STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215073	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lions Rehab Center	901 Seton Drive Cumberland, MD 21502

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 51489 Based on observations and interviews, it was determined that the facility failed to ensure resident's urine collection bag was kept in a privacy bag to maintain dignity. This was evident for 2 (#419, #64) of 3 residents reviewed for urinary catheters. The findings include: 1) On 1/8/25 at 11:19 AM, Resident #419 's foley bag was observed on the floor from the hall without a privacy cover. The Resident was in bed. On 1/8/25 at 11:46 AM, Resident #419's foley bag was observed attached to the bed rail from the hall without a privacy cover. On 1/8/25 at 1:16 PM, Resident #419 was observed in bed eating lunch using a wheeled bedside table. The foley bag did not have a privacy cover. On 1/8/25 at 1:49 PM, it was observed that the bedside table, without a food tray, had been moved away from the Resident. The foley bag lay on the floor without a privacy cover. On 1/13/25 at 10:30 AM, Resident #419 was observed asleep in bed. The foley bag lay on the floor without a privacy cover. On 1/13/25 at 10:57 AM Resident #419 was observed awake in bed. The foley bag lay on the floor without a privacy cover. On 1/13/25 at 12:26 PM, the foley bag hung from the bed rail without a privacy cover. On 1/13/25 at 12:40 PM, the surveyor and Staff #8, a Licensed Practical Nurse (LPN), observed the foley bag without a privacy cover. In an interview, Staff #8 said a privacy bag should be on when the Resident was in bed or on a chair. On 1/13/25 at 12:50 PM, the foley bag was on the floor without a privacy cover. (continued on next page)

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 12:51 PM in an interview, the director of nursing (DON) was informed that the foley bag was frequently observed without a privacy cover. The DON acknowledged that Resident #419's foley bag was frequently without a privacy cover. 48470 2) Resident #64 was admitted to the facility in early 2024. During the initial tour of the facility on 1/8/25 at 12:37 PM, the resident was observed in bed and the urine collection bag was on the right side of the bed, closer to the door, not kept in a privacy bag. This was visible from the hallway, outside the resident's room. The Registered Nurse (RN #3) who was assigned to the unit where Resident #64 resided was interviewed on 1/8/25 at 12:39 AM. During the interview, the concern was discussed that the resident's urine collection bag was observed without a privacy bag to maintain dignity. RN #3 confirmed the finding as it was visible from the hallway. RN #3 obtained a privacy bag, went in the resident's room and applied it. A review of Resident #64's medical record on 1/13/25 at 1:03 PM, revealed a care plan for catheter care with interventions that indicated, position catheter bag and tubing below the level of the bladder and away from entrance room door. On 1/17/25 at 12:26 PM, the concern was discussed with the Director of Nursing (DON) that the resident's urine collection bag was not kept in a privacy bag that was visible from the unit hallway. The DON verbalized understanding and acknowledged the concern.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48470 Based on record review, observation, and interviews, it was determined that the facility failed to ensure that call devices were kept within reach of the resident. This was evident for 1 (Resident #40) in 24 residents reviewed during the survey. The findings include: Resident #40 had been residing in the facility since 2022. Two complaints related to MD00210880 and MD00211651 indicated concerns with the resident's call device being placed on the roommate's nightstand outside the resident's reach. Minimum Data Set- The MDS is a federally-mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. On 1/9/25 at 11:33 AM, a review of Resident #40's most recent MDS assessment with a reference date of 12/20/24 was conducted. The review revealed that Resident #40 was coded as dependent on staff for transfers and mobility and needed substantial/maximal assistance from staff for toileting hygiene. On 1/10/25 at 10:43 AM, Resident #40 was observed sleeping in his/her room with the call device draped over the roommate's nightstand, outside the resident's reach. The Registered Nurse (RN #3) was informed of the observation on 1/10/25 at 10:45 AM. RN #3 went into Resident #40's room and confirmed the placement of the call device. RN #3 moved the call device to the resident's bed and secured it to the bedding with a clip attached to the cord. On 1/15/25 at 1:36 PM, Resident #40's medical record was reviewed and revealed a care plan for the resident's risk for falls. The interventions for this care plan included: 1) Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 2) Maintain call light within reach when resident in room. Reinforce use of call light to call for assistance when he/she needs to move from bed, chair, wheelchair, toilet, etc. This care plan had a revision date of 10/24/24. In an interview with the Director of Nursing (DON) on 1/15/25 at 2:05 PM, she confirmed that she knew of the complaints regarding the call device for Resident #40 being placed outside his/her reach. The DON reported that she had been aware since October 2024 and had done staff education. She also performed random inspections to ensure the call device was placed within the resident's reach. The observation on 1/10/25 was discussed with the DON, who reported that the current interventions to keep the resident's call light within reach were ineffective. The DON indicated that she would have to discuss with her staff to come up with a new plan to ensure that the call device was kept within the resident's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next day, on 1/16/25, at 7:45 AM, Resident #40 was observed sleeping in bed with the call device on the floor, outside the resident's reach. Shortly after, at 7:47 AM, the Geriatric Nursing Assistant (GNA #15) came into the resident's room and confirmed the finding. GNA #15 moved the call device to the resident's bed and secured it on the blanket with the attached clip.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 48259 Based on interviews and record review, it was determined that the facility failed to provide residents with quarterly statements in writing of their personal funds account managed by the facility. This was evident for one Resident (#22), who was reviewed for personal funds during the survey. The findings included: In an interview on 1/8/25 at 11:18 AM, Resident #22 responded Yes to keeping money in the facility like a bank. Then, it was added that s/he had not received a written quarterly statement of the account for a year. During a subsequent interview on 1/10/25 at 11:45 AM, the Business office manager (BOM) reported that he hand-delivered quarterly statements to residents who could make their own decisions. He also noted that he discussed the statements with the residents' who signed them and returned them to him for his records. He added that he only made copies for residents who requested them. A review of Resident #22 medical record contained a document completed by the Resident's attending provider that indicated the Resident could make his/her own decisions. In an interview on 1/10/25 at 12:19 PM, the BOM presented Resident #22's quarterly statement to the surveyor from 10/1/2 to 12/31/24. The statement contained a notation, hand-delivered on 1/10/25, and was signed with the Resident's name and initials. When questioned if the notation also meant that Resident #22 received a copy of his/her quarterly statement, the BOM said he understood the concern of just signing and not receiving a copy. He also added that he would change his process to include documentation that the quarterly statements were reviewed and that copies of the statements were also given to the residents quarterly. In a subsequent interview on 1/10/25 at 1:57 PM, the BOM reported that he went back to all the residents who could make their own decisions, discussed their quarterly statements from 10/1/24 to 12/31/24 and gave them copies with a notation of when the statements were reviewed, and copies were issued. The BOM added that would be his new process in the future.

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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. 48259 Based on medical record review and interview, it was determined that the facility failed to ensure they informed residents of their right to formulate an advance directive. This was evident for one resident (#269) who was reviewed for advance directives during the survey. The findings include: A medical record review for Resident #269 on 1/8/25 at 1:00 PM showed that the resident was admitted to the facility in December 2024. The review contained a document completed by the resident's attending provider on 12/22/24 that indicated the resident could make his/her own decisions. An advance directive is a legal 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 because of illness or incapacity. The review failed to show that Resident #269 had an advanced directive or that the resident or his/her representative had been informed of his/her right to formulate an advanced directive. During an interview on 1/8/25 at 1:16 PM, the nurse manager, also the social services designee (RN #12), reported that she had been fulfilling some of the roles of the social services department since November when the facility lost their social worker. She also said that during her assessment, she only asked residents if they had advance directives already formulated and did not discuss with residents their rights to develop one if they answered No. In an interview on 1/16/25 at 4:15 PM, the nursing home administrator indicated that his expectation of the facility staff was to help in establishing an advance directive if they did not have one. In an interview on 1/17/25 at 7:36 AM, with RN #12 in the presence of the director of nursing, she reported that after the surveyor's intervention, she had gone back to the residents she spoke to about advance directives and addressed whether they needed help in establishing one or not.

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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. 51712 Based on staff interviews, and record reviews, it was determined that the facility failed to notify the physician when a medication was held several times for low systolic blood pressure (SBP). This was evident for 1 (Resident #44) of 6 residents reviewed for unnecessary medications. The findings include: The review of Resident #44's medical records on 1/15/25 at 3:38 PM revealed an order, with a start date of 12/27/22 for Metoprolol 50 mg to be given twice a day for Cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body); and to hold (not administer) if the pulse was less than 60 or the systolic blood pressure (top number of a blood pressure) was less than 100. On 1/15/25 at 4:06 PM record reviewed revealed that on several occasions when the metoprolol was held due to low parameters; that no documentation was found to indicate that the physician was made aware. Review of the April 2024 MAR revealed that the metoprolol was held due to low SBP or low heart rate (HR) on the following dates: 4/3 pm - HR was 54 4/6 pm - BP was 99/73 4/9 am - BP was 93/51 4/9 pm - BP was 95/69 4/10 am - BP was 95/66 4/10 pm - HR was 53 4/12 am - HR was 54 4/13 am - BP was 90/50 4/13 pm - BP was 90/50 4/14 am - BP was 94/70 4/16 am - BP was 94/58 4/17 pm - BP was 90/42 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/18 am - BP was 96/72 On 1/15/25 at 4:14 PM the surveyor reviewed with DON the concerns regarding failure to notify the physician of holding meds on multiple occasions in April. On 1/16/25 at 8:12 AM the surveyor interviewed primary care physician #23 in reference to how things get communicated to her from the staff and their process. The physician #23 stated that she expected to be faxed the information and if urgent they can call her. And if medications are being held due to vital signs outside of parameters, she confirmed that she should have been notified.

