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	215069	A. Building B. Wing	10/22/2024

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Orchard Hill Rehabilitation and Healthcare Center	111 West Road Towson, MD 21204

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to notify the resident's physician and/or resident's representative when the resident had a change in condition (Resident #9 and #47). This was evident for 2 of 38 complaint residents reviewed during a complaint survey. The findings include: 1. Review of Resident #47's medical record on 10/16/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with diagnosis to include chronic respiratory failure and status post lung transplant. Review of the hospital discharge summary dated 9/25/23 revealed the Resident was on BiPAP for his/her chronic respiratory failure. BiPAP, or bilevel positive airway pressure, is a noninvasive ventilator that helps people breathe when they have medical problems that make it difficult. Review of Resident #47's October 2024 TAR revealed the facility staff did not document the Resident was administered the BiPAP on 10/4 and 10/6/23. Further review of Resident #47's medical record revealed a nurse's medication administration note on 10/6/23 at 11:50 PM that stated, Bi-pap mask missing to be followed up with Respiratory therapist. Further review of the medical record revealed when the BiPAP was not administered on 10/4 and 10/6/23, there is no notification to the Resident's physician to allow the physician to potentially adjust the Resident's oxygen treatment orders when the BiPAP was not available. Interview with the Director of Nursing on 10/16/24 at 12:30 PM confirmed the facility staff failed to notify Resident #47's physician when the Resident's BiPAP was not available. 18819 2. Resident #9 was admitted from the hospital to the facility on [DATE]. A review of complaint MD00177583 on 10/10/24 revealed allegations that the facility staff are not communicating with Resident #9's family about Resident #9's current plan of care regarding infections and how Resident #9 was identified with pubic lice. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #9's clinical record on 10/10/24 revealed documentation Resident #9 was tested by the State Health Department related being identified with an antibiotic-resistant organism on 07/12/23. A second nursing progress note, written by the ADON (Assistant Director of Nursing), dated 07/19/23 at 10:35 PM, indicated Resident #9 was informed by the ADON that S/he had been identified of having an antibiotic-resistant organism. The ADON's progress did not indicate Resident #9's responsible party was made aware of the results. Further review of Resident #9's clinical record 10/11 24 at 9 AM revealed a nursing progress note, dated 10/10/24 at 9:35 PM, that indicated Resident #9's responsible party was made aware of a 05/12/22 result that indicated Resident #9 had been identified with an antibiotic-resistant organism. In an interview with the facility ADON on 10/11/2024 at 9:42 AM, the ADON stated that Resident Cox was never identified with genital lice since being admitted to the facility in 2015. The ADON stated that she reviewed the EMR(electronic medical record)/chart and could not identify documentation that indicated Resident #9 was identified having genital lice. In an interview with the DON on 10/11/2024, 11:15 AM, the nurse surveyor asked the DON if Resident #9's family were notified of being identified having an antibiotic-resistant organism. The DON stated that Resident #9's family were not notified when the Resident #9 was first identified as being identified with the antibiotic-resistant organism on 05/12/2022. The facility DON was made aware of the non-compliance regarding immediately notifying Resident #9's responsible party when Resident #9 was identified with an antibiotic-resistant organism on or around 05/12/22.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of a facility reported incident, medical record review, and staff interview, it was determined the facility failed to protect a resident from inappropriate sexual contact from a geriatric nursing assistance (GNA) (Resident #21). This was evident for 1 of 39 facility reported incidents reviewed during a complaint survey. The findings include: On 10/10/24 at 1:21 PM a review of facility reported incident MD00187475 revealed on 1/7/23 at 6:00 AM the facility's previous Director of Nursing (DON), Staff #52 received a telephone call that a GNA was found by staff engaged in a sexual act with Resident #21, an alert and oriented resident. Police were notified and the GNA was sent home. Review of the facility's investigation revealed GNA #58 was from a staffing agency. The facility documented that Resident #21 discussed the situation with them and stated GNA #58 came in to provide care and made the sexual advances. Resident #21 stated he/she was not upset it happened. Resident #21 stated it was consensual. The social worker offered psychosocial support, and the resident was offered and accepted psychological support services. Review of Resident #21's medical record revealed the resident was admitted to the facility in August 2022 with diagnoses that included but not limited to major depressive disorder, (recurrent, moderate), generalized anxiety disorder, and other persistent mood disorders. Review of a 1/11/23 psychiatrist note documented Resident #21 had anxiety, depression, insomnia and past diagnoses of personality disorder and bipolar disorder. The note documented that the resident had a previous in-patient psych admission and a past suicide attempt and attempted to overdose on various medications during the teenage years. The note documented in the additional clinical considerations, the patient's psychiatric symptoms are reemerging and require close follow up and intervention. The assessment was, with chronic anxiety and depression reports ongoing/increase in depressive/anxiety sx (symptoms). On 10/15/24 at 11:22 AM an interview was conducted with the previous Social Work Director, Staff #14 who stated that she met with the resident. Staff #14 stated she thought Resident #21 was more so embarrassed that he/she was caught in the act, but he/she basically was telling me it was consensual. Staff #14 stated she told the resident she needed to talk with the resident and that the resident was embarrassed because everyone kept checking on him/her to make sure he/she was ok, and the resident didn't want to talk about it. Staff #14 stated it was an agency aide. Staff #14 stated the resident said no one forced him/her to do anything. He/she thought people were talking about it in the facility. Staff #14 also stated that Resident #21 required full care from the aides. Staff #14 stated the resident could not walk and used a power wheelchair. On 10/17/24 at 1:19 PM an interview was conducted with licensed practical nurse (LPN) # 28. LPN #28 stated she was supervising that day, and it was the unit nurse that noticed the incident going on in the resident's room. Attempts to reach the unit nurse twice during the survey were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #28 stated she walked in the room and stated the GNA had his/her bottom of his/her scrubs down. LPN #23 stated the nurse told her the GNA was on top of the patient. LPN #28 stated that she had gone in the room right away and before she got there the nurse had already told the GNA to get down, but the scrub pants were halfway down. LPN #28 stated, my assessment was the aide was kind of high, under some kind of an influence and said to me I don't know what you are talking about. Obviously, something corresponded between him/her and the patient. We called the police. LPN #28 stated, [he/she] refused to come out of the room; was acting very weird and didn't want to leave the room. [He/She] was sounding like someone under the influence. [He/She] was off [his/her] baseline and that is based on my nursing judgement. This happened around 3 am. Everything you told [him/her] to do [he/she] had an attitude and was acting very weird. Further review of the facility's investigation revealed that the GNA was reported to the agency as a do not return and a write-up regarding the incident was sent to the Board of Nursing (BON). Review of the write-up sent to the BON documented, CNA was observed having sex with a resident of the facility. [He/she] went into [his/her] room and began a conversation of a sexual nature which led to the sexual act. This was witnessed by the nurse [name] when she entered the room to give scheduled medications to the resident. On 10/21/24 at 11:25 AM a conversation was conducted with the Nursing Home Administrator and the DON. Informed them of the concern even though the resident stated it was consensual, the GNA was in a professional capacity at the facility and the resident was vulnerable due to their condition at the facility. The NHA and DON acknowledged the concern.

