STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Hill Rehabilitation and Healthcare Center	111 West Road Towson, MD 21204

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on record review and interviews with facility staff, it was determined that the facility failed to provide residents with information to formulate an advanced directive and ensure that a current copy of residents' advanced directives was in the residents' medical record. This was evident for 1 (Resident #56) of 3 residents reviewed for advanced directives during the recertification/complaint survey. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. On 3/10/25 at 11:44 AM the Director of Nursing (DON) confirmed and verified that the facility does not have paper charts for the residents. On 3/10/25 at 1:52 PM review of Resident#56's medical record revealed an original admitted [DATE]. Further review failed to reveal the resident's advance directives. On 3/10/25 at 2:10 PM a review of Resident #56's medical record revealed 2 Social Service Assessments dated 6/27/2022 and 9/27/2022. The 6/27/22 assessments, was marked as Admission assessment, and for Question #1, Section A: Advance Directives/Code Status, indicated the resident did not have an advanced directive, however there was no documentation that a discussion about advanced directives had occurred with the resident or evidence of any advanced directives the resident executed. In addition, the 9/27/22 assessment, which was marked as a Quarterly assessment, and for Question #1 in Section A: Advance Directives/Code Status, indicated the resident did not have an advanced directive and again there was no further documentation. On 3/11/25 at 11:44 AM a review of Resident #56's medical record revealed a hospital discharge summary dated 6/14/22 that documented, per psych patient has capacity enough to decide about whom to assign the power of attorney/decision-maker. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directive policy was reviewed on 3/12/25 at 12:22 PM. The review revealed, Prior to or upon admission of a resident, the social services 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. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. Further review of the policy revealed, If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advanced directives. and Nursing staff will document in the medical record the offer to assist and the residents' decision to accept or decline assistance. On 3/12/25 at 3:00 PM in an interview with the Social Services Director (SSD) #12 she stated anyone that comes to the facility has the right to initiate an advanced directive. If they come in with one, it is uploaded into the medical record. When asked if that is documented, she stated it is more of a verbal thing, but it is in the admissions packet that they have the right to formulate one. The surveyor reviewed the concern with the SSD #12 regarding the lack of documentation for Resident #56 about advanced directives in the medical record. When asked about documentation, she stated there was no documentation in the medical record that the Resident #56 was offered an advanced directive. She also stated that was done prior to her coming to this facility, but that she scrubbed the medical record and could not find anything.

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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. 49304 Based on record review and interview with facility staff, it was determined that the facility staff failed to notify a provider and/or resident representative of a significant weight loss for a resident. This was evident for 1 (Resident #113) of 47 residents reviewed for the facility's recertification/complaint survey. The findings include: On 3/10/25 at 2:56 PM a review of Resident #113's medical record revealed the following weights: 3/5/2025 11:29 134.4 Lbs (pounds) Mechanical Lift ADON (Manual) 2/5/2025 15:40 164.0 Lbs (pounds) Mechanical Lift ADON (Manual) In the weights section of the resident's medical record, the electronic medical record had flagged and documented (written between these two weights) that there was a significant weight loss over 30 days. On 3/13/25 at 9:54 AM in an interview with the ADON when asked if the physician and/or resident representative (RP) was notified of the Resident #133's significant weight loss, she stated, no, there was no documentation observed that the physician or RP was notified of his/her weight loss. The Regional Dietician #20 was interviewed on 3/13/25 at 1:16 PM. With her laptop open to Resident #133's medical record, she was asked if there was any evidence in the medical record that the physician and/or RP were notified of the resident's weight loss. The Regional Dietician #20 stated, she could not point to documentation in Resident #133's medical record as to where the physician and/or RP were notified of the weight loss. When asked if the physician and RP should be notified if a resident has significant weight loss, she stated yes and confirmed they should be notified.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 14894 Based on observation, resident interview, and staff interview it was determined that the facility staff failed to ensure showers maintained proper temperatures. This was evident for 1 out of 4 nursing units observed during the recertification/complaint survey. The findings include: Resident #100 was interviewed on 03/10/25 at 11:51 AM. Resident stated that the shower room for unit 2 doesn't have hot water so few showers are taken. During the tour of the facility with the Maintenance Director (Staff #31) on 3/17/25 at 11:17 AM he used his thermometer and checked the water temperature. It was observed that the water from the hand sprayer was 88.8 degrees Fahrenheit (F). Staff #31 then turned on the shower and the temperature was the same. He left the water running and we continued with checking the shower rooms on the other units. After verifying the other shower rooms had hot water Staff #31 rechecked the water in the Unit 2 shower room and it was still in the 80's. Staff #31 went to the resident rooms on either side of the shower room and the water in each room registered as 106F. Resident #100 asked if the shower room had hot water. Staff #31 replied Working on it. Talk to your nurse. She can have you go to unit 1. Staff #31 was interviewed on 3/17/25 at 1:38 PM. He said he went with the Administrator a while ago and the temperatures have not gone up. He will check again a little later. Review of the Maintenance logs began on 3/17/25 at 1:42 PM. The shower room for Unit 2 had temperatures of 55F on 3/4/25 and 3/5/25. Temperature was checked again on 3/5/25 and it was 110F. The vendor was contacted on 3/4/25 for the low temperature. The vendor came out on 3/5/25 and repaired the water tank. The vendor verified that hot water had returned. Staff #31 was interviewed on 3/17/25 at 1:52 PM. He stated that the water in Unit 2 shower room was still below 100F. He said he called the plumber and they will fix the problem. Informed Staff #31 on 3/17/25 at 3:22 PM that this is still a concern and that it will be taken back to the office. He replied that he understood.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on review of a facility reported incident, record review and interview it was determined the facility failed to ensure a resident (#120) was free from misappropriation of their personal funds. This was evident for 1 out of 2 facility reported incidents (#MD00212032) reviewed for misappropriation/personal property during the facility's recertification/complaint survey. The findings include: On 3/10/25 at 9:00AM the surveyor began review of a facility reported incident (#MD00212032) which was submitted by the facility to the Office of Health Care Quality on 11/14/24 which involved a family member of Resident #120 who notified the facility on 11/14/24 of unusual financial transactions which had occurred on the resident's personal bank account on 10/10/24 for $250.00 and 10/21/24 for $15.00. Review of facility reported incident #MD00212032 revealed the allegations were verified by the facility regarding the misappropriation of Resident #120's funds by Geriatric Nursing Assistant (GNA) #35. Review of the facility's complete investigation file for the #MD00212032 revealed documentation of the resident's family having provided facility staff with a phone number that had been provided to them by the resident's financial institution which was linked to the 10/10/24 transaction in which a water bill was paid out of the resident's personal bank account. Upon the facility's review of that phone number associated with the transaction, it was found to be GNA #35's phone number. Review of the facility's complete investigation file additionally revealed that when a different employee of the facility (GNA #36) attempted to provide a personal payment to GNA #35, that payment was received into Resident #120's bank account on 10/21/24 as reflected on the resident's bank account statement which was contained within the file. On 3/11/25 at approximately 11:00AM the surveyor conducted an interview of Business Office Director #8 who confirmed with the surveyor the following information: 1.) misappropriation of Resident #120's personal funds had occurred and was verified by the facility, 2.) GNA #35 had been terminated due to the facility's finding of their misappropriation of Resident #120's personal funds, 3.) they had personally observed that the resident came to the facility with personal bank account information which was present in their drawer and the account information they observed was the same bank account information as the account which was documented in the incident report, 4.) there was an additional incident regarding misappropriation for a different resident, (#67) in which GNA #35 had been named as an alleged perpetrator and had been suspended for, which occurred around the same time and prior to the incident regarding Resident #120, and GNA #35's employment with the facility was terminated, 5.) Resident #67 had previously observed GNA #35 in their purse, and 6.) there was also mention of there being recurring financial withdrawals to Resident #120's bank account which was identified. On 3/11/25 at 11:12AM the surveyor conducted an interview with the facility's Administrator who confirmed that GNA #35 was placed on suspension for two different resident incidents regarding misappropriation having been reported to the facility around the same timeframe, the facility substantiated the incident regarding misappropriation of Resident #120's personal funds, and GNA #35 was terminated as a result of the outcome of investigation for the facility reported incident regarding Resident #120 (#MD00212032.) The surveyor shared their concern at this time with the Administrator who acknowledged and confirmed understanding of the concern. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 12:00PM the surveyor reviewed email documentation sent by the facility's Director of Human Resources to union staff dated 12/8/24 regarding GNA #35 which stated the following reasons for the facility's termination of employment for GNA #35: 1.) Violation #5 theft or inappropriate removal or possession of property belonging to another, and 2.) Violation #20 violation of any company policies or the [NAME] Code of Conduct. On 3/11/25 at 12:17PM the surveyor reviewed the employment file for GNA #35 which revealed the following information was present: 1.) an employee separation form with a termination date of 12/8/24, 2.) a pre-term checklist dated 12/8/24 which stated:Employee was suspended pending investigation for misappropriation of funds, After investigation the allegation is substantiated, 3.) date of hire of 1/31/24, 4.) employee performance improvement notification of termination stating: Employee was suspended pending investigation for misappropriation of funds, After a thorough investigation the allegation is substantiated, and 5.) suspension of employment form dated 11/12/24. On 3/11/25 at 1:51PM the surveyor requested to the Director of Nursing (DON) to provide any and all documentation regarding action taken by the facility for reporting of GNA #35 to the Maryland Board of Nursing. On 3/11/25 at 2:00PM the surveyor conducted an interview with the DON who reported to the surveyor that they did not yet have a response as to if the facility had reported misappropriation by GNA #35 to the Maryland Board of Nursing. On 3/11/25 at 3:30PM the surveyor conducted an interview of the DON who reported to the surveyor that they were not aware of GNA #35 having been reported to the Maryland Board of Nursing by any facility staff. During an interview on 3/18/25 at 9:34AM the Director of Nursing confirmed with the surveyor that the facility had not reported the misappropriation concern regarding GNA #35 to the Maryland Board of Nursing. On 3/18/25 at 11:52AM the surveyor shared concerns with the facility's Assistant Director of Nursing #3 who acknowledged and confirmed understanding of the surveyor's concerns. On 3/18/25 at approximately 3:30PM the concern was again reviewed during the facility's exit conference with the DON and Administrator present. At the conclusion of the survey, no documentation was provided to the surveyor regarding any notification or complaint made to the Maryland Board of Nursing.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on review of a facility reported incident, record review and interview it was determined the facility failed to ensure the implementation of the abuse, neglect, exploitation and misappropriation policy and procedures. This was evident for 1 out of 2 facility reported incidents (#MD00212032) reviewed for misappropriation/personal property during the facility's recertification/complaint survey. The findings include: On 3/10/25 at 9:00AM the surveyor began review of a facility reported incident (#MD00212032) which was submitted by the facility to the Office of Health Care Quality on 11/14/24 which involved a family member of Resident #120 who notified the facility on 11/14/24 of unusual financial transactions which had occurred on the resident's personal bank account on 10/10/24 for $250.00 and 10/21/24 for $15.00. Review of facility reported incident #MD00212032 revealed the allegations were verified by the facility regarding the misappropriation of Resident #120's funds by Geriatric Nursing Assistant (GNA) #35. Review of the facility's complete investigation file for the #MD00212032 revealed documentation of the resident's family having provided facility staff with a phone number that had been provided to them by the resident's financial institution which was linked to the 10/10/24 transaction in which a water bill was paid out of the resident's personal bank account. Upon the facility's review of that phone number associated with the transaction, it was found to be GNA #35's phone number. Review of the facility's complete investigation file additionally revealed that when a different employee of the facility (GNA #36) attempted to provide a personal payment to GNA #35, that payment was received into Resident #120's bank account on 10/21/24 as reflected on the resident's bank account statement which was contained within the file. Review of interview documentation contained within the investigative file revealed the following question was asked of other residents of the facility on 11/14/24: Have you experienced any missing personal belongings (money) while in the facility? The surveyor noted that Resident #271 was documented as responding with the following allegation on 11/14/24: 'Yes, a few weeks ago, When I would go looking for it, it's gone, I don't know who would take it, Close to $600 is missing, It was not in my locked drawer. The surveyor noted that Resident #4 was documented as responding with the following allegation on 11/14/24: Yes, had credit cards stolen a few weeks ago, yes, I told someone, everybody, had a police report (incident report # was additionally documented). Surveyor review of the facility's follow up self report form for #MD00212032 dated 11/19/24 revealed the following information was documented which was reported to the Office of Health Care Quality: 1.) Residents interviewed denied missing funds and verbalized feeling safe in the facility, and 2.) The suspect will be terminated, and the license reported to the board of nursing. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at approximately 11:00AM the surveyor conducted an interview of Business Office Director #8 who confirmed with the surveyor the following information: 1.) misappropriation of Resident #120's personal funds had occurred and was verified by the facility, 2.) GNA #35 had been terminated due to the facility's finding of their misappropriation of Resident #120's personal funds, 3.) they had personally observed that the resident came to the facility with personal bank account information which was present in their drawer and the account information they observed was the same bank account information as the account which was documented in the incident report, 4.) there was an additional incident regarding misappropriation for a different resident, (#67) in which GNA #35 had been named as an alleged perpetrator and had been suspended for, which occurred around the same time and prior to the incident regarding Resident #120, and GNA #35's employment with the facility was terminated, 5.) Resident #67 had previously observed GNA #35 in their purse, and 6.) there was also mention of there being recurring financial withdrawals to Resident #120's bank account which was identified. Additionally, during the interview the surveyor requested for them to provide facility reported incidents to the surveyor for Resident #4 and Resident #271, as these two residents were identified by the surveyor as having misappropriation allegations which were observed documented on resident interview forms from interviews which were conducted during the course of the investigation for Resident #120. When the surveyor inquired as to if Business Office Director recalled any investigations having been performed regarding Residents # 4 and #271, they stated: I don't remember. On 3/11/25 at 11:12AM the surveyor conducted an interview with the facility's Administrator who confirmed that GNA #35 was placed on suspension for two different resident incidents regarding misappropriation having been reported to the facility around the same timeframe, the facility substantiated the incident regarding misappropriation of Resident #120's personal funds, and GNA #35 was terminated as a result of the outcome of investigation for the facility reported incident regarding Resident #120 (#MD00212032.) The surveyor shared their concern at this time with the Administrator who acknowledged and confirmed understanding of the concern. On 3/11/25 at 12:00PM the surveyor reviewed email documentation sent by the facility's Director of Human Resources to union staff dated 12/8/24 regarding GNA #35 which stated the following reasons for the facility's