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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. 51786 Based on interviews and record review, it was determined that the facility failed to implement its abuse policy. This was evident for one (#3) of two residents who alleged misappropriation of property and filed a grievance. The findings include: On 1/8/25 at 4:40 PM, during an interview with Resident #3, the resident stated that in December 2024, their items were stolen and they suspected a staff member. The resident reported the stolen items to the facility. On 1/9/25 at 11:20 AM, the Director of Nursing (DON) was asked to provide the facility's grievance log for 2024 and the facility's grievance policy. On 1/10/25 at 11:33 AM, a review of the December 2024 facility grievance log failed to show an entry of Resident #3's allegation. On 1/16/25 at 11:39 AM, during an interview with the DON, she stated that the Nursing Home Administrator (NHA) investigated Resident #3's allegation of stolen items. The DON also verbalized that it was the facility's policy that either the NHA or the DON reported any allegations of misappropriation of residents' property to the state agency. On 1/16/25 at 1:05 PM, the NHA was asked to provide investigation notes for Resident #3's alleged stolen items. On 1/16/25 at 2:59 PM, the NHA provided several documents which he said were the facility's investigation of the alleged misappropriation of Resident #3's property. One of the documents provided was titled Lion's Rehab Risk Management Statement Form. It contained a hand-written statement that was signed by Resident #3 on 12/01/24, and stated, Two die-cast model trucks were taken from my room, I have my suspicions of who it is that took them but I cannot 100% prove it. Further review of the documents provided by the NHA, revealed a typed witness statement signed and dated 12/02/24 by the NHA. The document was an interview between Resident #3 and the NHA regarding the resident's allegation of stolen items. On 1/16/25 at 2:29 PM, a review of the facility's abuse policy, which was provided by the DON during the first day of the survey, revealed that the policy stated: All alleged misappropriation of property will be reported by the facility administrator or his/her designee to the state licensing/certification agency responsible for surveying/licensing the facility. On 1/16/25 at 4:14 PM, in another interview with the NHA, he stated that he did not report the allegations of misappropriation of Resident #3's property to the state agency. On 1/17/25 at 11:42 AM, during another interview with the DON, she acknowledged that the facility failed to implement their abuse, neglect, mistreatment, and misappropriation of resident property.

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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. 51786 Based on interviews and record review, it was determined that the facility failed to report an incident of alleged misappropriation of resident's property to the Office of Health Care Quality.This was evident for 1 (Resident #3) of 2 residents who alleged misappropriation of property and filed a grievance. The findings include: The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's healthcare facilities and community-based programs. Allegations of misappropriation of property are to be reported to the Office of Healthcare Quality in a timely manner. On 1/8/25 at 4:40 PM, during an interview with Resident #3, the resident stated that in December 2024, their items were stolen and they suspected a staff member. The resident reported the stolen items to the facility. On 1/16/25 at 11:39 AM, in an interview with the Director of Nursing (DON), she stated that the Nursing Home Administrator (NHA) investigated Resident #3's allegation of stolen items. The DON also verbalized that, per the facility's policy, either the NHA or the DON was required to report any allegations of misappropriation of residents' property to the state agency. On 1/16/25 at 4:14 PM, in an interview with the NHA, he said that he did not report the allegations of misappropriation of Resident #3's property to the state agency. On 1/17/25 at 11:42 AM, during another interview with the DON, she confirmed that the facility failed to report the misappropriation of resident property to OHCQ.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51489 Based on record review and staff interviews it was determined that the facility failed to ensure essential care upon admission. This was evident for 1 (Resident #71) out of 4 residents reviewed for neglect during the survey. The findings include: Diabetes is a condition when one's body cannot transport glucose, the useable energy for cellular life, out of the bloodstream and into the individual cells of the body. Diabetic management may require that the Diabetic person receives insulin to help transport the glucose out of the bloodstream and into the cells. On 1/13/25 at 1:40 PM, a record review of Resident #71 lab results dated 4/20/23 showed blood glucose was 361.0 mg/dL at 10:24 PM. On 1/13/25 at 2:04 PM, a record review of hospital discharge orders dated 4/20/23 at 11:34 AM, documented insulin orders as: Lantus (long-acting) 14 units subcutaneous at night daily, Lispro (short-acting) 4 units before lunch and 9 units before breakfast. On 1/13/25 at 2:07 PM, a record review of the Medication Administration Record (MAR) lacked documentation that Insulin Lispro was administered on 4/20/23. On 1/13/25 at 3:43 PM a record review of the hospital discharge summary documented Insulin Glargine 14 units was given on 4/20/23 at 9:14 AM before transfer to the facility. At the time of discharge from the hospital, blood glucose was 118. On 1/16/25 at 10:48 AM, a record review of the Nursing admission note showed that Resident #71 was admitted to the facility on [DATE] at 3:30 PM. On 1/16/25 at 11:00 AM, a pharmacy note dated 4/21/23 at 9:30 AM, indicated that the chart and medications were reviewed and reconciled against the hospital discharge summary. A nurse's note showed that Resident #71 was seen by the doctor, and stated, No new orders. On 1/16/25 at 11:28 AM, in an interview, the Director of Nursing (DON) acknowledged that the facility missed the hospital discharge insulin orders on April 20, 2023 and stated, if a blood glucose was over 300 mg/dL, I expect the nurse to contact the doctor. On 1/17/25 at 10:55 AM, in an interview, the DON clarified that no new orders on admission means, To follow the hospital's discharge orders. The surveyor showed the hospital discharge orders dated 4/20/23 to the DON, and she confirmed that the insulin order was not entered into the system correctly and the insulin was not provided as ordered.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observations, record review, and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments 1) were accurately documented and 2) accurately reflected a Resident's status. This was evident for 4 (#60, #24, #64, #75) out of 35 residents reviewed during the survey The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. 1a) In an observation on 1/9/25 at 8:16 AM, Resident #60 was eating his/her breakfast and was noted to be edentulous (having no teeth). The Resident stated at that time that s/he wore complete dentures. On 1/13/25 at 4:18 PM, a review of Resident #60's medical record contained facility dental assessments dated 8/3/24 and 11/12/24. The assessments recorded that Resident #60 had no natural teeth. Continued review found a dental visit summary report dated 12/3/24 noted that Resident #60 was edentulous. However, further review of Resident #60's MDS assessment dated [DATE] showed an answer NO to the question No natural teeth or tooth fragment(s) (edentulous) in section L. In an interview on 1/13/25 at 4:22 PM, the director of nursing (DON) stated that Resident #60 had no natural teeth in his/her mouth and wore dentures. In a subsequent interview on 1/16/25 at 11:01 AM with the DON, she indicated that the facility's MDS staff worked full-time remotely and recorded the MDS assessments by record review or, in some instances, clarifying the formation via phone. The DON checked Resident #60's MDS dated [DATE] and confirmed that it was recorded inaccurately. 1b) In an initial observation, Resident #24 reported having no natural teeth and added, I'm trying to get dentures. A record review on 1/13/25 at 11:11 AM contained a dental visit summary report dated 4/15/24 for Resident #24 that noted, Patient is edentulous. Further review of Resident #24's MDS assessment dated [DATE] showed that it was recorded that the Resident had natural teeth. During an interview on 1/16/25 at 11:16 AM, the DON confirmed that Resident #24's MDS assessment dated [DATE] was documented inaccurately. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) A review of Resident #64's medical record included MDS assessments dated 8/22/24 and 11/21/24 that had both recorded one day of insulin use in section N. The continued review showed that the Resident had a diagnosis of diabetes and received Ozempic injections weekly for it. Further review of Resident #64's medication administration record (MAR) for August and November 2024 was done. The MAR had recorded that Resident #64 received an Ozempic injection on 8/20/24 during the observation period for the MDS assessment dated [DATE]. The Resident also received Ozempic injection on 11/19/24 during the observation period for the MDS assessment dated [DATE]. However, the review failed to show that Resident #64 received insulin injections during the MDS observation periods for both MDS assessments. In an interview with the DON on 1/16/25 at 11:01 AM, she stated that Ozempic was not considered insulin and that the MDS assessments were documented inaccurately. 16218 2) On 1/16/25 review of Resident #75's medical record revealed the resident was originally admitted to the facility on [DATE]. Review of the Admission Minimum Data Set assessment with an assessment reference date of 7/23/24 revealed documentation that the resident had two unstageable pressure ulcers and that both of these ulcers were present upon admission to the facility. Further review of the medical record revealed documentation from the wound specialist, dated 7/22/24, that the resident had two pressure ulcers, one in sacral area (at the base of the spine) and another on the right heel. The wound specialist had documented in the Wound Status section of the note: Present on Admission for both of these wounds. This assessment was 4 days after the resident was admitted to the facility. Review of the hospital discharge summary, facility nursing documentation and the primary care physician notes prior to 7/22/24 failed to reveal documentation to indicate the presence of the right heel wound. No orders were found for dressing or treatment to a heel wound prior to 7/22/24. On 1/17/25 at approximately 9:30 AM surveyor reviewed the concern with the Director of Nursing (DON) that no documentation was found to indicate the heel wound was present on admission. At 10:29 AM the DON reported that she did not find documentation about the heel ulcer on admission. On 1/17/25 at 11:22 AM a phone interview with the MDS nurse (Staff #27) revealed the two ulcers referenced in the 7/23/24 MDS were the sacral and heel ulcers. She reported she obtained the information that they were present on admission from the 7/22/24 wound specialist note. Surveyor reviewed the concern that there was no documentation found to indicate the presence of the heel wound prior to the 7/22 note. The MDS nurse indicated she was reviewing documentation at the time of the interview and stated I see what you are saying. When asked if this was a MDS assessment error the MDS nurse responded that she would have to ask the DON and the practitioner [wound specialist]. As of time of survey exit on 1/17/24 at 2:45 PM no additional documentation or information was provided to indicate the right heel ulcer was present at the time of admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross Reference to F 686