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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. 31145 Based on reviews of facility reported incidents with documentation and interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 3 (#17, #3, #10) of 39 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 10/15/24 at 9:43 AM a review of facility reported incident MD00183680 was conducted and revealed Resident #17 told the MDS nurse on 9/20/22 at 11:15 AM that he/she was hit in the leg that morning by a GNA while getting ready for dialysis. The MDS nurse report it to the NHA, and an initial facility report was sent to OHCQ at 12:36 PM. Review of the facility's investigation revealed an email from GNA #54 that documented Resident #17 wanted to speak to a supervisor because he/she wanted someone else to take care of him/her. When GNA #54 told Resident #17 who the supervisor was the resident started screaming, shouting, and crying. GNA #54 documented in the email that because of the loud noise and screaming, the nurse came in to see what was going on and Resident #17 was screaming that GNA #54 was biting the resident and then said GNA #54 was hitting the resident. GNA #54 documented that he left the room and when he returned Resident #17 did not know that another GNA was there too. GNA #54 documented that as soon as the 2 GNAs tried to get Resident #17 up that the resident started screaming, you are hurting me, you are hitting me, you are pushing me against the wall. The third GNA asked Resident #17 why he/she was making a false claim that he/she was being abused. Review of a written statement from LPN #56 documented that she went into the resident's room and Resident #17 was using profanity and stating that staff were ganging up on the resident. LPN #56 asked GNA #54 what was going on and GNA #54 stated that the resident accused GNA #54 and GNA #55 of hitting and biting the resident while getting the resident up for dialysis. LPN #56 failed to report the allegation immediately to administration. On 10/15/24 at 10:24 AM an interview was conducted with the Assistant Director of Nursing (ADON). The investigation was reviewed with the ADON, and she stated that the 2 GNAs were written up because they did not report the incident timely, and she stated they do not work at the facility any longer. When asked about LPN #56's email statement, the ADON agreed that LPN #56 should have reported the incident at that time. LPN #56 stated the nurse was an agency nurse and did not work at the facility. 2) On 10/15/24 at 2:05 PM a review of facility reported incident MD00180261 was conducted and revealed Resident #3 alleged that during the week of 12/16/21, Resident #3 was inappropriately touched and kissed by a geriatric nursing assistant (GNA). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 2:22 PM the Director of Nursing (DON) was interviewed and stated that they couldn't find any files related to the incident, therefore did not have any documentation as to when the incident was reported to OHCQ. 3) On 10/16/24 at 8:30 AM a review of facility reported incident MD00179520 revealed Resident #10 alleged that 2 staff members entered the resident's room to reposition the resident while in bed. The resident alleged that he/she refused and alleged that staff continued to provide care and twisted the resident's wrist while the resident was repositioned. Resident #10 could not identify the staff. On 10/16/24 at 8:50 AM an interview was conducted with the DON who stated that they could not find the intake information, an email confirmation, or investigation, therefore it was unknown if the report was sent in timely. On 10/21/24 at 11:25 AM the Nursing Home Administrator (NHA) and DON were informed of the concern and confirmed the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on documentation review and interview, it was determined the facility failed to thoroughly investigate allegations of abuse, neglect, exploitation or mistreatment for residents (Resident #3, #6, #10 and #43). This was evident for 4 of 39 residents reviewed for facility reported incidents during an annual survey. The findings include: Upon entry to the facility on [DATE] a list of facility reported incidents was provided to administration. At that time the request was for all investigations to be provided to the surveyors. 1. On 10/10/24 review of facility reported incident MD00182429 revealed Resident #6's emergency contact emailed the facility on 3/9/22 with allegations of neglect of the Resident. On 10/15/24 at 11:10 AM the Director of Nursing (DON) stated she could not find the investigation for facility reported incident MD00182429. Interview with the DON on 10/16/24 at 8:24 AM confirmed the facility does not have the email with the list of grievances, interview with the Resident, emergency contact or any staff. The DON confirmed at that time the facility staff failed to complete a thorough investigation of alleged neglect of Resident #6. 31145 2. On 10/15/24 at 2:05 PM a review of facility reported incident MD00180261 was conducted and revealed Resident #3 alleged that during the week of 12/16/21, Resident #3 was inappropriately touched and kissed by a geriatric nursing assistant (GNA). The facility failed to provide a copy of the investigation to the surveyor. On 10/15/24 at 2:48 PM the VP of Clinical Operations brought in an incident/QA report dated Thursday, December 16, 2021, at 11:20 AM and gave it to the surveyor. She stated they were still looking for the files, however, as of 10/22/24 at 1:00 PM the surveyor was not provided the investigation. On 10/16/24 at 8:50 AM an interview was conducted with the Director of Nursing (DON) who stated that they could not find the intake information, an email confirmation, or investigation. 3. On 10/16/24 at 8:30 AM a review of facility reported incident MD00179520 revealed Resident #10 alleged that 2 staff members entered the resident's room to reposition the resident while in bed. The resident alleged that he/she refused and alleged that staff continued to provide care and twisted the resident's wrist while the resident was repositioned. Resident #10 could not identify the staff. On 10/15/24 at 2:22 PM the Director of Nursing (DON) was interviewed and stated that they couldn't find any files related to the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 8:50 AM an interview was conducted with the DON who stated that they still could not find the investigative package related to the incident. On 10/21/24 at 11:25 AM the Nursing Home Administrator (NHA) and DON were informed of the concern and they confirmed that the investigations could not be found. 41274 3. The facility failed to ensure a thorough investigation was conducted when mistreatment was alleged by Resident #43. Resident #43 was admitted to the facility with diagnosis which included adult failure to thrive, pressure ulcer of sacral region stage 3, and muscle weakness. The Minimum Data Set (an assessment tool) dated 9/06/23 documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 15/15 which was indicative of intact cognition. On 10/10/24, review of facility reported incident (case #MD00196592) revealed on 9/6/23 at 12:30 AM, Resident #43 had called 911 to report GNA #51 had been rough with them while completing care during the 3:00 PM to 11:00 PM shift on 9/5/24. Law enforcement responded and met with the resident. The facility investigation included interviews conducted with other residents on the unit and statements were obtained from GNA #51 and other staff working during the time the allegation was made; however, the investigation did not include a direct statement from Resident #43. Upon request, the facility could not produce documentation that a statement was obtained from Resident #43. On 10/15/24 at 12:38 PM, during an interview with the Social Services Director (SSD), they stated when conducting investigations of alleged abuse/mistreatment, the resident who alleged the abuse/mistreatment should be interviewed and a direct statement obtained. The SSD stated it was important to obtain a direct statement from the resident for them to express how they felt and to provide specific details as to what happened. On 10/17/24 at 10/17/24 12:18 PM during an interview with the Nursing Home Administrator (NHA), they stated they functioned as the facility's abuse coordinator, however, had not participated in the investigation of the allegation made by Resident #43 as they were not employed with the facility at the time. They stated that a direct statement from any resident who alleged abuse or mistreatment should always be obtained in order to complete a thorough investigation.