termination of employment for GNA #35: 1.) Violation #5 theft or inappropriate removal or possession of property belonging to another, and 2.) Violation #20 violation of any company policies or the [NAME] Code of Conduct. On 3/11/25 at 12:17PM the surveyor reviewed the employment file for GNA #35 which revealed the following information was present: 1.) an employee separation form with a termination date of 12/8/24, 2.) a pre-term checklist dated 12/8/24 which stated:Employee was suspended pending investigation for misappropriation of funds, After investigation the allegation is substantiated, 3.) date of hire of 1/31/24, 4.) employee performance improvement notification of termination stating: Employee was suspended pending investigation for misappropriation of funds, After a thorough investigation the allegation is substantiated, and 5.) suspension of employment form dated 11/12/24. On 3/11/25 at 12:30PM the surveyor conducted an interview with the facility's Administrator who stated they were not aware of any issues regarding money/credit cards/misappropriation for Residents #4 and #271 and confirmed they were not aware of any actions having been taken in response to the documented interviews of Residents #4 and #271 having reported allegations of misappropriation which were documented during the course of the interviews which were conducted for Resident #120's investigation for misappropriation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1:36PM the surveyor conducted a review of the facility's abuse, neglect, exploitation and misappropriation policies and procedures which had been previously provided on 3/10/25 which was requested as part of the entrance conference process. Review of the policies and procedures revealed the following information: 1.) Objective #2: Develop and implement policies and protocols to prevent and identify: a.) abuse or mistreatment of residents; b.) neglect of residents; and/or c.) theft, exploitation or misappropriation of resident property, 2.) 8.) Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property, 3.) 9.) Investigate and report any allegations within timeframes required by federal requirements, 4.) Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation, 5.) If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law, 6.) Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents, 7.) 1.) All allegations are thoroughly investigated, 8.) minimum investigative procedures, and 9.) All relevant professional and licensing boards are notified when an employee is found to have committed abuse. On 3/11/25 at 1:51PM the surveyor requested to the Director of Nursing (DON) to provide any and all documentation regarding action taken by the facility for reporting of GNA #35 to the Maryland Board of Nursing. Additional documentation was requested by the surveyor at this time which included copies of all policies and procedures for abuse, neglect, exploitation, and misappropriation to be provided. On 3/11/25 at 2:00PM the surveyor conducted an interview with the DON who reported to the surveyor that they did not yet have a response as to if the facility had reported misappropriation by GNA #35 to the Maryland Board of Nursing. On 3/11/25 at 3:30PM the surveyor conducted an interview of the DON who reported to the surveyor that they were not aware of GNA #35 having been reported to the Maryland Board of Nursing by any facility staff. During an interview on 3/18/25 at 9:34AM the DON confirmed with the surveyor that the facility had not reported the misappropriation concern regarding GNA #35 to the Maryland Board of Nursing. On 3/18/25 at 11:52AM the surveyor shared concerns with the facility's Assistant Director of Nursing #3 who acknowledged and confirmed understanding of the surveyor's concerns. At this time they confirmed with the surveyor that the facility did not have any reported incidents to the Office of Health Care Quality for Residents #4 and #271 regarding the allegations made in the interview documents. On 3/19/25 at approximately 3:30PM the concern was again reviewed during the facility's exit conference with the DON and Administrator present. At the conclusion of the survey, no documentation was provided to the surveyor regarding any notification or complaint made to the Maryland Board of Nursing and no documentation of any investigations or facility reported incidents was provided for Residents #4 and #271.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on record review and interviews with facility staff, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days of the resident's enrollment and discontinuation in hospice. This was evident for 1 (Resident #33) of 2 residents reviewed for hospice during the recertification/complaint survey. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. A Significant Change in Status Assessment (SCSA) is required when a resident enrolls in a hospice program and when a resident receiving hospice services discontinues those services. Completion of the SCSA ensures a more thorough review of factors related to the identified decline(s) or improvements in a resident's condition and ensures a comprehensive review of all related care planning. On 3/14/25 at 1:34 PM review of Resident #33's medical record revealed the resident was admitted to the facility on [DATE]. Further review of the medical record revealed two physician orders for Hospice: 1) 9-23-22 to 10-3-22 and 2) 4-22-23 to present (active). However, there were no SCSAs for any dates in the resident's medical record. On 3/14/25 at 1:56 PM in an interview with MDS Coordinator #26 when asked when a SCSA must be completed she stated if the resident had a decline in two or more ADL's (activities of daily living), sometimes a decline in cognition, a new diagnosis, if they become hospice, or there's an improvement. During the interview when asked when SCSA's must be completed she stated we try our very best to have it completed and transmitted in 7-10 days. On 3/14/25 at 2:08 PM an interview with MDS Coordinator #26 she stated that Resident #33's 9/29/22 Annual MDS should have been marked as a significant change MDS, but there was an error. On 3/14/25 at 2:54 PM an interview with the Director of Nursing (DON) she stated she saw there was an initial hospice order for Resident #33 on 9/23/22 and then a second hospice order for 4/22/23. During the interview the DON confirmed and verified there were no SCSAs for either hospice order (9/29/22 or 4/22/23) and that we are all 3 (surveyor, DON and MDS Coordinator #26) on the same page there was not a SCSA completed for Resident #33.

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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. 14894 Based on interview with residents, review of medical records and interview with facility staff, it was determined that the facility failed to hold care plan meetings of the interdisciplinary team for residents at the time of the quarterly revision of the Minimum Data Set (MDS). This was evident for 3 (Resident #55, Resident #104, Resident #37) of 28 residents reviewed for care plan during this recertification/complaint survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive MDS assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team, including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). 1) Resident #55 was interviewed on 3/10/25 at 9:23 AM. Resident stated that they have not had any care plan meetings since admission. A review of Resident #55's clinical record on 3/18/25 revealed that they had care plan meetings as recent as 6/13/24, 9/11/24, and 1/9/25. The MDS's were completed on 5/14/24, 8/14/24, 11/14/24, and 2/12/25. Care plans are based on the MDS and the MDS needs to be just prior to the care plan meeting to ensure accuracy and relevancy. The June care plan meeting was one month after the MDS. The September care plan meeting was held almost one month after the MDS was completed. The January care plan meeting was held almost two months after the MDS. The most recent MDS was completed almost two months before the next scheduled care plan meeting. The Director of Nursing (DON) was interviewed on 3/18/25. She was shown the MDS dates, the care plan meeting dates, and it was explained that the MDS comes first since the care plans that are developed are based on the MDS. She said she understood. I informed her that if she had or found evidence to dispute this finding then she could give it to me later that day. She replied that she did not think she could dispute it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #104's clinical record was reviewed on 3/13/25. The MDS's were completed on 10/11/24, 1/11/24, and 1/29/25. The most recent care plan meetings were held on 8/23/24 and 1/2/25. The most recent set of care plans that were developed were on 10/11/24 and 1/9/25. It appeared that the January care plan was developed before the January MDS was completed. The care plans developed were based on an outdated assessment that may not have been completely accurate by the time the care plans were developed. The team members interviewed the social workers on 3/13/25 at 9:01 AM. They said they arrange the care plan meetings, schedule the time, and document the outcomes. Stated they recognized that the timeline of residents' MDS's did not match when the care plan meetings were held and when care plans were developed. The DON was interviewed on 3/18/25. She was shown the MDS dates, the care plan meeting dates, and it was explained that the MDS comes first since the care plans that