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51489 Based on record review and staff interviews, it was determined that the facility failed to provide a person-centered comprehensive care plan developed and implemented to meet residents' needs. This was evident for 1 (Resident #419) out of 3 residents who were reviewed for care planning during a survey. The findings include: An indwelling Foley catheter is a medical device used to treat urinary incontinence, the involuntary leakage of urine, that transports urine through a tube, from the bladder to an external bag. On 1/13/25 at 4:13 PM, a record review of the physician orders showed an order to maintain 16 French [indwelling] Foley catheter and [give] catheter care every shift. On 1/13/25 at 4:18 PM, a record review of the Treatment Administration Record (TAR) showed that foley care was being completed. On 1/13/25 at 4:41 PM, a record review of Resident #419's comprehensive Care plan failed to plan, develop and implement catheter care. On 1/16/25 at 11:40 AM, during an interview with the Director of Nursing (DON), she stated, I expect residents with an indwelling foley catheter to have a comprehensive care plan that addresses their needs. The DON reviewed the existing care plan and acknowledged that it does not address the resident's catheter care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48470 Based on record review, observation, and interviews, it was determined that the facility failed to ensure that a resident participated in the care plan process and failed to revise a resident's care plan. This was evident for one (#40) of eight residents reviewed for activities of daily living (ADL) and one (#269) of three residents reviewed for care planning during the survey. The findings include: 1) Resident #40 was admitted to the facility in late 2022. A review of the resident's most recent comprehensive assessment with a reference date of 12/20/24, was conducted on 1/9/25 at 11:33 AM. the review revealed Section GG (Functional Abilities), where the resident was coded according to the amount of assistance provided to complete several activities. These activities include: o Eating: Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. o Mobility: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity. o Transfers: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity. This assessment was compared to the previous comprehensive assessment, with a reference date of 9/20/24, and revealed that Resident #40 had declined with these activities listed above. On 1/16/25 at approximately 7:50 AM, the surveyor observed a Geriatric Nursing Assistant (GNA #15) bring in the breakfast tray for Resident #40. GNA #15 elevated the head of the bed, set up the bedside table with the breakfast tray, encouraged the resident to start eating and then left the resident's room. A review of Resident #40's care plan for ADL's was conducted on 1/16/25 at 9:44 AM. the review revealed interventions that include: o Eating- The Resident requires set up assistance by one staff to eat. (Date Initiated: 04/24/2023; Revision on: 10/24/2024) o Bed Mobility-Limited assistance in re positioning. (Date Initiated: 04/24/2023; Revision on: 10/24/2024) o Transfers- Assistance as needed. (Date Initiated: 07/18/2023; Revision on: 10/24/2024) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nursing Supervisor (RN #12) was interviewed on 1/16/25 at 10:14 AM. during the interview, RN #12 reported that she was currently responsible for scheduling care plan meetings and that the schedule was usually within 7 days after on the assessment reference dates of the comprehensive assessment. RN #12 indicated that when changes with a resident's level of care are brought to her attention, she reports them in the care plan meeting and updates the resident's care plan. Resident #40's care plan meeting notes held on 12/20/24 was reviewed with RN #12. RN #12 reported that the meeting was originally scheduled later but the resident's family requested it to be moved earlier due to the holiday. The concern was discussed with RN #12 that there was no indication that she discussed the decline in Resident #40's level of assistance needed to complete several ADL's, and that the resident's current care plan did not reflect these decline. RN #12 indicated that she was not informed about the changes. She does not review the comprehensive assessment and that she only looks at the reference dates to know when to schedule the meetings. RN #12 verbalized understanding that the comprehensive assessment drives the care plan, and the care plan drives the resident's care. RN #12 reported that she would review and revise the resident's care plan. In an interview with the Director of Nursing (DON) on 1/16/25 at 11:27 AM, she reported that comprehensive assessments are done by Staff #27 remotely. Any change noted in the assessments are reported to RN #12 verbally during team meetings. The concern was discussed with the DON that Resident #40 had changes noted in the assessments, but RN #12 reported that she was not notified about them, therefore it was not discussed in the care plan meeting and the care plan was not updated. The DON verbalized understanding and indicated that the facility would benefit if Staff #27 can make rounds in the facility. A review of Resident #40's care plan revealed a revision date of 1/16/25. 48259 Care plans are developed to guide residents' care in the facility. They must be created within 7 days of completion of a resident's admission comprehensive Minimum data set (MDS) assessment and revised at least every quarter (or more often as needed). The Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions. The facility must 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). 2) In an interview on 1/8/25 at 1:09 PM, Resident #269 was asked if s/he participated in his/her care plan meeting. The Resident responded, I don't know. If they did, I would not have been part of it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #269's record later that day showed that, s/he had been admitted to the facility in December 2024. Continued review contained an MDS assessment dated [DATE] that was completed on 1/2/24. Further review showed a care conference note dated 1/2/25 that stated that Resident #269 did not attend the meeting. During an interview on 1/8/25 at 1:16 PM, the nurse manager, also the social services designee (RN #12) confirmed that, Resident #269's care conference meeting was held on 1/2/25. However, the Resident and the representative were not part of the meeting because of the gastrointestinal outbreak (GI outbreaks are often caused by viruses and characterized by diarrhea and vomiting) in the facility. RN #12 also added that she reached out to the Resident's representative after the meeting to give an update and then stated she should have followed up with the Resident because she could make his/her own decisions. A review of a list of residents affected by the GI outbreak on 1/8/25 at 1:20 PM showed that Resident #269's GI symptoms were resolved on 1/1/25. Further review contained an attending provider's order for Resident #269 to discontinue contact precautions for gastroenteritis on 1/1/25. However, the Resident care conference meeting was held on 1/2/25, and s/he was not part of the meeting. In an interview on 1/14/25 at 1:11 PM, the director of nursing said the Resident was off contact isolation on 1/1/25 and should have been part of his/her meeting unless she declined.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record reviews and interviews, it was determined that the facility failed to 1) provide residents with the amount of assistance needed during meals and 2) ensure that residents unable to carry out activities of daily living (ADL) were given incontinence care. This was evident for 5 (#469, #74, #270, #60, #22) of 8 residents reviewed for ADL during the recertification survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. 1a) A review of complaint #MD00193700 dated 6/23/23 revealed an allegation that Resident #469 required assistance with eating but was not helped by the staff to eat. The continued review contained an MDS assessment dated [DATE] for Resident #469. The MDS recorded that the Resident required extensive to total assistance from staff with all ADLs and extensive assistance with eating. Further review of geriatric nurse aide (GNA) ADL documentation for Resident #469's meal percentage and fluid consumed for May 2023 was done. The review lacked documentation for 8 out of 31 days for meal percentage and fluid consumed. The review also lacked documentation for helping Resident #469 with eating for 6 out of 31 days. In an interview with the director of nursing (DON) on 1/15/25 at 2:08 PM, she checked Resident #469's GNA ADL documentation for May 2023 with the surveyor. The DON said the lack of documentation indicated that the staff did not provide care on those days. 1b) A review on 1/15/25 at 1:05 PM of complaint #MD00193700 dated 6/23/23 contained an allegation that the facility staff failed to help Resident #74 eat his/her meals. A review of Resident #74's plan of care for self-care deficit noted an intervention initiated on 1/3/22 and revised on 12/29/22 that stated, Offer assistance with meals to increase intake. A continued review of Resident #74's MDS assessment dated [DATE] showed that the Resident's diagnosis included Dementia, required extensive to total assistance from staff with most ADLs, and extensive assistance for eating. A review of GNA ADL documentation for Resident #74's meal percentage and fluid consumed for May 1-May 31, 2023, lacked documentation for 10 out of 31 days and 6 out of 31 days for eating. An interview with the DON on 1/15/25 at 2:08 PM confirmed concerns. The DON said that care was not provided due to the lack of documentation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) A review of complaint # MD00193700 dated 6/23/23 noted an allegation that staff did not provide the needed assistance that Resident #270 needed with eating. Continued review showed that Resident #270 had moderately impaired cognition and required extensive assistance from staff with his/her meals. A review of GNA ADL documentation for May 1- May 31, 2023, revealed a lack of documentation for meal percentages and fluids consumed for 9 out of 31 days. The review also failed to prove that Resident #270 was assisted with eating for 9 out of 31 days in May 2023. In an interview on 1/15/25 at 2:08 PM, the DON confirmed concerns and stated that the GNA documentation was something the facility was working on to improve. 2a) Review of complaint #MD00204488 on 1/9/25 at 8:30 AM noted an allegation that Resident #60 was transferred to the emergency roiagnom on [DATE] and upon arrival, PT FOUND TO BE IN SOILED BRIEF THAT APPEARS TO HAVE HAD URINE IN IT FOR SO LONG THAT IT HAS DRIED IN BRIEF. The continued review contained an MDS assessment dated [DATE] for Resident #60, which noted that the Resident's diagnosis included Dementia, severe cognitive impairment, and required substantial/maximal assistance from staff for completing toileting hygiene. Further review of a change in condition form dated 4/8/24 stated that Resident #60 was transferred to the hospital around 1030 for evaluation. A review of GNA ADL documentation for Resident #60 for April 1-April 8, 2024, was completed. The review showed a lack of documentation of toileting hygiene care for 4/4/24 day and evening shifts. The staff documented N/A (Not applicable) for the night shift on 4/4/24. On 4/7/24, there was no documentation of toileting hygiene care for day, evening, and night shifts. On 4/8/24, there was no documentation of hygiene care before the Resident was transferred to the hospital. During an interview on 1/15/25 at 4:14 PM, the DON indicated that the Resident was transferred out to the emergency roiagnom on [DATE] around 10 AM. She added that per the GNA documentation, Resident #60 did not get care from the staff the night and morning prior to the transfer. 51786 2b) On 1/9/25 at 1:34 PM, an interview was conducted with Resident #22. The resident stated that he/she depended on staff to provide incontinence care but there were days when he/she was left soiled. The resident also stated that he/she was aware that a complaint was filed with the state agency. On 1/13/25 at 9:15 AM, a review of Resident #22's electronic health record revealed the resident's care plan contained an intervention that the resident required assistance with toilet hygiene. On 1/13/25 at 10:15 AM, a review of confidential complaints reported to the state agency revealed two separate complaints. Complaint #MD00193082, received in June 2023, alleged that Resident #22 did not receive toilet care on 5/19/23. Complaint #MD00205727, received in May 2024, also alleged that the resident did not receive toilet care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 3:30 PM, the Director of Nursing (DON) was asked to provide records for the Activities of Daily Living (ADL) provision for Resident #22 for May 2023. On 1/13/25 at 4:00 PM, Geriatric Nursing Assistant (GNA) documentation for Resident 22's care for May 2024 was received. A review of the document revealed that 4 of 31 days (5/2/24, 5/17/24, 5/23/24, 5/30/24) lacked any documentation that toilet care was provided to the resident. On 1/13/25 at 4:15 PM, an interview was conducted with DON to review the documents provided which revealed a lack of toilet care in May 2024. The DON confirmed the findings. She was then asked again to provide May 2023 toilet care documentation. On 1/13/25 at 4:30 PM, the GNA documentation for May 2023 was received. A review of the documentation revealed that staff failed to provide toilet care to Resident #22 for 5 of 31 days (5/7/23, 5/21/23, 5/22/23, 5/27/23, 5/30/23). On 1/13/25 at 4:30 PM, an interview with the DON was conducted. During the interview, the DON confirmed that toilet care was not provided to Resident #22 daily.