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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. 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2 (#59, #24) of 61 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 10/10/24 at 11:54 AM Resident #59's medical record was reviewed and revealed Resident #59 sustained a fracture of the proximal phalanx of the fifth toe according to an x-ray report dated 7/30/24. Review of the Discharge Return Anticipated MDS with an assessment reference date (ARD) of 7/31/24 failed to capture the fracture in Section I, diagnosis. On 10/10/24 at 1:10 PM an interview was conducted with Staff #4, the Regional Director of Clinical Case Management, who confirmed the error. On 10/21/24 at 12:15 PM an interview was conducted with MDS coordinator, Staff #45 who confirmed the MDS error. Staff #45 stated she was going to do a significant change in condition, but the resident never came back to the facility. 2) On 10/15/24 at 11:50 AM Resident #24's medical record was reviewed. The MDS with an assessment reference date of 2/13/23 documented that Resident #24 received antipsychotic medications during the 7-day lookback period. Review of Resident #24's February 2023 Medication Administration Record failed to produce evidence that Resident #24 received antipsychotic medication from 2/7/23 to 2/13/23. On 10/21/24 at 12:15 PM an interview was conducted with Staff #45 who confirmed the MDS error. Staff #45 stated she was not the one that did the MDS. The Director of Nursing and the Nursing Home Administrator were informed at exit conference.

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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** 31145 Based on review of a facility reported incident, record review, and staff interview it was determined that facility staff failed to update care plans when there were changes in resident needs and failed to have evidence of care plan meetings. This was evident for 2 (#10, #4) of 61 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1) On 10/16/24 at 8:02 AM a review of facility reported incident MD00196462 alleged that on 9/1/23 Resident #10 was slapped by staff while being provided with ADL (activities of daily living) care. Review of the facility's investigation revealed staff interviews that Resident #10 was agitated with the staff who were attempting to change the resident, and the resident kicked and punched at the GNA (geriatric nursing assistant). On 10/16/24 at 9:20 AM an interview was conducted with Licensed Practical Nurse (LPN) #13 about Resident #10's behaviors. LPN #13 was asked what she did when Resident #10 had behaviors. LPN #13 stated, we just redirect. LPN #13 stated they talk softly to the resident and come back later when the resident is ready. They don't force the resident if he/she is combative. They listen to the resident's demands and come back when he/she is ready. On 10/16/24 a review of Resident #10's medical record revealed a care plan that was initiated on 6/21/23 that stated, is periodically resistant to care related to ADL's/showers, refusing care and being combative with staff. Interventions included to allow the resident to make decisions to provide sense of control, educate, encourage participation in care, give a clear explanation of all care activities prior to and as they occur, and praise the resident when behavior is appropriate. The care plan was not updated to reflect redirection, to come back later after the resident has calmed down, and to talk softly to the resident. On 10/16/24 at 9:50 AM an interview was conducted with the Director of Nursing (DON) about the care plan and the DON agree and stated, something else should have been on there like checking for pain or any other issues. 2) On 10/21/24 at 8:28 AM a review of complaints MD00180436 and MD00178893 alleged that Resident #4's guardian went to the facility on [DATE] and found Resident #4 in a ghostly state and without oxygen over the weekend and that a visiting nurse hooked up the oxygen once it was brought to their attention. Additionally, the guardian complained that she was unable to get updates about Resident #4's care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission nursing note dated 11/30/21 documented the resident had a past medical history significant for myasthenia gravis and COPD on 3 L (liters) of oxygen at baseline. A 1/17/22 nursing note documented that Resident #4 was noted with increased lethargy, weakness, coughing and congestion and was currently on antibiotic therapy for pneumonia. On 1/18/22 a change in condition note documented the resident was receiving oxygen, was unable to open eyes, and had unclear speech. Resident #4 was sent to the hospital for monitoring. A 1/22/22 nurses note documented the resident returned from the hospital and was receiving oxygen. A 1/24/22 nurses note documented the resident was receiving oxygen continuously and a 1/25/22 nursing documented, continue on O2 (oxygen) as ordered. Review of Resident #4's physician's orders for January 2022 failed to produce an order for oxygen along with the amount of oxygen to be administered. Review of Resident #4's care plan, I have shortness of breath r/t hypoxia that was initiated on 11/30/2021, failed to have anything about oxygen usage, how many liters of oxygen, how to care for the oxygen tubing and equipment or what the oxygen saturation levels should be maintained at. Further review of Resident #4's medical record failed to produce documentation that care plan meetings were held with the guardian. On 10/21/24 at 1:10 PM an interview was conducted with the Director of Nursing who confirmed the findings.

