side of the top end of the bed. 3) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #160 in bed with two 1/4 bed rails up on either side of the top end of the bed. 4) On 01/13/25 at 8:48 AM, during the initial phase of the survey, the surveyor observed Resident #167 in bed with two 1/4 bed rails up on either side of the top end of the bed. 5) On 01/13/25 at 8:44 AM, during the initial phase of the survey, the surveyor observed Resident #188 in bed with two 1/4 bed rails up on either side of the top end of the bed. On 1/15/25 at 1:15 PM, review of the facility's policy titled, Bed Safety and Bed Rails indicated that maintenance staff was to routinely inspect all beds and related equipment to identify risk and problems including potential entrapment risks. On 01/16/25 at 03:35 PM, during an interview with the Director of Nursing, the surveyor requested the routine maintenance logs for risk of bedrail entrapment. On 01/17/25 at 09:22 AM, an interview with the Nursing Home Administrator (Staff #1) revealed that maintenance does not routinely check bedrails for entrapment. She further indicated that the staff assessed all resident bedrails the night prior for entrapment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 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. The findings include: 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]. 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. 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. 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. 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]. 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. 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. 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. 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. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	21859 4. During an observation of the facility on 1/13/25 at 9 am the following was observed: 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. 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. On 1/15/25 at 4pm the Administrator was made aware of the resident concerns.