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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. 51712 Based on staff interviews, and record review, it was determined that the facility failed to follow the physician's orders for weights. This was evident for 1 (Resident #44) of 6 residents reviewed for unnecessary medications. The findings include: On 1/13/25 at 12:08 PM, during a review Resident #44's medical record revealed a diagnosis of congested heart failure (CHF). Review of the care plan revealed a plan for Potential for fluid volume imbalance related to CHF and included an intervention of daily weights as ordered. This intervention was most recently revised on 10/24/24. Review of the medical record revealed a fax coversheet that documented that the facility notified the physician on 10/21/24 that the resident was refusing daily weights, and asked Can we just do weekly weights on [him/her]? The physician had responded with a yes and her signature and the date on the return fax was 10/25/24. Further review of the medical record revealed there was an order for daily weights in effect from 4/29/24 until it was discontinued on 11/8/24. Further review of the medical record failed to reveal documentation to indicate the order for the weights was changed to weekly. Review of the current orders revealed an order, with a start date of 4/30/24, for Monthly weights. On 1/13/25 at 2:11 PM, Assistant Director of Nursing (ADON) reported no documentation to indicate the response fax was acknowledged and confirmed there was no order for weekly weights. On 1/16/25 at approximately 8:00 AM, interview with the primary care physician (Staff #23) revealed that the order for weights should be for weekly weights. On 1/17/25 further review of the medical record revealed the order for monthly weights was discontinued. A new order was in place for weekly weights to start on 1/22/25.

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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** 16218 Based on medical record review and interview it was determined that the facility failed to provide necessary treatment and services to promote healing of pressure ulcers. This was found to be evident for 1 (Resident #75) out of 4 residents reviewed for pressure ulcers during the survey. The findings include: Review of Resident #75 medical records on 1/16/25 revealed the resident was admitted to the facility on [DATE] after a hospitalization for surgical repair of a hip fracture. The resident ' s diagnosis included but not limited to diabetes, anemia, and high blood pressure. The hospital transfer summary also included documentation of a sacral decubitus (pressure) ulcer. The sacral area is located at the base of the spine. Review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date [last date of assessment] of 7/23/24, revealed the resident required partial assist for rolling left to right and substantial assistance with moving from sitting to lying. This assessment also revealed the resident was always incontinent of bowel [unable to control when a bowel movement occurs]. Review of the 7/18/24 Weekly skin check assessment revealed documentation of a surgical wound with staples to the left hip and an open area to sacrum. This assessment was signed by a Licensed Practical Nurse (LPN Staff #13). Further review of the medical record failed to reveal documentation to indicate the presence of other skin breakdown on the day of admission. A care plan was initiated on 7/19/24 to address potential nutritional problems related to hip fracture, diabetes, receiving a therapeutic diet and increased protein needs to support skin status. Review of the 7/19/24 Mini Nutrition Evaluation, signed by dietician (Staff #14), revealed: Resident skin status reviewed, surgical incision noted to hip and open area, etiology [cause] unknown, noted to sacrum Initiate Prostat 30 ml BID (100 kcal, 15 g PRO [protein] per serving). Prostat and ProSource are both nutritional supplements high in protein. The 7/19/24 dietician ' s note indicates the protein supplement was to be given two times a day. Review of the Medication Administration Record revealed an order, dated 7/19/24, for: ProSource one time a day for wound healing liquid protein 30 ml BID (100 kcal, 15 g PRO per serving). BID means twice a day. This order had conflicting documentation in regard to the number of times the ProSource was to be administered per day. Further review of the July 2024 Medication Administration Record (MAR) revealed documentation that the Prosource was administered 1 time a day at 9:00 AM from 7/20/24 thru 7/31/24. On 1/16/25 at 2:51 PM the surveyor reviewed the concern with the Director of Nursing (DON) that the ProSource was to be administered twice a day but was only given once a day for more than a week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the primary care provider ' s (PCP Staff #16) Admission History and Physical note, dated 7/20/24 revealed documentation of a stage 3 decubitus ulcer in the sacral area and that the plan was for the wound team to follow. No other pressure ulcer was documented in this note. No documentation was found in this note regarding the supplement order. No documentation was found in the medical record to indicate the rationale for only ordering the Prosource once a day. On 8/1/24 a new order was put in place to administer the ProSource 30 ml two times a day. During an interview with the PCP #16 on 1/17/24 at 11:52 AM, when asked how he manages residents with pressure ulcers, he reported they have a wound specialist and indicated the facility will follow the specialist ' s recommendations. Further review of the MAR and the Treatment Administration Record (TAR) for July failed to reveal documentation to indicate there was an order for a treatment or dressing change for the sacral ulcer from the time of admission on 7/18/24 until 7/22/24, when the resident was seen by the wound specialist. Review of the 7/22/24 wound specialist ' s (Staff #17) note revealed documentation of the surgical wound, the sacral wound, and a wound on the right heel. Both the sacral wound and the heel wound were documented as unstageable. An Unstageable Pressure Ulcer has obscured full-thickness skin and tissue loss. The extent of the tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. Further review of the 7/22/24 wound specialist note revealed the right heel wound was documented by the wound specialist as present on admission, however no documentation was found about the heel wound prior to this assessment, which was 4 days after admission. On 1/17/25 at approximately 9:30 AM surveyor reviewed the concern with the Director of Nursing (DON) that no documentation was found to indicate the heel wound was present on admission. On 1/17/25 at 10:29 AM the DON reported that she did not find documentation about the heel ulcer on admission. The 7/22/24 wound specialist treatment recommendation for the right heel wound was to apply Skin Prep to the base of the wound, secure with Bordered foam and change daily. Review of the TAR revealed an order on 7/23/24 for the right heel: Cleanse with soap and water, apply skin prep and cover with a bordered foam dressing, every Tues/Friday for skin integrity prevention and protection. This order was for twice weekly dressing changes, not daily as indicated by the wound specialist ' s recommendations. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the TAR revealed the order was discontinued on 7/23 and a new order was put in place to start on 7/24/24, the only change to the order was that the treatment and dressing were to be completed on Wednesday and Saturdays, not daily as indicated by the wound specialist's recommendations. During an interview with the Assistant Director of Nursing (ADON) on 1/17/24 at 10:35 AM she reported that the wound specialist comes in on Tuesdays for new admissions and Thursday for weekly rounds. She confirmed that the wound specialist ' s recommendations are entered into the orders and the PCP is notified. The surveyor then reviewed the concern that the recommendation for the heel wound was for daily dressing changes, but the order was entered for two days a week. Review of the 7/25/24 weekly skin check, signed as completed by LPN (Staff #20) revealed documentation that the resident had no newly identified alterations in skin integrity but did indicate there were pre-existing areas. However the Body Diagram section failed to include documentation about the heel wound, it only documented the surgical wound and the open area to the sacrum. Review of the 7/31/24 wound specialist progress note revealed the right heel wound was a stage 3 pressure ulcer. The wound specialist completed a surgical wound debridement of the heel wound to remove necrotic tissue. Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement in order to remove tissue or matter from a wound to promote healing. The 7/31/24 post debridement treatment recommendation was cleanse with wound cleanser, apply hydrogel, silver alginate to base of the wound, secure with bordered foam and change the dressing daily. Silver alginate is a product that is highly absorbent and has antimicrobial properties of silver. A new order was put in place on 8/1/24 that reflected the wound specialist ' s 7/31/24 recommendations for the heel wound, but it was not started until 8/2/24. Further review of the wound specialist 7/31/24 note revealed the sacral wound was documented as Worsening, and the size was 9.5 cm x 10 cm x 0.1cm. The treatment recommendation for the sacral wound was to Cleanse with wound cleanser; Apply Santyl to base of the wound; Secure with bordered foam; and change BID[twice a day] and prn [as needed]. Review of the TAR revealed an order, dated 8/1/24, for the sacral wound to be cleansed with wound cleaner, apply Santyl to the wound bed and cover with a bordered foam dressing every day shift. No documentation was found to indicate the wound specialist's recommendation of BID (twice daily) dressing changes was implemented. This order was discontinued on 8/8/24. There was a prn order for Santyl but no documentation found to indicate a second daily dressing change occurred during this time period.