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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** 34484 Based on medical record review and interview, the facility staff failed to administer medications and treatments as ordered by the physician (Resident #5, #22, #47, #56). This was evident for 4 of 61 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to administer pain medication timely for Resident #5. Review of Resident #5's medical record on 10/10/24 for a complaint regarding timely administration of pain medication in March 2022 revealed the Resident was admitted to the facility on [DATE] with diagnosis to include malignant neoplasm of endometrium. A malignant neoplasm of the endometrium, also known as endometrial cancer, is a type of cancer that occurs when cells in the lining of the uterus grow out of control. Further review of Resident #5's medical record revealed the Resident was ordered to receive A) Morphine Sulfate 30 mg every 12 hours for pain and B) Gabapentin 300 mg three times a day for peripheral neuropathy. Gabapentin is a medication used to treat nerve pain. Review of the Resident's Medication Administration Audit Report for 3/1-7/2022 provided by the Regional Nurse on 10/15/24 revealed the following: A. Morphine 1) 3/1/22 9 PM 30 mg not given 2) 3/3/22 9 AM 30 mg not administered until 11:29 AM 3) 3/6/22 9 AM 30 mg not administered until 3:30 PM 4) 3/6/22 9 PM 30 mg not administered until 11:08 PM 5) 3/7/22 9 AM 30 mg not administered until 11:57 AM 6) 3/7/22 9 PM 30 mg not given B. Gapabentin 1) 3/1/22 4 PM 300 mg not administered until 6:50 PM 2) 3/1/22 9 PM 300 mg not given 3) 3/2/22 4 PM 300 mg not administered until 6:50 PM 4) 3/3/22 8 AM 300 mg not administered until 12: 22 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) 3/3/22 4 PM 300 mg not administered until 5:07 PM 6) 3/5/22 8 AM 300 mg not administered until 12: 42 PM 7) 3/6/22 8 AM 300 mg not administered until 3:29 PM 8) 3/6/22 4 PM 300 mg not administered until 9:09 PM 9) 3/6/22 9 PM 300 mg not administered until 11:12 PM 10) 3/7/22 4 PM 300 mg not administered until 7:31 PM 11) 3/7/22 9 PM 300 mg not administered until 10:36 PM Interview with the Director of Nursing on 10/15/24 at 1:22 PM confirmed the Surveyor's findings for delay in pain medication administration for Resident #5. 2. The facility staff failed to change treatment for Resident #22 in a timely manner. Review of Resident #22's medical record on 10/15/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with an unstageable right heel and sacral pressure ulcer, a left below the knee amputation surgical wound, and right leg and foot arterial wounds. Further review of the Resident's medical record revealed the Resident's right leg and foot arterial wounds were assessed by the Wound Nurse Practitioner (WNP) on 1/11/23 and at that time the WNP ordered skin prep daily. Review of Resident #22's Treatment Administration Record revealed the right leg and foot wounds' treatment was not changed from the hospital discharge summary ordered treatment to the WNP recommendations on 1/11/23 until 1/26/23. Interview with the Director of Nursing on 10/15/24 at 1:15 PM confirmed the facility staff failed to change treatment to Resident's right leg and foot arterial wounds in a timely manner. 3. The facility staff failed to administer medication as ordered by the physician for Resident #47. Review of Resident #47's medical record on 10/16/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with diagnosis to include chronic respiratory failure and status post lung transplant. Review of the hospital discharge summary dated 9/25/23 revealed the Resident was ordered to receive Tacrolimus 5 mg each morning. Tacrolimus is a medication used in the prevention and treatment of solid-organ transplant rejection. Review of Resident #47's September and October 2023 Medication Administration Records revealed the Resident was not administered Tacrolimus 5 mg on 9/26, 9/28 and 10/3/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 10/16/24 at 12:30 PM confirmed the facility staff failed to administer Tacrolimus 5 mg as ordered by the physician for Resident #47 on 9/26, 9/28 and 10/3/23. 41274 4. The facility failed to ensure accurate skin assessments were completed for Resident #56. Resident #56 was admitted to the facility with diagnosis which included anemia (red blood cell deficiency), congestive heart failure and dementia. The Minimum Data Set (an assessment tool) dated 2/20/24 documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 5/15 which was indicative of impaired cognition. On 10/11/24, review of Resident #56 ' s medical record, revealed LPN #13 documented they completed skin assessments on 4/09/24 and 4/17/24 and the resident had no skin issues; however, review of progress notes revealed the resident was identified to have skin issues on 4/15/24 and new treatment was ordered. A progress note dated 4/15/24 documented Resident #56 ' s representative/family member had voiced concerns regarding a rash on the resident ' s back and breasts and an open area between their buttocks. The Assistant Director of Nursing (ADON) completed a head-to-toe assessment, and the resident was observed with a rash on their bilateral breasts, dry skin on their back and the right buttock was noted with scattered moisture associated skin dermatitis with 100% granulation tissue (new connective tissue and microscopic blood vessel formed during wound healing). The care plan in place was updated to reflect changes and prevent additional skin ulceration. The resident ' s medical provider was notified and a new treatment for Nystatin powder was ordered to be applied underneath bilateral breasts for 14 days for fungal rash. On 10/15/24 at 12:50 PM, an interview was conducted with LPN #13. They stated they could not recall whether Resident #56 had skin issues. They stated they had previously documented skin assessments in an incorrect way and would document only if they observed a new skin issue. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	They stated skin assessments should be head to toe and document any existing and new skin issues. On 10/17/24 at 11:49 AM, an interview was conducted with the ADON. The ADON recalled that Resident #56 ' s representative/family had expressed concern about the resident ' s skin. They stated they assessed the resident and observed the resident had a rash. They stated they reviewed the resident record and found that Resident #56 ' s skin issues had not been documented by nursing staff. They stated skin assessments should be complete and accurate to ensure continuity