are developed are based on the MDS. She said she understood. The Surveyor informed her that if she had or found evidence to dispute this finding then she could provide it later that day. She replied that she did not think she could dispute it. 43096 3) A review of Resident #37's medical records on 3/11/25 at 1:30 PM revealed that the resident's quarterly MDS assessment was completed on 6/21/24, 8/09/24, 11/09/24, and 1/27/25, however, the care plan meeting attendance records documented on 6/14/24, 9/11/24, and 1/10/25; two care plan meeting (June 2024 and January 2025) held prior to MDS assessment, September 2024 care plan meeting held a month later than MDS assessment, and no care plan meeting held after November 2024's MDS assessment. In an interview with the facility social workers (Staff #11 and Staff #12) on 3/13/25 at 9:01 AM, they stated that the care plan meeting was held upon admission and quarterly. They said, The timeline is not matched with MDS. We go by the previous assessment time. We tried to follow MDS's assessment, but it was not always matched. In an interview with the DON on 3/13/26 at 9:45 AM, the surveyor reviewed Resident #37's MDS assessments and care plan meeting attendance sheet. She said, I don't do the care plan meeting. When the social workers arranged them, the nursing department jumped in for our area. The surveyor asked about the timeline of the MDS assessment and care plan meeting. The DON stated that she understood a care plan meeting should be held after the MDS assessment. She validated the above concerns.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47200 Based on observation, interview, and medical record review it was determined the facility failed to ensure medical orders were followed for the provision of thickened liquids. This was evident for 1 (Resident #46) out of 1 residents reviewed for hydration during the facility's recertification/complaint survey. The findings include: On 3/12/25 at 12:22PM the surveyor conducted an observation of Resident #46 who was observed laying in bed asleep at meal time with a covered meal tray which included beverages on it which was sitting in front of them on the over bed table positioned over their bed. The contents of the tray appeared to be unopened and not yet consumed by the resident. On 3/14/25 at 10:50AM the surveyor observed a cup of thin water sitting on the nightstand furniture next to Resident #46 which appeared to be untouched with straw paper still present on part of the straw. On 3/14/25 at 1:20PM the surveyor observed Resident #46 in bed sleeping after meal time with a cup of thin water at their bedside on their nightstand furniture. On 3/17/25 at 9:03AM the surveyor reviewed the medical record for Resident #46 which revealed the following information: 1.) a medical order which stated: diet, pureed texture, nectar consistency, asp (aspiration) precautions; total feeding assist for diet, and 2.) a care plan intervention with an initiated date of 11/1/24 which documented Resident #46's diet order which included the following information: puree texture, nectar thick liquids. On 3/17/25 at 9:11AM the surveyor conducted an observation of Resident #46 who was observed to have the following items present sitting on their furniture within their room: 1.) a cup of thin water with the following information written on it: 3/17, 11-7 and 2.) a small bottle of thickened consistency water which was dated 3/10/25. At this time, the surveyor requested for Licensed Practical Nurse (LPN) #33 to participate in a dual observation with the surveyor. At this time the surveyor shared their concern with LPN #33 who observed, acknowledged, and confirmed understanding of the concern. LPN #33 was then observed removing both beverages from the furniture and throwing them away into the trash can. LPN #33 confirmed with the surveyor that the resident was to only have liquids by mouth that are nectar thickened. On 3/17/25 at 9:37AM the surveyor requested and reviewed the most recent speech therapy discharge summary and recommendations for Resident #46 which revealed that on 2/3/25 Speech Language Pathologist #32 signed the discharge summary with the following recommendation made: nectar thick liquids. On 3/17/25 at 9:53AM the surveyor conducted an interview with the facility's Assistant Director of Nursing #3 (ADON) and shared the concern. ADON #3 stated the following information to the surveyor: Staff shouldn't have done that and I will address that. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 10:36AM the surveyor was approached by ADON #3 who reported to the surveyor that they had performed a facility wide audit to identify residents who were to receive thickened consistency liquids and were in the process of providing education to staff in response to the surveyor's concern. On 3/17/25 at 3:20PM the surveyor shared the concern with the facility's Director of Nursing who acknowledged and confirmed understanding of the concern and stated the following: We started education and we will remedy that. On 3/18/25 at approximately 3:30PM the concern was again reviewed during the facility's exit conference with the DON and Administrator present.

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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. 43096 Based on medical record review and staff and resident interviews, it was determined that the facility failed to monitor/access residents related to potentially leading to smoking accidents. This was evident in 5 (Resident # 37, #44, #61, #93, and #100) of 5 residents reviewed for smoking during this recertification/complaint survey. The findings include: a) On 3/12/25 at 7:16 AM, a review of Resident #61's medical records revealed that on 2/25/25 a social worker (Staff # 11) wrote in a progress note, Resident was caught in the courtyard by the Activities Director smoking outside of the scheduled smoking times. Writer wrote up a smoking behavioral contract for this infarction and issued it to the Resident. On 3/12/24 at 12:03 PM, the surveyor interviewed with Staff #11. She said that on 2/25/25 the activity director found four residents (Resident #37, #44, #61, and #100) were smoking in the courtyard when it was not the facility's scheduled smoking hours. Staff #11 said, I don't know how they had their smoking material. They supposed not to have them. She also stated that she had started to fill out the behavior contract form regarding the smoking rule issue. In an interview with the activities director (Staff #14) on 3/12/25 at 12:16 PM, the staff explained that the facility conducted a smoking evaluation upon residents' admission, and the nursing department assessed them quarterly and as needed. The residents' cigarettes were kept in a lock box in the activity office. Residents had scheduled smoking times, 9 AM, 11 AM, 2 PM, 4 PM, and 6 PM, every day: they meet at the courtyard door, go outside together, and are supervised by the facility staff. Staff #14 recalled the episode on 2/25/25; she was unsure how four residents (Resident #37, #44, #61, and #100) came out to the courtyard. However, she said that the facility assumed these residents followed another resident's family member while they visited the facility. During an interview with the Nursing Home Administrator (NHA) on 3/12/25 at 1:14 PM, she explained that the nurses were expected to complete smoking evaluation admission, quarterly, and as needed. The surveyor asked about the smoking episode on 2/25/25. The NHA said she met residents individually and reviewed policy and contract behaviors. Also, the surveyor asked about the facility's investigation of the episode and whether they figured out who brought the cigarette and lighter. The NHA said, I will review my notes and let you know. On 3/12/25 at 3:40 PM, the Director of Nursing (DON) reported that the facility figured out Resident #44's niece lit the cigarette and passed it to the other residents. Since Resident's family members knew the code to go out to the courtyard, Resident #44 was outside with his/her niece. Then, they opened the outside door to let three other residents in. The surveyor requested any follow-up documentation regarding this episode, such as family and residents' education and/or updated smoking evaluation. The DON stated that since Resident #44's niece's information was not listed on his/her chart, they could not contact her. Also, the evaluation was not completed right after the episode. On 3/12/25 at 3:50 PM, the surveyor reviewed residents' recent smoking evaluation: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #100: smoking policy signed on 11/01/24, and smoking evaluation documented on 2/01/25. - Resident #44: smoking policy signed on 11/01/24, and smoking evaluation documented on 10/29/24. - Resident #61: smoking policy signed on 10/21/24, and smoking evaluation documented on 2/12/25. - Resident #37: smoking policy signed on 10/21/24, and smoking evaluation documented on 2/12/25. There were no smoking evaluations after the unscheduled time smoking noted on 2/25/25. b) During an interview with the NHA on 3/12/25 at 1:14 PM, she mentioned an additional smoking-related incident about Resident #61. While reviewing video footage, the NHA noted that Resident #93 handed a lightened-up cigarette to Resident #61 during the smoking time on 3/03/25, and Resident #61 smoked it. The NHA said, It was not allowed at all. I interviewed the Resident and met with the Resident's sister about the issue. On 3/12/25 at 1:29 PM, a review of Resident #93's medical record revealed that Social worker (Staff #11) wrote a progress note on 3/04/25 at 10:41 PM as Writer and NHA met with Resident and [Resident's sister name]. Staff reviewed smoking policy and reiterated that residents are to refrain from sharing smoking material, assisting other residents with smoking, or lighting other Resident's cigarettes. Staff discussed how violating smoking agreement could pose a safety risk for residents. Writer reviewed that she provided Resident with a copy of behavioral contract on 3/3/2025 but Resident declined to sign stating that he did not help anyone break any rules. Resident was informed that if he does not adhere or violate smoking policy, facility will assist with finding alternate placement for Resident. Resident was given the opportunity to express his/her opinion about smoking policy and behavioral contract. Resident once again denied that he/she violated smoking policy. Staff reviewed violation, with Resident eventually acknowledging and apologizing for infraction. Staff to contact the Ombudsman program and inform of smoking policy and behavioral contract. Staff will continue to monitor behavior However, there was no smoking evaluation and no updated care plan for Residents #93 and #61. During an interview with the Director of Nursing (DON) on 3/12/25 at 3:40 PM, the surveyor shared concerns about handing another resident a lit cigarette. The DON validated this.