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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. 48470 Based on observations, records review and interviews, it was determined that the facility failed to ensure fall mats were in proper placement. This was evident for 1 (Resident #10) in 3 residents reviewed for accidents. The Findings include: Resident #10 had been residing in the facility since 2018. An interview with the Resident's responsible party on 1/9/25 at 9:31 AM indicated that the resident was a fall risk. On the same day at 10:02 AM, Resident #10 was observed in bed, no care was actively being provided. The fall mat was folded up on the floor, against the cabinet by the foot of the resident's bed. On 1/10/25 at 9 AM a review of Resident #10's care plan regarding potential for injury from falls had interventions that include to apply fall mats to the left side of the bed. On 1/10/15 at 10:36 AM, the resident's fall mat was observed folded up on the floor, against the cabinet by the foot of the resident's bed. The resident was in bed, no one else was in the room with the resident. A review of the most recent fall risk evaluation with a reference date of 12/30/24 was conducted on 1/10/25 at 11:15 AM. The review indicated that Resident #10 was at risk for falls. On the same day at 2:34 PM, Resident #10 was observed in bed, noted to be sideways with his/her head hanging over the side of the bed. The fall mat was observed still in the same place. A staff member who saw the surveyor, came in the room and repositioned the resident. The staff member was Geriatric Nursing Assistant (GNA #4) GNA #4 was interviewed outside Resident #10's room. In the interview, GNA #4 reported about Resident #10 and how the resident communicates, bed mobility, and stated, s/he can still move in his/her bed and s/he's quick. That's why you have to keep an eye on him/her. GNA #4 was asked about the fall mat. The GNA looked in the resident's room and stated, oh yeah, I should use that. Then proceeded to go in the resident's room and unfolded the fall mat and laid on the floor, on the left side of the resident's bed. On 1/17/25 at 12:28 PM, the concern was discussed with the Director of Nursing (DON) that on several observations, Resident #10's fall mat was not utilized or applied in the proper place to prevent injury. The DON verbalized understanding and acknowledged the concern.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48470 Based on record review, interviews,and observations, it was determined that the facility failed to provide appropriate treatment and services for care of residents with indwelling catheter. This was evident for 2 (#64, #419) of 3 residents reviewed for urinary catheters. The findings include: 1) Resident #64 was admitted to the facility in early 2024. During the initial tour of the facility on 1/8/25 at 12:37 PM, the resident was observed in his/her room and the urine collection bag was lying directly on the floor. The Registered Nurse (RN #3) who was assigned to the unit where Resident #64 resided was interviewed on 1/8/25 at 12:39 AM. During the interview, the concern was discussed that the resident's urine collection bag was observed lying directly on the floor in the resident's room. RN #3 went in the resident's room, confirmed the finding and hung the urine collection bag on the resident's bed frame. An indwelling catheter, also known as a Foley catheter, is a thin, flexible tube that is inserted into the bladder to drain urine. The catheter is held in the bladder by a water-filled balloon, which prevents it from falling out. On 1/13/25 at 9:12 AM, Resident #64's medical record was reviewed and revealed medical orders for catheter care that include, Maintain (size) Fr Foley catheter with __ml balloon, monitor for s/s of infection/obstruction Q shift every shift for Monitoring. There was no other documentation in the resident's medical record to indicate the size of the catheter and the amount of fluid to fill the balloon to secure it in the resident. A subsequent review of Resident #64's medical record on 1/13/25 at 1:03 PM, revealed a care plan for catheter care with interventions that include: o Maintain catheter tubing and bag above the floor and below the level of the bladder. Maintain tubing without kinks or occlusions. Secure catheter with leg strap if needed. Use universal precautions when handling urinary drainage. o Perform catheter care daily and PRN. On 1/13/25 at 2:37 PM, the licensed Practical Nurse (LPN #5) was interviewed about Resident #64's catheter care. LPN #5 indicated that the catheter was changed a week ago and that she was sure of the information because she was working that day when it was performed. LPN #5 was asked if she knew the size of the resident's catheter and the amount of fluid for the balloon. LPN #5 reviewed the resident's orders in the computer and reported and confirmed that the order was incomplete. LPN #5 reported that it was size 16 with 10 ml and stated, I fixed it. A copy of the new order was provided to the surveyor that read: Maintain (size) 16 Fr Foley catheter with 10_ml balloon, monitor for s/s of infection/obstruction Q shift. (Order date: 1/13/25 at 2:39 PM) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 9:22 AM, the Assistant Director of Nursing (ADON) was interviewed about Resident #64's catheter orders. The concern was discussed with the ADON that LPN #5 revised the order to indicate the size of the catheter, however, the surveyor did not see any documentation in the resident's medical records to verify it. The ADON reviewed Resident #64's electronic health record and hard chart. The ADON reported that the resident was admitted with the catheter and confirmed that there was no documentation in the resident's medical records to confirm the size of the catheter. A statement was provided to the surveyor that was signed by LPN #5, dated 1/14/25, that read: Resident currently has a 16F indwelling foley catheter. Call was placed to Urology for clarification of the catheter size but was unable to obtain the information. Resident has an upcoming appointment with the Urology next week. PCP agreeable to maintain current order of 16F until new recommendations are given from the urology appt. On 1/17/25 at 12:26 PM, the concern was discussed with the Director of Nursing (DON) of the failure to ensure a resident with a catheter receive appropriate services for care by failing to keep the urine collection bag off the floor and failing to have a complete and verified order for catheter care. 51489 2) On 1/8/25 at 11:19 AM, Resident #419's foley bag was observed on the floor from the hall. The resident was in bed. On 1/8/25 at 1:16 PM, Resident #419 was observed in bed eating lunch using a wheeled bedside table. 80% of the foley bag was on the floor, and the other 20% rested on the leg of the bedside table. On 1/8/25 at 2:08 PM, the cleared bedside table was moved away from Resident #419 and the foley bag was observed on the floor. On 1/9/25 at 8:14 AM, Resident #419 was observed in bed with a personal computer on top of the bedside table. The foley bag lay on the floor. On 1/9/25 at 8:37 AM, Resident #419 was observed sitting in bed with a food tray on top of a bedside table. The foley bag was observed on the floor. On 1/9/9/25 at 9:14 AM, Resident #419 was observed sitting in bed. The food tray was not observed on the table. The foley bag lay on the floor. On 1/10/25 at 6:05 AM, Resident #419 was observed sleeping in bed, 50% of the foley bag lay on the floor. On 1/10/25 at 07:07 AM, the surveyor and Staff # 2, a Licensed Practical Nurse (LPN,) observed the foley bag laying on the floor. In an interview, Staff #2 confirmed that the foley bag should not be on the floor. On 1/13/25 at 12:46 PM, during an interview, the DON was made aware that the foley bag was frequently observed on the floor. DON acknowledged that a foley bag left on the floor can be a source of infection.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 48259 Based on medical record review and interviews, it was determined that the facility failed to document the reasons for administering as-needed (PRN) pain medications, failed to document pain assessment to include the location of the pain and type of pain, and failed to implement non-pharmacological interventions before administering pain medication to a Resident reporting pain. This was evident for 1 (#24) of 6 Residents reviewed for unnecessary medications and 2 (#59, #64) of 3 residents reviewed for pain management. The findings include: 1) A review of Resident #24's medical record on 1/9/25 at 2:04 PM showed that the resident had been residing in the facility since August 2015 with diagnoses including chronic pain, Arthritis, neuropathy (pain from the nerves) and was able to communicate his/her needs. A pain scale is a numerical scale, usually 1-10, used to rate a person's severity of pain. A continued review of Resident 24's medication administration record for November 2024 to January 2025 showed that the resident had received pain medication on 11/7/24 for a pain level of 4, 11/18/24 for a pain level of 4, 11/28/24 for a pain level of 4, 12/17/24 for a pain level of 6, 12/21/24 for a pain level of 4, 12/24/24 for a pain level of 4, 12/26/24 for a pain level of 4, and 1/1/25 for a pain level of 7. However, the review lacked documentation of why the pain medication was given and the resident's pain assessment, including the location and type of pain. Further review of Resident #24's plan of care for pain included an intervention initiated on 5/17/2023 and revised on 10/24/24 that stated, Document non-pharmacological interventions [NPI- are interventions without medications] before administering PRN pain med such as, but not limited to, food, social interactions, positioning, movement, massage, and music. However, the review failed to show that NPI was implemented before giving the resident the pain medicine. In an interview on 1/14/25 at 11:41 AM, a licensed practical nurse (LPN #10) said that she only provided NPIs to residents who complained of pain if the attending provider's orders stated to do so. During an interview with the director of nursing, she stated that the attending provider's orders for NPIs for pain got dropped off from the facility's electronic health record. She also added that her expectation of the staff was to complete a pain assessment for Resident #24, including the location of pain, the intensity, and characteristics of the pain, and document their findings in the resident's record. 