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #22). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). Review of Resident #22's medical record on 10/15/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with an unstageable right heel and sacral pressure ulcer, a left below the knee amputation surgical wound, and right leg and foot arterial wounds. A. Review of the Hospital Discharge Summary dated 12/31/22 revealed the Resident was to wear Bunny air boot while in bed per podiatry recommendations. Further review of the Resident's medical record revealed the Bunny air boot was not ordered and documented administered until 2/16/23. B. Further review of Resident #22's medical record revealed the Resident's right heel pressure ulcer was assessed by the Wound Nurse Practitioner (WNP) on 1/11/23 and at that time the WNP ordered skin prep daily and speciality bed. Review of Resident #22's Treatment Administration Record revealed the right heel wound treatment was not changed from the hospital discharge summary ordered treatment to the WNP recommendations on 1/11/23 until 1/26/23. Review of the Resident's physician orders revealed the air mattress was not ordered until 2/16/23. Interview with the Director of Nursing on 10/15/24 at 1:15 PM confirmed the facility staff failed to order bunny air boots and air mattress and failed to change treatment to Resident's right heel in a timely manner.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of facility reported incidents, medical record review, facility documentation review, and staff interviews, it was determined the facility failed to keep residents who required either extensive assistance or total dependence with turning and repositioning in bed free from falling out of bed while providing activities of daily living (ADL) care, resulting in actual harm to Resident #33 and Resident #17. The failure of the facility staff to protect a resident from a fall resulted in a hematoma for Resident #33 and bilateral femur fractures for Resident #17. This was evident for 2 (#33, #17) of 39 residents reviewed for facility reported incidents. The findings include: 1) On 10/16/24 at 7:42 AM a review of facility reported incident MD00191729, that was received by the State Survey Agency (SA), alleged on 4/24/23, Resident #33 was receiving care and rolled from the bed. The facility called 911 and the resident was sent out to the hospital. The hospital reported that Resident #33 had a pelvic fracture and a hematoma in the gluteal area. On 10/16/24 at 7:42 AM a review of Resident #33's medical record was conducted and revealed Resident #33 was admitted to the facility in March 2023 with diagnoses that included end stage renal disease with dependence on renal dialysis, hemiplegia and hemiparesis following a stroke that affected the left non-dominant side, osteomyelitis of vertebra, thoracic region, discitis of the thoracic region and type 2 diabetes mellitus with diabetic neuropathy. The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #33's 4/18/24 5-day MDS, section G, Activities of Daily Living (ADL) Assistance, A. Bed mobility - how residents moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture as a (3) which was Extensive assistance - resident involved in activity; staff provide weight-bearing support with 1-person physical assist. The MDS also coded the resident extensive assistance with 1-person physical assistance with eating and personal hygiene. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #33's activities of daily living care plan (ADL), that was created on 4/13/23 documented, I am dependent on staff for turning and repositioning and I am dependent on staff for grooming/personal hygiene. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a SBAR (change in condition) note dated 4/24/23 at 23:25 (11:25 PM) documented, the resident fell in the room from the bed to the floor when staff tried to give patient care. The note documented, there was circular swelling on the left side of the head and 911 was called per administrative directive. On 10/16/24 at 12:50 PM a review of the emergency room report dated 4/25/23 documented, presented after a fall, was being changed when [he/she] rolled off the bed, fell on [his/her] left side. Endorsing left sided head pain. Endorsing LUE and LLE pain diffusely. A secondary survey (assessment of resident) documented, large hematoma on L scalp. The physician documented, large hematoma on left scalp and multiple large ecchymotic areas along the left side of [his/her] body. [He/she] is tender along [his/her] chest wall, [his/her] entire LUE and LLE, with point tenderness in the L hip. A CT scan documented, L gluteal hematoma with active extrav (extravasation) (contrast material leaked) (trauma consulted) and pubic rami fracture (old, seen on 4/4/ CT). The note documented that trauma surgery was consulted and ordered a repeat CBC (complete blood count) and type and crossed for 2U (units of blood). Recommend ice packs, compression and CBC (complete blood count) BID (2 x day). Review of the facility ' s investigation revealed a statement from Geriatric Nursing Assistant (GNA) #20 that documented she was assigned to Resident #33. GNA #20 rolled the resident towards me and didn ' t realize [he/she] was so close to the edge, and I pulled [him/her], and [he/she] fell on the left side of the floor. A witness statement from GNA #21 documented that she was called to the resident ' s room and saw the resident on the floor. The nurse and I and two other aides picked [him/her] up from the floor. A statement from Licensed Practical Nurse (LPN) #22 documented that she was in another patient ' s room when she heard Resident #33 fall and hit the floor. Resident was lying on [his/her] right side. Alert and crying. The statement documented, complained of pain in right arm. In resident normal condition. [He/she] have weakness in both arms and legs. Have large swollen area on left side of resident head. Resident stated, I ' m ok, but I hurt while pointing to [his/her] right arm and rubbing [his/her] left thigh to indicate pain. Also, resident express pain and wanted an oxycodone tab. It was explained to resident because of a possible head injury I cannot give [him/her] an oxycodone at that time. On 10/17/24 at 3:26 PM an interview was conducted with GNA #20. GNA #20 stated, I pulled [him/her] towards me. I don ' t know how much [he/she] weighed; [he/she] was a little stocky. I rolled [him/her], and it must have been too hard, and [he/she] fell on the floor. I must have not realized how hard I pushed to roll [him/her] over. These people come and go, and I can ' t keep up with their names. They never told us if [he/she] was a 1 or 2 person assist. I can ' t remember if I had education after the incident. I can ' t even remember [his/her] name. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	GNA #20 was asked how she knew a resident ' s mobility status related to turning and positioning. GNA #20 stated, if the person is alert enough to tell me or I will get another aide or nurse. I usually go get the nurse and just ask them about the resident. The surveyor asked GNA #20 if the mobility status was documented somewhere for the staff to know the status. GNA #20 stated, if they have it documented, I don ' t know where it is documented. If it is in their file I don ' t know about it. We are not supposed to go in their file. The surveyor asked GNA #20 where she documented care that she gave the residents every day. GNA #20 stated, the computer on the wall is where I document their care. The surveyor asked if the mobility and bed positioning was in the computer. GNA #20 stated, yes, but at that time when the incident happened to the patient, I didn ' t know you could get the information from the computer. 