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on review of medical records and interview with facility staff, it was determined that the facility failed to monitor and timely address a significant weight loss for a resident. This was evident for 1 (Resident #113) of 3 residents reviewed for nutrition during the recertification/complaint survey. The findings include: Resident #113's medical record was reviewed on 3/10/25 at 2:56 PM. The review revealed the resident was admitted to the facility on [DATE] and all of the weights obtained by the facility for the resident were as follows: - 3/5/2025: 134.4 lbs (pounds) - 2/12/2025: 165.0 lbs - 2/5/2025: 164.0 lbs - 1/24/2025: 164.0 lbs - 1/22/2025: 163.0 lbs The above weights reflected that the resident experienced a 29 lb (18%) significant weight loss between 2/5/2025 and 3/5/2025. On 3/12/25 at 11:13 AM review of Resident #113's medical record revealed a Nutritional Risk assessment dated [DATE] as follows: - Section A Weight status; loss or gain- Comments: Per resident's son, his/her UBW (usual body weight) is 160 lbs (pounds). No suspected weight changes. - Section J- Evaluate and Summary: RD (Registered Dietician) talked to resident's son regarding weight history and food preferences. Resident has been weight stable at around 160 lbs. Resident is on a regular diet with variable PO (by mouth) intakes 25-100% since admission. Per resident's son, mom's not a picky eater and eats about anything. No reported skin breakdown or edema. RD will continue to monitor. On 3/12/25 at 11:21 AM review of Resident #113's orders revealed an order for, Weights Weekly every day shift every Wed for 4 weeks with an order date of 1/22/2025 and end date of 3/12/25. In an interview with the Assistant Director of Nursing (ADON) on 3/12/25 at 9:54 AM, she verified and confirmed that the facility did not obtain weights for Resident #113 on 1/29/25 or 3/12/25. The surveyor shared concerns with the facility being able to monitor the resident's weight with half (2 of 4) of the ordered weights missing. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 11:31 AM review of the facility's Weight Assessment and Intervention revealed, Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If a weight is verified, nursing will immediately notify the dietician in writing. On 3/12/25 at 11:49 AM review of the Resident #113's medical record did not reveal any evidence that the dietician was immediately notified in writing of the verified weight change of 5% or more. Additionally, the review did not reveal any evidence that the dietician addressed the weight loss. On 3/13/25 at 1:16 PM in an interview with the Regional Dietician #20, when asked prior to surveyor intervention (on 3/12/25) how the facility addressed Resident #113's significant weight loss, she confirmed and verified that prior to surveyor intervention on 3/12/25, there were no interventions put in place for this resident's significant weight loss and the physician and RP (responsible party) were not notified of the significant weight loss. When asked why she stated she could not explain why no further action was taken.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43096 Based on medical record review and interviews with residents and staff, it was determined that the facility staff failed to obtain/monitor pre and post-dialysis body weights. This is evident for 1 (Resident # 220) of the 1 resident reviewed for dialysis services during the recertification/complaint survey. The findings include: Hemodialysis is a treatment that filters wastes and water from the blood, as the kidneys did when they were healthy. It helps control blood pressure and balance essential minerals, such as potassium, sodium, and calcium, in patients' bodies. During an interview with Resident #220 on 3/10/25 at 8:12 AM, the resident reported that he/she transferred to the hospital on 1/19/25 due to shortness of breath. Also,the resident claimed that he/she still had some discomfort with breathing and edema. On 3/12/25 at 7:30 AM, a review of Resident #220's discharge summary from the hospital dated 1/25/25 showed that the resident was admitted to the hospital due to respiratory failure with hypoxia (Hypoxia is a condition in which there is an inadequate supply of oxygen to the body's tissues) secondary to volume overload. And recommended follow-up with outpatient for repeat paracentesis. (Paracentesis is a procedure that drains excess fluid called ascites from your abdomen.) In a review of Resident #220's medical record on 3/12/25 at 8:31 AM, it was revealed that the resident had a diagnosis that included end-stage kidney disease, which required hemodialysis three times a week. During an interview with a Registered Nurse (Staff #24) on 3/14/25 at 7:14 AM, Staff #24 stated that the facility staff communicated with the dialysis center using the 'Hemodialysis Communication Record' form located in the unit binder. Staff #24 added that the form had sections 1 to 3; section 1 is completed by the facility prior to transfer, the dialysis center completes section 2, and the facility completes section 3 upon return from dialysis. Staff #24 confirmed that the facility reviewed section 2 (section 2 included pre- and post-body weights, vital signs, and any event, as well as administered medications and shut site observations) to acknowledge residents' conditions. On 3/17/25 at 9:11 AM, the surveyor reviewed Resident #220's Hemodialysis communication records and the dialysis center's record from 1/25/25 to current. The review revealed the following: - On 2/08/25, the communication record documented post-dialysis weight as 83.4kg (183.9 lb-pound), and the treatment details report from the dialysis center documented pre-weight as 83.4 kg(183.9 lb) and post-weight as 80.8 kg (178.1lb). - On 2/13/25, the communication record documented only post-dialysis weight as 86.1 kg (189.4 lb), and the treatment report documented pre-weight as 83.0 kg (183.0 lb) and post-weight as 79.9 kg (176.1 lb). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 2/18/25, the communication record documented only post-dialysis weight as 88.4 kg (194.48 lb), and the treatment report documented pre-weight as 83.5 kg (184.1 lb) and post-weight as 80.9 kg (178.4 lb). - On 3/11/25, the communication record documented only the pre-dialysis weight as 93.4kg(205.9 lb) and the post-dialysis weight as 90.8 kg (200.2 lb). - On 3/13/25, the communication record documented only the pre-dialysis weight as 90.1 kg (198.6 lb), and the treatment report documented the pre-weight as 90.1 kg (198.6lb) and the post-weight as 87.5 kg (192.9 lb). On 3/17/25 at 10:44 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). She verified that the facility nursing staff used the hemodialysis communication record to monitor residents' condition. They referred to residents' vital signs and body weights from the sheet. The surveyor shared concerns regarding Resident #220's body weight, which was not monitored pre- and post-dialysis, and/or discrepancies in body weights from dialysis center records and the facility's record sheet. Also, the surveyor informed the concerns about Resident #220's ascites and recommended repeat paracentesis, which required monitoring of the resident's body weight trends. The ADON agreed on the importance of monitoring body weight for dialysis residents. She validated the above concerns.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 14894 Based on observation it was determined that the facility staff failed to post staffing information in an easily accessible location. This was evident for 4 out of the 7 days of the recertification/complaint survey. The findings are: The survey team observed upon entrance and subsequent tours of the facility that the facility staff had not posted the nurse staffing information for the facility in an easily accessible location. The team then observed on March 14, 2025, that a sign with the nurse staffing information was placed on a table in the reception area adjacent to St Patrick's Day decorations. The survey team informed the facility of the citation at the exit conference.