48470 Minimum Data Set- The MDS is a federally-mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #59 was admitted to the facility in early 2024. An MDS indicator identified the resident as having constant pain. On 1/8/25 at 11:16 AM, the resident was observed in his/her room. The resident was lying in bed, appeared to be in discomfort, and when asked to conduct an interview, the resident declined and stated, I'm not feeling too good. PRN is an abbreviation for the Latin phrase pro re nata, which means as the need arises. On 1/10/25 at 9:41 AM, Resident #59's medical orders were reviewed and revealed that the resident had routine orders for pain medications as well as PRN that included: a) Morphine Sulfate Tablet 15 MG - Give 7.5 mg by mouth every 6 hours as needed for Severe Pain 5-10 b) Acetaminophen Oral Tablet 325 MG - Give 1 tablet by mouth every 4 hours as needed for General Discomfort c) Resident to receive PRN dose of Morphine 30 minutes prior to dressing change, every day-shift, every Tue, Thu, and Sat. (start date 12/19/24) The orders failed to reveal initiation of Non-Pharmacological Interventions (NPI) prior to administration of PRN pain medications. On 1/10/25 at 10:03 AM, a continued review of Resident #59's medical records revealed that the PRN pain medications were administered in December of 2024 and January of 2025. However, there was no documentation to indicate that staff had initiated or attempted to perform NPI's prior to administering the PRN pain medications. The facility's Administering pain medication policy was reviewed on 1/10/25 at 10:30 AM. The review revealed 9 steps in the procedure, where step #5 stated, Evaluate and document the effectiveness of non-pharmacological interventions followed by step #6, which was to administer the pain medication as ordered. In an interview with the Director of Nursing (DON) on 1/14/25 at 11:15 AM, the concern was discussed that there was no evidence to indicate that the nursing staff initiated or attempted to perform NPI's before administering PRN pain medications. The DON indicated that the order for NPI's would be documented in the treatments and will review and report to the surveyor when she finds the documentation. On the same day at 12:59 PM, the DON reported and confirmed that there was no documentation or order for NPI's and stated, non-medicated approach should always be the first step. The DON verbalized understanding and acknowledged the concern. 3) Resident #64 has been a resident of the facility since early 2024. A quick look into the resident's medical record indicated that s/he had a crushing injury with paralysis in both legs. On 1/13/25 at 9:10 AM, Resident #64's medical orders were reviewed and reveal a PRN pain medication order. However, the orders failed to reveal initiation of NPI's prior to administration of PRN pain medications. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 11:20 AM, Resident #64's electronic Medication Administration Record (eMAR) was reviewed and revealed that s/he received a dose of the PRN pain medication. However, there was no documentation to indicate that staff had initiated or attempted to perform NPI's prior to administering the medication. The facility's Administering pain medication policy was reviewed earlier on 1/10/25 at 10:30 AM. The review revealed 9 steps in the procedure, where step #5 stated, Evaluate and document the effectiveness of non-pharmacological interventions followed by step #6, which was to administer the pain medication as ordered. In an interview with the Director of Nursing (DON) on 1/14/25 at 11:15 AM, the concern was discussed that there was no evidence to indicate that the nursing staff initiated or attempted to perform NPI's before administering PRN pain medications. The DON indicated that the order for NPI's would be documented in the treatments and will review and report to the surveyor when she finds the documentation. On the same day at 12:59 PM, the DON reported and confirmed that there was no documentation or order for NPI's and stated, non-medicated approach should always be the first step. The DON verbalized understanding and acknowledged the concern.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 48259 Based on record review and interviews, it was determined that the facility failed to ensure that a resident's care was overseen by a physician. This was evident for 1 (#24) of 6 residents reviewed for unnecessary medications. The findings include: A review of Resident #24's medical record showed that s/he had been living in the facility since 2015 and received antidiabetic and thyroid medications daily. The continued review contained Resident #24's attending provider's (provider #23) notes from January-December 2024. The notes referred to the resident's A1C and TSH blood work results from 2022 and 2023 (A1c is a blood test that measures the average blood glucose level over the past 2-3months and TSH- is a test that measures the level of thyroid-stimulating hormone in the blood). However, the review failed to show that A1C and TSH blood work were done in 2024 for Resident #24. Further review of attending provider #23's notes dated 6/27/24 contained a statement to do A1C blood work as ordered. Then, on July 7/23/24, the notes said to recheck A1C the following month. The notes for August, dated 8/21/24, showed a statement to do A1C blood work as ordered. However, the review lacked documentation that the blood work was completed as documented by the provider. The review also failed to show attending provider #23's orders to complete the blood work for Resident #24 on those dates. In an interview with the director of nursing (DON) on 1/13/25 at 2:24 PM, she reported that she did not have documentation that indicated that A1C blood work was ordered for Resident #24 as stated in attending provider #23's notes. The DON added that the facility only received provider #23's notes for 2024 from her office a day before this interview and was not aware of any orders in the past for blood work for Resident #24. In an interview on 1/13/25 at 2:37 PM, the medical director for the facility said that his expectation was for Resident #24 to get his A1c and TSH blood work done every 3 months. When informed that the resident did not have blood work completed for A1c and TSH since 2023, he responded that it might have been an oversight by the resident's attending provider. During an interview with attending provider #23 on 1/14/25 at 8:12 AM, she said TSH blood work should be checked every 6 months and A1C every 4 months. The provider checked the medical record for Resident #24 and confirmed that no TSH or A1C blood work was done in 2024. The attending provider also added that she missed giving the orders for the resident's blood work and agreed with the surveyor's concerns about not overseeing Resident #24's care.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 48259 Based on medical record review and staff interviews, it was determined that the facility failed to ensure that physician's notes were complete, accurate, signed, and dated at each visit and part of the medical record. This was evident for 2 (#24, #44) of 35 residents reviewed during the survey. The findings include: 1) Record review on 1/9/25 at 11:00 AM showed that Resident #24 had been residing in the facility since 2015. A continued review lacked documentation of Resident #24's attending provider's (provider #23) visit notes from January to December 2024. The director of nursing (DON) was questioned at the time and stated that there were no attending provider visit notes in the facility's electronic medical record (EMR) for Resident #24. On 1/13/25 at 12:07 PM, the DON presented the attending provider's notes from January- December 2024 to the surveyor. The notes were not part of the medical record for Resident #24 at the time of the survey. Continued review revealed that Resident #24 had received visits from attending provider #23 on 1/3/24, 1/31/24, 2/28/24, 3/26/24, 4/29/24, 5/21/24, 6/27/24, 7/23/24, 8/21/24, 9/25/24, 10/30/24, 11/16/24, 12/18/24. However, the review failed to show that attending provider #23's progress notes were all signed at each visit. All the visit notes were signed as complete on 1/12/25. Further review of the notes included statements that blood sugars are stable per the notes dated 2/28/24, blood sugar has been controlled per the 3/26/24 notes, sugar seems to be doing better, patient's A1c has improved [A1c-is a blood test that measures the average blood glucose level over the past 2-3months] per 5/21/24 notes. However, the review lacked proof that Resident #24's blood sugar or A1c had been checked from January to December 2024. An interview with the DON later that day, showed that Resident #24's blood sugars and A1c were not tested from January to December 2024 because there were no attending provider's orders to do so. In a subsequent interview on 1/13/25 around 1:30 PM, the DON reported that the facility had just received attending provider #23's notes for January-December 2024 on 1/12/25. The DON added that the notes were not part of Resident #24's medical record before 1/12/25. She also stated that the notes should have been in the medical record for staff to review and refer to. In an interview with attending provider #23 on 1/14/25 at 8:12 AM, she was questioned about the statement in her notes that Resident #24's blood sugar seems to be doing better when there was no provider's order to check blood sugar. She reported that she only documented in her notes what the staff told her about Resident #24's blood sugars and did not review the resident's blood sugar logs. Provider #23 confirmed that her visit notes were inaccurate, late, and not part of the facility's medical record. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51712 2) On 1/13/25, review of Resident #44's medical record revealed that the resident has resided at the facility for more than a year. Resident #44 had a diagnosis of Atrial fibrillation (an irregular heart beat) and was receiving coumadin on a daily basis. Coumadin is an anticoagulant (blood thinner) medication you take to prevent and treat blood clots that can hurt you. You will need frequent INR (international normalized ratio) or PT (prothrombin time) tests to measure your blood-clotting time and determine your Coumadin dose. The resident had orders for weekly PT/INR tests that were being completed. Further review of the medical record failed to reveal documentation from the primary care provider for 2024. On 1/13/25 at 1:03 PM nurse manager #12 was asked for Resident #44 physician's progress notes. Nurse manager #12 stated that the physicians usually upload their notes in the Electronic Health Record (EHR) but she wasn't sure of the process. On 1/13/25 at 2:19 PM surveyor informed the Director of Nursing (DON) that no physician progress notes were found for 2024 in the hard chart or seen in the EHR. The DON indicated she would check to see if the primary care physician (Staff #23) sent them over On 1/14/25 at 8:45 AM the primary care physician #23 had her progress notes faxed to the facility for the entire year of 2024 on the resident #44. All notes had been signed off on 1/13/25. Further review of the PCP (Staff #23) progress notes for visits in 2024 revealed documentation of lab values from prior to 2024. No documentation was found regarding the goal range for the resident's PT/INR results. No documentation of lab results from 2024 were found in these notes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 51786 Based on record review and interview, it was determined that the facility failed to ensure nursing staff were competent with their skills set. This was evident for 2 Registered Nurses (RN #19 and RN #3) of 2 nursing staff evaluated for competency. The Findings include: Nursing competence is defined by the American Nurses Association as an expected level of performance that integrates knowledge, skills, abilities, and judgment. On 1/08/25 at 10:57 AM, a list of all employees was requested. On 1/09/25 at 2:50 PM as part of the staffing task for the recertification survey, the Director of Nursing (DON) was asked to provide competency evaluations for 2 randomly selected nurses. On 1/14/25 at 2:21 PM, staff documents were received and a review revealed: 1). RN #19 was hired in August 2024 and had no record of competency evaluation, 2). RN #3 was an agency staff hired in May 2023 and had no record of competency evaluation. On 1/15/25 at 3:53 PM, an interview with the DON was conducted. The DON was asked if the facility had any evidence of competency evaluations for RN #3 and RN #19. On 1/16/25 at 10:00 AM, in another interview with the DON, the DON stated that there were no records of competency evaluations for RN #3 and RN #19. She acknowledged that this was a deficiency.