2) On 10/17/24 at 8:03 AM a review of facility reported incident MD00193742, that was received by the State Survey Agency (SA), alleged on 6/23/23, Resident #17 fell from the bed. A telehealth visit was conducted, and Resident #17 was sent to the emergency room for further evaluation. On 10/17/24 at 8:03 AM a review of Resident #17's medical record was conducted and revealed Resident #17 was admitted to the facility in January 2020 with diagnoses that included end stage renal disease with dependence on renal dialysis, hemiplegia and hemiparesis following a stroke that affected the left non-dominant side, and legal blindness. Review of Resident #17's 6/19/23 quarterly MDS, section G, Activities of Daily Living (ADL) Assistance, A. Bed mobility - how residents moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture as a (4) which was total dependence which was full staff performance; with two + person physical assist. The MDS also coded the resident total dependence with two + persons physical assist for transfers, dressing, toileting, and personal hygiene. Review of Resident #17's ADLs self-care performance deficit related to hemiplegia/hemiparesis, that was created on 5/24/23 documented, I require 2 staff assist with turning and repositioning. Review of a SBAR (change in condition) note dated 6/24/23 at 01:05 AM documented that at approximately 10:15 PM the assigned GNA came to the nurse ' s station and stated that Resident #17 was on the floor during ADL care. Resident #17 was observed on the floor on the left side of the bed, leaning on the right side between the wheelchair and tote box. Resident #17 was assisted back to bed and the resident complained of pain in the left upper thigh. The resident was sent to the emergency room . Review of a 6/26/23 at 17:37 general progress note documented, follow-up call done to [name of initial hospital] patient transferred to [second hospital name] due to fracture from fall. Review of a 6/27/23 at 21:51 after hours telemed patient note documented, had a fall earlier, having severe left leg pain and requested to go to ED (emergency department). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the initial hospital ' s emergency room note documented, pt reports that nurse was cleaning [him/her] in bed [he/she] accidentally rolled off the bed and fell on the floor. Pt. c/o severe pain to BLE (bilateral lower extremities). The physical exam documented, is in acute distress. Pt. in mild to moderate distress due to pain. The musculoskeletal exam documented, difficult to evaluate LE due to pain, positive spastic deformity, swelling, pain with light palpation to the left thigh/hip, right hip. The x-ray results documented, positive for proximal fracture of the left femur with angulation, and right intertrochanteric fracture. The CT of the femur documented, comminuted proximal 3rd femur fracture with overriding fracture fragments. The distal fracture fragment is impacted into the left intertrochanteric region with shortening to the left femur. The CT to the pelvis confirmed the right intertrochanteric fracture and the proximal left femoral diaphysis fracture along with a hematoma within the left anterior extensor muscles. The disposition of the resident was to transfer to a higher level of care that was not available at that hospital. Review of the facility ' s investigation revealed a statement from GNA #24 that documented she was assigned to Resident #17. GNA #24 documented that GNA #25 helped her put Resident #17 into the bed, turned the resident, and removed the Hoyer pad from underneath the resident. GNA #24 documented that she then turned Resident #17 on his/her left side to remove the diaper and began cleaning Resident #17 up and the resident was fine on the bed. GNA #24 documented that she started to clean the resident up and applied A&D Ointment when the resident started to lean over towards the floor on [his/her] left side. There was a tote and a wheelchair that broke the resident ' s fall. Review of a written statement from GNA #25 documented that GNA #25 assisted GNA #24 with the Hoyer to put the resident in bed. Resident #17 told her she ' ll need help with changing [him/her]. She insisted she didn ' t. GNA #25 documented that she left the room to finish tending to another resident. Included in the investigation was a complaint form for the Maryland Board of Nursing for GNA #24 that documented at approximately 10 pm on Friday, June 23, 2023, resident [#17] was injured. GNA #24 was assigned to care for Resident #17 that evening during her 3-11 pm shift. GNA #25 assisted GNA #24 with the use of a Hoyer lift to transfer the resident from the Geri-chair to the bed. After the resident was placed in bed, the 2 GNAs turned Resident #17 left to right to remove the Hoyer lift pad that was under him/her. GNA #24 told GNA #25 that she did not need help changing the resident. GNA #25 and Resident #17 both stated he/she required 2 people to care for him/her, but GNA #24 insisted on caring for him/her alone. GNA #25 left the room to assist the other GNA on the unit. While performing ADL to change Resident #17 ' s incontinence device, GNA #24 turned Resident #17 onto his/her left side. On Resident #17 ' s left side of the bed was a Geri-chair and tote. When GNA #24 began to apply A&D ointment, Resident #17 continued to lean more on his/her left side and fell out of bed onto the Geri-chair and tote. Resident #17 was alert and oriented to person, place and time, assessed, and placed back in bed using the Hoyer lift. Resident #17 began to complain of pain in the left upper thigh. Virtual on call physician notified of incident and status of Resident #17 and ordered him/her to be transferred to the hospital for further evaluation. Around 3 pm on Saturday, June 24, 2023, Staff #26 called the hospital for an update and was told he/she had a closed fracture of the right hip and closed displaced oblique fracture of the left femur and was transferred from one hospital to another in the morning. After the investigation was completed, GNA #24 was terminated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 at 9:00 AM and 10:00 AM a call was placed to GNA #24 with a voice mail message left for a call back. As of 10/18/24 at 10:30 AM GNA #24 had not returned the surveyor ' s phone call. On 10/17/24 at 3:17 PM GNA #25 was interviewed and stated, that night I assisted her with putting [him/her] to bed with the Hoyer lift and [he/she] said you will need another person. She said no I don ' t, I had you before and I have done you myself. I left the room, she had [him/her] before. GNA #25 stated there were certain people that the resident would allow to do him/her by themselves. GNA #25 stated she continued her rounds and came out of another resident ' s room when she was informed of the fall. GNA #25 stated, I went to the room, and [he/she] asked me to stay with [him/her]. GNA #25 stated that Resident #17 was in pain. [He/she] was in a lot of pain. GNA #25 stated, [he/she] was a 2 person assist with bed mobility. It said it on the Kardex, but [he/she] would allow certain people to just do it by themselves. GNA #25 stated, She declined the help. On 10/17/24 at 3:47 PM LPN #26 was interviewed and stated, I remember [he/she] fell out of bed during care. LPN #26 stated he was called to the resident ' s room. [He/she] said help me, help me please, they made me fall. We assisted [him/her] back to bed. I