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	215069	A. Building B. Wing	03/18/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43096 Based on a review of the resident medical records and interview with facility staff, it was determined that the facility failed to ensure that drug records were maintained in a manner that allowed for reconciliation of dispensed and administered medication. This was evident for 4 (Resident #14, #31, #52, and #100) out of 4 residents reviewed for administration of narcotic medication during this recertification/complaint survey. The findings include: Oxycodone is narcotic medication used to treat moderate to severe pain. It is at high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol or other illicit drugs such as heroin and cocaine. A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. On 3/12/25 at 8:48 AM, the surveyor reviewed the opioids books count sheet for four residents (Resident #14, #31, #52, and #100) from three different units and different carts. 1) Resident #100 had an order of Oxycodone 15 mg (milligrams) for pain every 4 hours as needed. The count sheet documented that three tablets of Oxycodone 5 mg were used on 2/13/25 at 8 AM, 2/13/25 at noon, and an unmarked (the column was vacant) date and time. However, a review of the February 2025 Medication Administration Record (MAR) for Resident #100 revealed that these administrations were not recorded under the MAR. 2) Resident #31 had an order of Oxycodone 5mg for pain every 6 hours as needed. The review of the March 2025 MAR for Resident #31 revealed that the resident received the medication on 3/08/25 at 7 PM. However, it was not documented on the count sheet. 3) Resident #52 had an order of Oxycodone 20mg by mouth every 4 hours as needed for pain. The review of the March 2025 MAR for Resident #52 revealed that the resident received Oxycodone 20mg on 3/02/25 at 9:47 AM and 2:04 PM and on 3/03/25 at 7:57 AM and 1:29 PM. However, these were not documented on the count sheet. Additionally, the count sheet documented that the medication was removed on 3/04/25 at 1:50 PM and 6:56 PM; these were not documented in the residents' MAR. 4) Resident #14 had an order of Oxycodone 2.5mg by mouth every 4 hours as needed for pain. The count sheet documented that the medication was administered on 2/22/25 at 9 AM, 2/23/25 at 9 AM, 2/25/25 at 9 AM and 1 PM, 3/01/25 at 5:50 PM, 3/04/25 at 1 PM, and 3/11/25 at 9 AM and 3 PM. However, those medication administrations were not documented in the February and March 2025 Medication Administration Records for Resident #14. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with a Registered Nurse (Staff #37) on 3/12/25 at 11:13 AM, Staff #37 explained the process of administering controlled medication: make sure residents order, count the medication in their medication card (residents' medication storage in a bubble pack in cardboard), pull the medication, and document in the MAR and the count sheet.) The staff verified that the nurses were supposed to document in the MAR and the count sheet with the date, time, quantity used, remaining, and signature. In an interview with the Director of Nursing (DON) on 3/12/25 at 2:54 PM, she confirmed that all nurses were required to document any controlled medication in the count sheet and residents' MAR. The surveyor informed the above findings. She validated it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on observation and staff interview it was determined that the facility staff failed to ensure medications are kept in a secure location. This was evident for 1 out of the 4 nursing units observed during the recertification/complaint survey. The findings include: During the tour of the facility on 3/10/25 at 8:09 AM an unlocked medication cart was observed on Unit Two between rooms [ROOM NUMBERS]. There were no residents in the hallway at this time. Three facility staff members walked past the medication cart during the observation period and not one locked the cart. At 8:22 AM, the Director of Nursing (DON) walked up to the medication cart, opened the controlled substance logbook, and pushed in the lock. This surveyor walked up to the DON, informed her that I had been standing in the hallway, and that the medication cart had been unlocked for almost 15 minutes. She confirmed it was unlocked when she went up to the cart.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 43096 Based on observation, review of medical records, and interviews with residents and staff, it was determined that the facility failed to ensure that residents received necessary and/or recommended dental services in a timely manner. This was evident for 1 (Resident #61) of 2 residents reviewed for dental services during the recertification/complaint survey. The findings include: During an interview with Resident #61 on 3/10/25 at 12:29 PM, the resident reported that he/she had broken teeth that still retained roots. The resident said, I need oral surgery to remove this remaining piece. But the staff canceled my appointment. On 3/13/25 at 11:33 AM, the surveyor reviewed Resident #61's medical records. The review revealed that the dental consultation was placed on 4/24/24; the consultation form included a copy of an X-ray that showed a broken tooth. Further review of medical records revealed that Resident #61 was seen by [name of contracted dental group] on 6/11/24. On that day, the dentist documented that Patient has retained roots 11 & 12 that are partially embedded in gingiva and will need to be surgically removed. Recommend Patient go to outside facility that can provide surgical extractions. The resident was seen by the dental group regularly for routine cleaning on 7/19/24, 10/22/24, and 1/24/25 for fluoride varnish. However, there was no follow-up consultation regarding tooth extraction. During an interview with the Director of Nursing (DON) on 3/13/25 at 12:44 PM, the surveyor asked about Resident #61's oral surgery (tooth extraction) status. She explained that the facility staff were still in the process of arranging appointments. She said, Since the resident's insurance was not covering the procedure, it takes longer to find a dentist. Also, the DON verified that there was no documentation to support the facility was still trying to find a dentist for Resident #61. On 3/13/25 at 2:38 PM, the DON said, The resident went out to see an outside dentist. Since the doctor did not take the resident's insurance, the procedure was not done. We decided to pay for it ourselves, then contacted [name of contracted dental group]. They scheduled to come to evaluate the resident on 4/01/25. The DON confirmed that the oncoming dental service group is the same group that recommended the outside facility on 6/11/24. On 3/14/25 at 7:40 AM, the DON brought a copy of transportation documentation showing Resident #61 had an appointment with an oral surgeon on 6/24/24. The DON said, Since the resident did not receive any procedure there, we did not have any documentation about that. The surveyor interviewed Resident #61 on 3/14/25 at 8:48 AM. The resident said, The broken teeth are still sharp here; it bothers me. I went out, but the procedure was not done at that time. After that, no more appointments were scheduled. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 10:16 AM, the surveyor contacted a [contracted dental group] representative person via phone. She stated that the tooth extraction procedure can/cannot be performed at the facility bedside; depends on the dentist's decisions. She reviewed Resident #61's notes and said, In June 2024, the dentist documented that the resident's tooth root was retained in the gum, so he/she recommended doing it as a surgical extraction. She verified that even though the procedures can be changed upon the dentist's evaluation, the schedule for the following appointment on 4/01/25 was set for routine check-ups. During an interview with the DON on 3/14/25 around 11 AM, the surveyor shared concerns regarding Resident #61's tooth extraction procedure was not arranged timely. She validated it.