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51786 Based on interview and record review, it was determined the facility did not have a Director of Nursing who worked on a full-time basis. This was evident during the recertification survey and had the potential to impact all residents, staff, and visitors. The findings include: On 1/14/25 at 9:40 AM, an interview with the Director of Nursing (DON) was conducted. The DON confirmed that she was the only Infection Preventionist (IP) nurse in addition to her role as the DON of the facility. She also explained that she knew the dual role created a concern with the lack of a full-time basis DON. The DON stated that the facility's administration was aware of this concern. On 1/16/25 at 2:03 PM, during another interview with the DON, she acknowledged that her dual role as the IP nurse and DON created a deficiency for a full-time DON at the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48259 Based on medical record review and interviews, it was determined that the facility failed to ensure that Irregularities identified by the pharmacist were reviewed and acted upon timely by the attending physician and failed to develop policies and procedures for the monthly Medication Regimen Review (MRR) to include time frames for the different steps in the process. This was evident for one (#24) of 6 Residents reviewed for unnecessary medications. The findings include: A medical record review on 1/9/25 at 2:04 PM showed Resident #24 had been residing in the facility since 2015 and received multiple drugs, including an antifungal cream, to the abdomen folds. The continued review contained monthly pharmacy review notes from January- December 2024. On 5/21/2024, the pharmacy recommendation stated, Resident continues Nystatin powder BID [twice daily] for MASD [moisture associated skin damage] to Abd. [abdominal] folds. Per the antibiotic stewardship program, it is recommended to use antifungals for the shortest duration possible. Please review if [he/she] can change to a barrier cream such as Remedy or Calmoseptine at this time. Please review. The review showed that Resident #24's attending provider signed the recommendation dated 5/21/24 on 9/25/24, recommending that the antifungal cream be changed to diaper rash cream as needed. However, the Resident continued receiving the antifungal cream until 12/11/24. Further review of a copy of the facility's policy and procedure for MRR provided by the director of nursing (DON) was done. A statement in the policy and procedure stated that within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physician for each resident identified as having a non-life-threatening irregularity. However, the review failed to show the timeframe for when the provider was to address the MRR irregularity. In an interview with the DON on 1/10/25 at 11:24 AM, she reported that her regional office told her that MRRs needed to be addressed within 30 days. However, Resident #24's MRR dated 5/21/24 was not reviewed by the attending provider until 9/25/24. In a subsequent interview on 1/10/25 at 12:57 PM, the DON was asked why the MRR was signed on 9/25/24, but the Resident's order for the antifungal cream did not change until 12/11/24. The DON responded that even though it was signed on 9/25/24, the facility did not receive the report from the attending provider's office until 12/11/24 when she saw and implemented the new order. The DON also confirmed that the MRR policy and procedure was inadequate because it did not state the appropriate time frame for the provider to address the MRR recommendations.

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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. 48470 Based on record reviews and staff interviews, it was determined that the facility failed to keep residents' drug regimens free from unnecessary medications by failing to ensure residents received their medications according to the attending physician's orders. This was evident for 2 (#59, #44) of 6 residents reviewed for unnecessary medications. The finding include: 1) Resident #59 had been residing in the facility since early 2024. On 1/8/25 at 11:16 AM, the resident was observed in his/her room. The resident was lying in bed, appeared to be in discomfort, and when asked to conduct an interview, the resident declined and stated, I'm not feeling too good. Morphine is used to treat pain severe enough to require daily, around-the-clock, long-term opioid treatment and when other pain medicines did not work well enough or cannot be tolerated. Morphine belongs to the group of medicines called narcotic analgesics PRN is an abbreviation for the Latin phrase pro re nata, which means as the need arises. On 1/10/25 at 9:41 AM, a review of Resident #59's medication orders were conducted. The review revealed different pain medication orders that included: a) Morphine Sulfate Tablet 15 MG - Give 7.5 mg by mouth every 6 hours as needed for Severe Pain 5-10 b) Resident to receive PRN dose of Morphine 30 minutes prior to dressing change, every day-shift, every Tue, Thu, and Sat. (start date 12/19/24) A subsequent review of Resident #59's medical records on 1/10/25 at 10:03 AM, revealed that s/he received a dose of Morphine on 12/3/24 for a pain level of 3. In addition, the resident received the medication on 12/20/24, 12/22/24, 12/23/24, 12/25/24, and 12/27/24; however, there was no documentation to indicate the resident's pain level prior to the administration of the medication. On 1/14/25 at 11:15 AM, the Director of Nursing (DON) was interviewed. The concern was discussed with the DON that Resident #59's PRN Morphine was administered outside of its parameter on 12/3/24; and was administered without adequate indication for its use on 12/20/24, 12/22/24, 12/23/24, 12/25/24, and 12/27/24. The DON reviewed the resident's medical records and confirmed the findings. The DON acknowledged the concern. 51712 2) A review of Resident #44's medical records on 1/15/25 at 3:38 PM revealed an order, with a start date of 12/27/22 for Metoprolol 50 mg to be given twice a day for Cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body); and to hold (not administer) if the pulse was less than 60 or the systolic blood pressure (top number of blood pressure) was less than 100. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the March 2024 Medication Administration Record (MAR) revealed that on 3/21/24, for the morning dose, the resident's BP was 95/78, and the Metoprolol was administered. A review of the April MAR revealed that on 4/15/24 for the evening dose, the resident's Blood Pressure was 92/72, pulse was 59, and the Metoprolol was administered. Further review of the April MAR revealed an order for Spironolactone (used to treat the build-up of fluid in your body caused by heart failure) 25mg given once a day for high blood pressure and to hold if the Systolic blood pressure was less than 100. The medication was documented as administered on the evening of 4/15/24 when the blood pressure was reported as 92/72. On 1/15/25 at 4:14 PM, the surveyor reviewed the concern regarding failure to hold medications as per the ordered vital sign parameters with the Director of Nursing. No additional documentation or information was provided regarding this concern prior to the survey exit on 1/17/24 at 2:45 PM.

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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** 45139 Based on observations, interviews, and record review, it was determined that the facility failed to 1) accurately document the reconciliation of controlled medications and 2) store medications in accordance with professional standards by failing to discard expired medications, failing to date medications when opened, and failing to ensure that medications were not left at a resident's bedside. This was evident for 1 out of 2 narcotic record books reviewed and 1 (#26) out of 35 residents observed during the survey and 2 of 2 medication carts observed. The findings include: 1) On 1/8/25 at 11:25 AM, an observation on of a narcotic record book laying on the medication cart, in the 400-hallway was made. Observation revealed the nurse that reconciled that narcotic count at 7:00 AM also signed in the space reserved for the change of shift for 3:00 PM. On 1/8/25 at 11:27 AM, during a brief interview with Nurse (Staff #7), she reported that she did sign the narcotic transfer book in its designated line at 7:00 AM at the start of her shift. She also reported that she signed the narcotic record in the space designated to be signed at 3:00PM when the oncoming nurse would take possession of the narcotics. On 1/08/25 at 12:35 PM, the Director of Nursing (DON) was interviewed. The DON reported that a signature in the narcotic record book indicates that a narcotic pill count was completed at the time when narcotics are transferred from one nurse to another nurse. She confirm that a signature in the 3:00 PM space prior to the counting and transfer of narcotic to another nurse was incorrect. 01/16/25 01:21 PM, the DON provided controlled substance policy. Review of policy revealed in the section Dispensing and Reconciling Controlled Substances, that the nurse coming on duty and the nurse going off duty are to count the narcotic pills together, document the count and report any discrepancies to the director of nursing services. 48470 2a) On 1/13/25 at 1:59 PM, the Licensed Practical Nurse (LPN #5) assigned to the 300's unit, also referred to as the Up-ramp unit, was asked for her permission and agreed for her medication cart to be inspected. During the inspection, expired medications found in the medication cart include: 1) Allergy Relief (Loratadine) 10 mg tablet with an opened date of 10/24/24, expired on 10/2024 2) [NAME]-Tussin DM (Dextromethorphan/Guaifenesin) 20/200 mg with an opened date of 11/10/24, expired on 11/2024 3) Oyster shell (Calcium) 500 mg tablet with an opened date of 11/11/24, expired on 8/2024 4) Fish oil 500 mg softgel with an open date of 9/17/24, expired on 9/2024 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Mucus relief (Guaifenesin) extended-release tablet 600 mg with an opened date of 9/25/25, expired on 12/2024 6) Mucus relief (Guaifenesin) extended-release tablet 600 mg with an opened date of 10/28/24, expired on 12/2024 Shortly after at 2:22 PM, The findings were discussed with LPN #5, and she confirmed that the medications were expired. LPN #5 reported that she would discard all the medications that were identified. On the same day at 3:31 PM, the Licensed Practical Nurse (LPN #6) assigned to the 100's unit, also referred to the Front unit, was asked for her permission and agreed for her medication cart to be inspected. During the inspection, the concern with expired medications found in the medication cart include: 1) Vitamin C 500 mg tablet with an opened date of 10/22/24, expired on 9/2024 2) Dulcolax (Bisacodyl) 5 mg with an opened date of 7/28/24, expired on 12/2024 3) Fish oil 500 mg softgel with an open date of 8/7/24, expired on 9/2024 4) Aspirin 325 mg with an open date of 10/29/24, expired on 12/2024 Another concern identified while doing the inspection was the Incruse