can ' t remember anything else. [He/she] just kept saying please help me [name], get me up. On 10/17/24 at 3:54 PM the ADON stated they did bed mobility training on all staff along with abuse training after each incident. The ADON stated they took the fall ' s issue to QA (Quality Assurance) and did a QA Ad hoc meeting for both falls along with audits. The ADON stated that it was self-identified that the care plan and Kardex was not patient centered related to specifics of 1 person assist, or 2 person assist or if mechanical lift for transfers and bed mobility was needed. Review of the facility ' s in-service documentation revealed GNA #24 ' s signature for the 4/27/23 to 5/1/23 in-service on documentation and communication of transfer/bed mobility status and for the 6/3/23 in-service on turning and repositioning. On 10/17/24 at 4:14 PM the Director of Nursing (DON) joined the interview with the ADON. The surveyor discussed how Resident #33 fell out of bed during care in April 2023 and then it happened to Resident #17 in June 2023 even though the GNA involved in the June 2023 incident (GNA #24) had received training in April 2023 and on 6/3/23 which was 20 days prior to the incident in June 2023.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide respiratory care treatment for residents (Resident #47 and #4). This was evident for 2 of 3 residents reviewed for respiratory care services. The findings include: 1.Review of Resident #47's medical record on 10/16/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with diagnosis to include chronic respiratory failure and status post lung transplant. Review of the hospital discharge summary dated 9/25/23 revealed the Resident was on BiPAP for his/her chronic respiratory failure. BiPAP, or bilevel positive airway pressure, is a noninvasive ventilator that helps people breathe when they have medical problems that make it difficult. Review of the Resident's physician orders and September 2024 TAR (Treatment Administration Record) revealed the Resident's Bipap was not ordered and documented as administered until 9/29/23, 4 days after admission. Review of Resident #47's October 2024 TAR revealed the facility staff did not document the Resident was administered the BiPAP on 10/4 and 10/6/23. Further review of Resident #47's medical record revealed a nurse's medication administration note on 10/6/23 at 11:50 PM that stated, Bi-pap mask missing to be followed up with Respiratory therapist. Interview with the Director of Nursing on 10/16/24 at 12:30 PM confirmed the facility staff failed to order and document administration of the BiPAP on 9/25, 9/26, 9/27 and 9/28/23 and also failed to administer the BiPAP on 10/4 and 10/6/23 for Resident #47. 31145 2. On 10/21/24 at 8:28 AM a review of complaints MD00180436 and MD00178893 alleged that Resident #4's guardian went to the facility on [DATE] and found Resident #4 in a ghostly state and without oxygen over the weekend and that a visiting nurse hooked up the oxygen once it was brought to their attention. Review of Resident #4's medical record revealed the resident had been admitted to the facility in November 2021 with diagnoses that included myasthenia gravis, Chronic Obstructive Pulmonary Disease (COPD), and chronic respiratory failure. Review of an admission nursing note dated 11/30/21 documented the resident had a past medical history significant for myasthenia gravis and COPD on 3 L (liters) of oxygen at baseline. (continued on next page)

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	215069	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 1/17/22 nursing note documented that Resident #4 was noted with increased lethargy, weakness, coughing and congestion and was currently on antibiotic therapy for pneumonia. On 1/18/22 a change in condition note documented the resident was receiving oxygen, was unable to open eyes, and had unclear speech. Resident #4 was sent to the hospital for monitoring. A 1/22/22 nurses note documented the resident returned from the hospital and was receiving oxygen. A 1/24/22 nurses note documented the resident was receiving oxygen continuously and a 1/25/22 nursing documented, continue on O2 (oxygen) as ordered. Review of Resident #4's physician's orders for January 2022 failed to produce an order for oxygen along with the amount of oxygen to be administered. Review of Resident #4's January 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to produce documentation that the resident was receiving oxygen. There were no orders for oxygen, the amount, when to change the tubing, and if there was supposed to be humidification with the oxygen administration. On 10/21/24 at 12:15 PM an interview was conducted with Registered Nurse (RN) #44. RN #44 was asked if someone was on oxygen should there be a physician's order. RN #44 stated, yes and it will be on the MAR to be checked off when administered and there will be a place to check off when the oxygen tubing is changed, and I think 11-7 does that. On 10/21/24 at 1:10 PM the Director of Nursing confirmed the findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility failed to ensure a resident's drug regimen was free from an unnecessary drug (Resident #47). This was evident for 1 of XX residents reviewed during a complaint survey. The findings include: Review of Resident #47's medical record on 10/16/24 revealed the Resident was admitted to the facility on [DATE] from the hospital. Review of the hospital discharge summary dated 9/25/23 revealed the Resident was to receive Metoprolol 25 mg two times daily, Please do not take on the morning of dialysis days. Review of the Resident's medical record revealed the Resident went to dialysis on Tuesdays, Thursdays and Saturdays. Metoprolol is a medication that is used to lower blood pressure and heart rate. Further review of the Resident's medical record revealed the Resident received Metoprolol on the following days that the Resident also received dialysis: 9/28, 9/30, 10/3, and 10/5/23. Interview with the Director of Nursing on 10/16/24 at 12:30 PM confirmed the facility staff administered Metoprolol for Resident #47 on dialysis days and not according to the physician's orders.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review, observation and interview, the facility staff failed to obtain outside services for residents in a timely manner (Resident #27). This was evident for 1 of 61 residents reviewed during a complaint survey. The findings include: 1. During interview with Resident #27 on 10/17/24 at 12:30 PM, the Resident stated the facility never got me the splints for my foot drop. Observation of the Resident at that time revealed the Resident had heel protector boots but no foot drop splints in place. Review of Resident #27's medical record on 10/17/24 revealed the Resident was readmitted to the facility on [DATE] with diagnosis to include muscle wasting and atrophy of right lower leg and tibia fracture of left leg. Further review of Resident #27's medical record revealed the Resident went to a vascular specialist on 6/18/24 and at the time the vascular specialist recommended foot drop splints. The Resident went to the Specialist on 7/12/24 for complaints pain feet and ankles and pain in both legs. The Specialist documented last time we recommended foot drop splint boots which patient reports doesn't have. Review of Resident #27's physician orders revealed a physician order on 6/18/24 for foot drop splints every shift while in bed. Review of Resident #27's nurse's notes revealed a note on 7/12/24 at 12:42 PM that stated, Resident returned from appointment with the following recommendations, podiatry consults, heel protector boot, foot drop splint boots. During interview with the Director of Nursing (DON) on 10/17/24 at 9:48 AM, the DON was asked if aware of Resident #27's concern for splints for foot drop. The DON stated no she was not aware. Interview with the Director of Rehabilitation (DOR) on 10/17/24 at 10:18 AM, the DOR stated the therapist told her the Resident needs bilateral foot splints and is currently working with a vendor to obtain the splints. Interview with the DON on 10/17/24 at 1:50 PM confirmed the facility staff failed to obtain bilateral foot splints for Resident #27 in a timely manner.