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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. 47200 Based on observation and interview it was determined the facility failed to: 1) ensure food items were labeled, 2) ensure food items were discarded appropriately, 3) ensure the freezer was maintained free from ice accumulation, 4) ensure the device utilized for dispensing of juice was not stored on the kitchen floor, 5) ensure safe storage of cleaning chemicals and 6) ensure consistent required temperature levels for dishwashing sanitization. These deficient practices have the potential to affect all facility residents. On 3/10/25 beginning at 8:00 AM the surveyor conducted an initial tour of the facility's kitchen. On 3/10/25 at 8:12 AM the surveyor observed a metal container in the reach in refrigerator with the following label present: Monday Sauces/Gravies Homemade prep/opened on 3/3/25 1:25 PM, use by 3/5/25 1:25 PM. Further observation of the contents of the metal container revealed a white, lumpy, and crusty appearance of the gravy. On 3/10/25 at 8:13 AM the surveyor observed 10 unlabeled side item containers present within the reach-in refrigerator. Upon further observation of one of the side items, the puree mixture was noted to have a crusty appearance. On 3/10/25 at 8:16 AM the surveyor observed the juice station within the kitchen with four juice lines in which three of those lines were connected to bags of juice concentrate, with the fourth juice line laying directly on the surface of the kitchen floor with stains and debris present on the floor area. On 3/10/25 at 8:17 AM the surveyor requested and conducted a dual observation of the concerns with [NAME] #38 who immediately removed the gravy from the reach-in refrigerator and threw the gravy away into the trash. On 3/10/25 at 8:18 AM the surveyor observed Dietary Aide #39 immediately remove the unlabeled side items from the reach-in refrigerator. On 3/10/25 at 8:22 AM the surveyor observed a metal container of pineapple slices which was partially uncovered with saran wrap with the following label present: Tuesday pineapple sliced, prep/opened on 3/4/25 3:30 PM, use by 3/6/25 3:30 PM. On 3/10/25 at 8:22 AM the surveyor observed a metal pan containing chicken salad which was partially uncovered with saran wrap with the following label present: Thursday chicken salad prep/opened on 3/6/25 at 1:38 PM, use by 3/8/25 1:38 PM. On 3/10/25 at 8:23 AM the surveyor observed extensive ice accumulation covering approximately three-fourths of the ceiling of the facility's walk in freezer with some areas of ice being approximately 2 to 3 inches in depth. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 8:24 AM the surveyor observed a storage room located within the kitchen containing various cleaning solutions and chemicals. Further observations included: 1) various chemicals which included partially utilized chemicals were stored close to disposable food pans, 2) racks for food holding were stored reaching across the disposable food pans and resting onto a broom head, 3) a dust mop head resting over the disposable food pans, 4) a container of chemical with a plastic utensil sitting next to it, 5) uncovered plastic utensils, and 6) boxes of sandwich bags stored on shelving next to various cleaning chemicals. On 3/10/25 at 8:26 AM the surveyor conducted an interview and dual observation of concerns with Certified Dietary Manager (CDM) #40 who acknowledged and confirmed understanding of the concerns. CDM stated the following information in response to observation of the pears and chicken salad in the walk-in refrigerator: I'm disposing of it. On 3/12/25 at 2:46 PM the surveyor observed the dishwashing machine with CDM #40 who ran dishes through the machine and then observed with the surveyor and acknowledged that the temperature gauges on the machine were not moving as the machine completed the dishwashing cycle. At this time the surveyor shared their concern that the temperature gauges were not moving. The surveyor noted that the machine was labeled with the following notice: This machine is currently in hot water sanitizing mode. Further review of the machine's manufacturer plaqard indicated the following minimum temperatures for hot water sanitization; 160F for minimum wash temperature, and 180F for minimum rinse temperature. On 3/14/25 at 2:28 PM the surveyor observed the dishwashing machine in operation with CDM #40 at which time the machine was observed to be utilizing chemical sanitization although the machine continued to be marked as in heat sanitization mode, and was observed to be unable to sustain consistent temperature readings on the gauges when dishes were continually put through the system. The dishwasher temperature gauges were observed at times to not be moving throughout complete dishwashing cycles. When the surveyor inquired as to why this was occurring, CDM #40 reported to the surveyor that they didn't know the gauges weren't working properly and confirmed that after it was initially identified by the surveyor and shared with them on 3/12/25 they had a contractor assess the machine, and there was now a recommendation for a larger booster (specialized water heater to reach high temperatures) to be installed. On 3/17/25 at 7:23 AM the surveyor conducted an interview with CDM #40 who confirmed with the surveyor that chemical sanitization was currently being used as a back up method for sanitization of dishes because the dishwashing machine was unable to meet required temperatures consistently for heat sanitization. CDM #40 reported that they were currently awaiting the specifications for a larger booster because there were electrical considerations which needed to be addressed for the installation, and that after the booster replacement that would eliminate the need to utilize the chemical currently in place. On 3/17/25 at 7:51 AM the surveyor received and reviewed requested dishwasher machine maintenance records and noted that on 3/13/25 the following notes were present on the outside contractor's work summary: Need to increase the incoming water temperature and work on getting a bigger booster as well as fixing the hood, Normal water temperature and it goes down after it starts due to the hood being open and letting cold water come in, Normal rinse temp and it goes down due to the booster being too small for the dish machine and also the incoming water is only at 90. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25 at 7:56 AM the surveyor conducted an interview with the dishwashing machine service provider who reported having assessed the machine on 3/13/25. During the interview the service provider stated they had observed that when the dish machine was running comfortably, it was unable to keep up with required temperatures and boosters go bad with time and they had recommended the facility obtain a larger booster in order to achieve a better water temperature. On 3/18/25 at approximately 3:30 PM the concern was reviewed during the facility's exit conference with the DON and Administrator present.

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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** 14894 Based on review of medical records and interview with facility staff, it was determined that the facility failed to 1) ensure contracted services for wound care were timely documented in the medical record and 2) failed to ensure the resident's medical record was no longer accessible by a provider once that provider was no longer involved in the care of the resident. This was evident for 3 (Resident #121, #119, #270) of 47 residents reviewed during the facility's recertification/complaint survey. The findings include: 1) A review of Resident #121's clinical record on 3/12/25 at 2:41 PM revealed that on 3/6/25 the Certified Registered Nurse Practitioner (CRNP #34) wrote a note for a wound care visit that was done on 11/20/24. The resident was seen on wound care rounds for the evaluation of wounds on the right foot. The Director of Nursing (DON) was shown the note on 3/12/25 and informed it was written for a wound care consult that occurred almost four months earlier. She replied that she did not recognize who CRNP #34 was. She then added that she would look into it. 43096 2) On 3/14/25 at 2:17 PM, the surveyor reviewed Resident #119's medical records for the system-selected residents for death. The review revealed that the resident passed away on 12/23/24 while receiving hospice care in this facility. However, Resident #119's progress note contained a wound note that was written by CRNP #34 on 3/6/25 at 3 PM: the note had details of the wound status. During an interview with the DON on 3/18/25 at 9:35 AM, she confirmed that CRNP #34 and their group were terminated on 12/10/24. They were no longer working in the facility. The surveyor asked to provide the facility's policy for furnishing a specific service from outside resources. The DON stated that the facility did not have policies for that. Also, she said that she expected the medical documentation to be updated within 24 hours. The surveyor shared concerns regarding Resident #119's wound note, which was uploaded to the medical record more than 2 months after his/her death. She validated the concerns. 47200 3) On 3/14/25 at 12:26 PM the surveyor conducted a review of the medical record for Resident #270 at which time the surveyor observed that the resident had a discharge date of [DATE], however, a skin/wound note with a date of service of 11/20/24 was observed to be documented in the medical record of the resident with a creation date of 3/7/25, an effective date of 3/6/25, and an electronic signature and review date of 3/6/25 was present on the note which was signed by CRNP #34. The surveyor noted that wound documentation was documented in Resident #270's medical record approximately 106 days after the contracted provider's visit date of service, and after they were no longer residing within the facility. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 12:22 PM the surveyor conducted an interview with CRNP #34 who reported to the surveyor that there were wound notes that did not get uploaded to the medical record for several residents of the facility which included Resident #270. On 3/17/25 at 12:32 PM the surveyor conducted an interview with the facility's Administrator who reported the following information in response to the surveyor's inquiry as to if the prior contracted wound care professionals including CRNP #34 were still able to be accessing and documenting in the medical record: They should not be, no, just the most current company, They should not, I don't understand why they would, you are bringing something to my attention I had not heard. At this time the surveyor shared their concern. On 3/17/25 at 3:32 PM the surveyor conducted an interview with the facility's DON who confirmed and acknowledged understanding of the surveyor's concern and confirmed with the surveyor that the facility was not uploading on behalf of CRNP #34, and CRNP #34 was directly accessing and uploading into the medical record. On 3/18/25 at 9:34 AM the surveyor conducted an interview with the DON who stated the following in response to the surveyor's inquiry as to the facility's policy for limiting access to the medical record when outside care providers were no longer contracted to provide resident care: There is no policy, it's just a procedure, once a provider or someone has provided all material their access is terminated. When the surveyor inquired as to the timeframe the facility requires for outside providers to provide all materials, the DON responded: According to the regulation 30 days, notes are supposed to be put in timely, 24 hours or something like that. When the surveyor inquired to the DON as to what the facility's expectation for timely documentation by providers was, they stated: same day documentation. At this time the surveyor confirmed with the DON that there was no written policy or procedure in place regarding termination of access to the medical record. When the surveyor inquired to the DON as to if the facility had been contacted by the outside provider about an outstanding need to put notes into the medical record they stated: no. When the surveyor inquired to the DON as to who was responsible for termination of access to the medical record after a contract with a provider is no longer in effect, they reported the following information to the surveyor: Ultimately we terminate access via our global solutions, our IT (internet technology department), ultimately it's us. Regarding the wound care provider group in which the facility had contracted with to provide wound care to facility residents which included CRNP #34, the DON stated the following information to the surveyor: They are all not here, they all were terminated and all access should have been terminated by the facility to (the outside provider) and their group. On 3/18/25 at approximately 12:00 PM after several surveyor requests, a copy of the wound care provider contracts was provided to and reviewed by the surveyor which included a letter of cancellation of agreement for the wound care provider group which was dated 11/19/24 in which the facility's Administrator notified the wound care provider that their wound care agreement and all services was terminated as of 12/10/24. On 3/18/25 at approximately 3:30 PM the concern was again reviewed during the facility's exit conference with the DON and Administrator present.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 43096 Based on review of the facility records and interview with facility staff, it was determined that the facility failed to monitor and track antibiotic usage. This was evident by 1) the delayed start of the antibiotic and 2) a resident receiving an extra dose. This was found to be true for 1 (Resident #94) out of 3 residents reviewed for antibiotic use during the recertification/complaint survey. The findings include: 1) As part of the investigation into Urinary tract infection, the surveyor reviewed Resident #94's medical record on 3/17/25 at 7:30 AM. The review revealed that the resident's urine test on 2/24/25 resulted in a positive for infection, and the provider prescribed oral Augmentin 875/125mg (antibiotic) twice a day for five days on 2/26/25. Further review of Resident #94's Medication Administration Record (MAR) for February 2025 revealed that the afternoon dose scheduled at 9 PM for Augmentin 875/125mg was signed by a nurse, then the order was discontinued at 11:16 PM on 2/26/25. The new order (the same indication, dose, duration, and frequency) was placed with a starting date of 2/27/25 at 9 AM. The record revealed that Resident #94 received a total of 11 doses of Augmentin. During an interview with the Infection Control Preventionist (Staff # 29) on 3/17/25 at 2:20 PM, she stated that the facility staff monitored residents' antibiotic usage through antibiotic stewardship: indications, dose, signs and symptoms, strength, criteria, and side effects. The surveyor shared concerns regarding Resident #94's Augmentin order on 2/26/25. On 3/18/25 at 9:19 AM, Staff #29 stated that the MAR on 2/26/25 was documented as 'NA-not applicable'. She confirmed that the facility staff contacted the nurse who signed off on that medication and verified that the medication was not given. They verified that the nurse discontinued the original order and re-ordered the same order with the starting day as 2/27/25. Further review of the order detail information for Augmentin on 2/26/25 revealed that the order was placed at 2:28 PM on that day. The surveyor requested the medication list for the emergency medication (known as the med Bank: the medication storage in the facility for emergency use). On 3/18/25, around 10 AM, the review of the content of the med Bank revealed that Augmentin 875/125mg was in stock when Resident #94 had an order for 2/26/25. On 3/18/25, around 10:30 AM, the surveyor informed the Director of Nursing that the above concerns related to antibiotics were started with a one-day delay. She validated it. 2) On 3/17/25 at 7:30 AM, a review of Resident #94's medical record revealed that the resident had a yeast infection in urine noted on 3/06/25 from his/her urine test on 3/04/25. The provider ordered Fluconazole (medication for treating and preventing fungal infections) tablet 100mg (milligrams) once a day for infection for 5 days, starting 3/07/25 at 9 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Hill Rehabilitation and Healthcare Center	111 West Road Towson, MD 21204

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #94's Medication Administration Record (MAR) for March 2025 revealed that the resident received Fluconazole 100mg on 3/07/25, and the order was discontinued on 3/07/25 at 11:55 AM. There was another order (the same order): Fluconazole 100mg give 1 tablet by mouth one time a day for yeast in urine for 5 days start 3/08/25 to 3/12/25. The review revealed that Resident #94 received a total of 6 doses of Fluconazole. During an interview with the Infection Control Preventionist (Staff # 29) on 3/17/25 at 2:20 PM, the surveyor reviewed Resident #94's Fluconazole administration record. Staff #29 confirmed that the resident received one more extra dose. She explained that since the order indication was changed from infection to yeast in urine, the resident took one more extra dose. Staff #29 stated that it should be five doses. On 3/18/25, around 10:30 AM, the surveyor informed the Director of Nursing of the above concerns related to the extra antibiotic used for the resident. She validated it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. Building B. Wing	03/18/2025

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 47200 Based on observation and interview, it was determined the facility failed to ensure the kitchen steam table was maintained in safe operating condition. This was evident for one out of one steam tables observed to be in operation during the surveyor's initial tour of the facility's kitchen during the recertification/complaint survey. The findings include: During the surveyor's initial tour of the facility's kitchen on 3/10/25 at 8:04 AM the surveyor observed the steam table which was holding food had two out of six indicator lights (utilized to indicate to staff that the steam wells are on and ready for use) which were inoperable and four out of six knobs (to control the temperature levels of the steam wells used to maintain food temperatures) which were missing. On 3/10/25 at 8:05 AM the surveyor shared their concern and conducted an interview with [NAME] #38 who stated the following information regarding the steam table conditions: It's been like that for years. On 3/10/25 at 8:26 AM the surveyor conducted an interview and dual observation of concerns with Certified Dietary Manager #40 who acknowledged and confirmed understanding of the concerns. On 3/18/25 at approximately 3:30 PM the concern was reviewed during the facility's exit conference with the DON and Administrator present.