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on administrative and medical record reviews and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #9 and #22). This was evident for 2 of 61 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1. Review of Resident #22's medical record on 10/15/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with an unstageable right heel pressure ulcer, a left below the knee amputation surgical wound, and right leg and foot arterial wounds. Further review of Resident #22's medical record revealed the Resident was seen by the Wound Nurse Practitioner on 1/4 and 1/17/23 but the medical record failed to include the wound evaluation reports. The Wound Evaluation Report includes the wound measurements, observations and dressings instructions. Interview with the Director of Nursing on 10/18/24 at 10:58 AM confirmed the 1/4 and 1/17/23 Wound Evaluation Reports are not in Resident #22's medical record. 18819 2. Resident #9 was admitted from the hospital to the facility on [DATE]. A review of complaint MD00177583 on 10/10/24 revealed allegations that the facility staff are not communicating with Resident #9's family about Resident #9's current plan of care regarding infections. A review of Resident #9's electronic medical record on 10/10/24 revealed the facility staff had held a quarterly care plan meeting that Resident #9's responsible party attended via phone on 09/26/24. A review of the 09/26/24 attendance sign in sheet for Resident #9's quarterly care plan meeting included: the social service associate, the facility dietician (via phone), Resident #9's responsible party (via phone), and a nursing unit manager for Unit 1 and Unit 2 (Staff #31). The staff documented that Resident #9 did not attend the care plan meeting due to Resident's health precluded attending the meeting. In an interview with Staff #31 on 10/11/24 at 10:44 AM, Staff #31 stated that S/he is the nursing unit manager for Unit 1 and Unit 2. Staff #31 stated that Resident #9 resides on Unit 4. Staff #31 stated that S/he is not familiar with Resident #9's plan of care. Staff #31 stated that S/he was not aware why the Unit 4 nursing manager 4 did not attend Resident #9 care plan meeting on 09/26/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the facility social service assistant (Staff #37) on 10/11/24 at 1:30 PM, Staff #37 stated that S/he coordinated and held Resident #9's 09/26/24 quarterly care plan meeting. Staff #37 stated that S/he usually obtains staff signatures, of the staff who attended the care plan meeting, later after the care plan meetings. Staff #37 stated that Staff #36 attended Resident #9's 09/26/24 quarterly care plan meeting. In an interview with the Unit 4 nurse manager (Staff #36) on 10/11/24 at 2:05 PM, Staff #36 stated that S/he did not attend Resident #9's 09/26/24 quarterly care plan meeting due to working on facility reports with the director of nurses (DON). In a follow-up interview with Staff #31 on 10/11/24 at 2:20 PM, Staff #31 confirmed the S/he did not attend Resident #9's quarterly care plan meeting on 09/26/24. The facility Director of Nurses was made aware of the noncompliance on 10/11/24 at 2:30 PM.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation and resident and staff interview, it was determined that the facility staff failed to maintain the resident call bell system in working order. This was evident for 1 of 14 resident rooms on the Unit 3 nursing unit which affected 2 (#10, #35) of 37 residents that resided on Unit 3 during a complaint survey. The findings include: On 10/16/24 at 8:54 AM observation was made in Resident #10 and Resident #35's room of small handheld bells sitting on the over the bed tray tables. On 10/16/24 at 8:58 AM Resident #35 was interviewed and was asked about the handheld bell. Resident #35 stated, you can ring it, but they don't come. Resident #35 was asked how long the call bell had not been working. Resident #35 stated, over a week, at least 10 days. Maintenance was waiting for a part; he said that on Monday. On 10/16/24 at 8:58 AM the surveyor rang the handheld bell. The surveyor rang the bell again at 9:08 AM. There was no nursing staff that came to the resident's room. At 9:15 AM the surveyor rang the bell constantly until 9:16 AM when Licensed Practical Nurse (LPN) #17 came in and said she only heard the bell because she just came out of the bathroom. LPN #17 was asked how long the call bell had been out and she stated it had been on and off for a week or so, 10 days. The surveyor informed LPN #17 the times that the call bell was rung by the surveyor and that it had been 18 minutes until she came in the room. It was noted at the time that the resident's room was the second to the last room on the right side of the end of the hallway and the nurse's station was at the other end of the hall. Observed in the hallway outside of the room was a dehumidifier which was loud. The hallway was also loud due to the television that was loud in room [ROOM NUMBER]. On 10/16/24 at 10:03 AM the Maintenance Director, Staff #18, was interviewed and asked how he was made aware of any repairs. Staff #18 stated they had a system called TELS and that was how the nursing staffing reported problems. Staff #18 stated, they may pull me up in the hall and ask me to address the issue too. Staff #18 was informed of the call bell observation in room [ROOM NUMBER]. Staff #18 stated they had the issue in room [ROOM NUMBER] and room [ROOM NUMBER]. The Assistant Director of Nursing (ADON) was also present at that time and the surveyor informed them of the amount of time the surveyor waited for a response once the bell was rung. The surveyor also pointed out how noisy the hallway was at the time. Staff #18 stated it was the mother board that was the issue, not the plug in part of the cord. At that time the surveyor requested to know when the problem was put into TELS, what part was ordered and when was the part ordered. On 10/16/24 at 12:09 PM Staff #18 came back to show the surveyor that the part had arrived on 10/16/24 and had just been replaced in the resident's room. Staff #18 was asked when the part was ordered, and he stated it was ordered on 10/14/24. The Nursing Home Administrator and the DON were informed of the issue on 10/21/24 at 11:25 AM.