Ellipta (Umeclidinium) inhalation powder 62.5 mcg for Resident #16. The medication had 30 doses, and a counter was visible at the bottom of the inhaler that indicated it still had 29 doses. An area beside the counter was indicated for staff to write the date when the inhaler was opened. This area was left blank. Instructions on the inhaler and box where the inhaler was kept indicated that it should be discarded in 6 weeks from opening or when the counter reads 0, whichever comes first. LPN #6 was interviewed on 1/13/25 at 4:02 PM. LPN #6 confirmed the expired medication found in the cart and reported that she did not administer the inhaler for Resident #16. LPN #6 indicated that she had just started her shift at 3 PM and that it must have been the day shift nurse and stated, I will call and ask her. On 1/13/25 at 4:14 PM, the Director of Nursing (DON) was interviewed. The concern was discussed regarding the expired medications found in the 2 medication carts and the inhaler that was not dated from when it was opened. The DON stated, An audit was just done last Friday (1/10/25) by the pharmacist, and indicated she would create another process for inspecting the medication carts. The DON also reported that she would contact the day shift nurse that was assigned to the 100's unit to ask about the inhaler. The DON verbalized understanding and acknowledged the concern. On 1/17/25 at 12:26 PM, the DON reported that she still had not heard back from the nurse that worked the day shift on 1/13/25 for the 100's unit. 51489 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2b) On 1/8/25 at 11:00 AM, an observation of a plastic medicine cup with many pills sat on Resident #26's bedside table. The resident was in bed with the door open. Several other residents and staff moved about the hall independently. On 1/8/25 at 11:10 AM, in an interview with Staff #7, a Licensed Practical Nurse (LPN) stated, The resident takes ' the medications' when s/he wants to. I can't make her/him take them. The Medication Administration Record (MAR) showed that the medications were documented as given at 8:00 AM. On 1/13/25 at 05:18 PM, in an interview, the Director of Nursing (DON) confirmed that the facility does not have a process to ensure when Resident #26 takes her/his medications. On 1/16/25 at 12:14 PM, a record review of the Medication Storage and Labeling Policy revealed that medications were to be locked or not to be left unattended if opened or potentially available to others. On 1/17/25 at 8:10 AM, in an interview, the DON and ADON acknowledged that the facility needs to develop procedures to secure Resident #26's medications until s/he is ready to take them.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51712 Based on staff interviews and record review, it was determined that the facility failed to have a qualified dietary staff. This was evident for 1 of 1 Director of Food Services. The findings include: On 1/13/25 at 3:43 PM, an interview with the Director of Food Services (Staff #22) and the Regional Manager of Food Services (Staff #21) was conducted. When asked for their credentials for their current positions, Staff #22 stated that she was currently enrolled in school for her certification and she would provide the information for her school records. On 1/14/25 at 3:31 PM, the surveyor called to speak with the Clinical Dietitian, who began working remotely with the facility the last week of November 2024, and is currently employed with Nutrico. During the interview, the dietitian confirmed that she does interact with the kitchen staff for snacks, supplements and menus for the residents but that she does not manage or supervise the kitchen. On 1/17/25 at 12:08 PM, surveyor reviewed the concern with the Regional Manager of Food Services (Staff #21) that the Director of Food Services (Staff #22) does not hold the required credentials. The Regional Manager reported the Director of Food Services is currently enrolled in classes and expected to complete them in July.

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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. 51712 Based on observations, interviews, and record review, it was determined that the facility failed to monitor temperatures for the dishwasher machine to ensure adequate sanitation, and ensure temperatures were checked for mechanical soft and pureed foods before serving. This was evident for 5 of 8 daily dish machine logs and 3 of 13 daily food temperature logs reviewed. The findings include: 1) On 1/8/25 during the initial entrance conference, the Director of Nursing (DON) reported that the facility was currently experiencing a GI (gastrointestinal) outbreak. A tour of the kitchen on 1/8/25 at 11:10 AM, revealed that the dish machine log had no entries since 1/3/25. At 11:15 AM, the surveyor reviewed the concern with the Nursing Home Administrator (NHA) and the DON that they were currently in a GI outbreak and that there was no indication that the dish machine temperatures had been checked for several days. During a follow up tour of the kitchen on 1/14/25, surveyor confirmed that the dishwasher provided heat sanitation of the dishes. After several runs through, the dishwasher temperature reached the required temperature of 180 degrees. 2) On 1/14/25, a review of the food temperature logs for January 2024 failed to reveal documented temperatures for the pureed and mechanical soft diets for the dinner meals for 3 of the 13 days reviewed. On 1/14/25 at 10:14 AM, the Regional Manager (Staff #21), confirmed the failure to document the temperature for the pureed and mechanical soft foods for the January 5th, 8th and 9th dinners.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 48168 Based on interview and record review it was determined that the facility failed to comply with State regulations when the facility failed to 1) employ a qualified social worker, 2) monitor employee's relevant health status, 3) provide a minimum of 3 hours of bedside care per occupied bed per day, and 4) ensure the Quality Assurance committee contained the required members. These deficiencies were found during the recertification survey and had the potential to affect all residents, staff and visitors. The findings include: 1). The State of Maryland Code of Regulations at 10.07.02.30 B states that B. (S 1320, ' Staff Qualifications ') Social Work Staff Responsibility. (1) Social services responsibilities in the nursing home shall be assigned to a: (a) Licensed bachelor social worker; (b) Licensed graduate social worker; (c) Licensed certified social worker; or (d) Licensed certified social worker-clinical. (2) If the social worker is not a licensed certified social worker (LCSW) or a licensed certified social worker-clinical (LCSW-C), the nursing home shall arrange for an LCSW or LCSW-C to provide sufficient hours of supervision. On 1/8/25 at 10:57 AM an entrance conference meeting was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), and a list of key personnel was requested. On 1/8/25 at 1:16 PM an interview was conducted with Administrative Nurse (Staff #12) who said she was the nurse manager for all the units. She explained that she also performed social worker duties since November 2024 when the facility social worker left. She further stated that the DON also performed some social work duties. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 1:21 PM in an interview with the Staffing Coordinator/Human Resources Director (Staff #18), she said she had worked at the facility for 2.5 years. She confirmed that there was no social worker employed by the facility and said that there was no regional social worker or consultant social worker who provided social work services or oversight to the facility. On 1/17/25 at 12:21 PM an interview with the DON was conducted to review concerns identified during the survey. She confirmed that the facility did not employ a social worker nor have any social work consultant who provided social work services to the facility and she said there was no additional evidence to provide. She further stated that she had discussed these concerns with NHA and that the company ' s Chief Operating Officer was also aware of the deficiency. 2). Maryland state regulations at 10.07.02.34 A. states The nursing home's infection prevention and control program shall monitor the relevant health status of all employees, as it relates to infection prevention and control. The regulation at 10.07.02.34 B. 2. States The nursing home shall ensure that employees may not provide services that require direct access to residents without documented evidence that the employee is free from communicable tuberculosis. Maryland state regulations at 10.07.02.34 C. (1) states The nursing home shall screen and maintain written documentation of each employee ' s proof of immunity to common childhood infections including measles, mumps, rubella, and chickenpox (varicella). Maryland state regulations at 10.07.02.34 D. states Hepatitis B. The nursing home shall require that all new employees receive immunization for Hepatitis B, unless medically contraindicated, against the employee's religious beliefs, or after being fully informed of the health risks of not being immunized. The nursing home shall inform all new and current employees of the health risks of not being immunized. If the employee refuses to be immunized, the nursing home shall document the refusal and the reason for the refusal. On 1/8/25, during the entrance conference, the facility was asked for a list of all employees. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 2:50 PM the Director of Nursing (DON) was asked to provide evidence of immunizations and tuberculosis (TB) tests for 5 randomly selected employees. On 1/13/25 at 9:38 AM a review of the health records revealed that: 1) Registered Nurse (RN #3) lacked evidence of varicella immunization, 2) RN #19 lacked evidence of TB tests, and 3) dietary aide (Staff #24) lacked evidence of TB tests and evidence of immunization for Hepatitis B. On 1/15/25 at 3:53 PM an interview with the DON was conducted and she was asked to provide further evidence of TB tests and immunization records for RN #3, RN #19, and Staff #24. On 1/16/25 at 11:45 AM in a follow up interview with the DON, she stated that she did not have any further evidence of TB tests or immunizations for RN #3, RN #19, or Staff #24. She confirmed that the facility failed to monitor the relevant health status of all staff. 3). Maryland state regulations at 10.07.02.19 B. state Nursing Services - Staffing, (S 0670, ' Hours of Bedside Care ') Hours of Bedside Care - Nursing Home. (1) A nursing home shall employ supervisory personnel and a sufficient number of support personnel to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week. (2) Bedside hours include the care provided by: (a) Registered nurses;(b) Licensed practical nurses; and (c) Support personnel. (3) Only those hours which the director of nursing spends in bedside care may be counted in the 3-hour minimum requirement. (4) The director of nursing's time counted in bedside care shall be documented. On 1/9/25 at 2:50 PM the Director of Nursing (DON) was asked to provide the facility ' s data for hours of bedside care provided to residents from 11/08/24 through 1/08/25. On 1/13/25 at 9:29 AM the hours of bedside care (PPD) data for 11/08/24 through 1/08/25 was received. A review of the data revealed that 27 of 60 days failed to have a PPD of 3.0. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:18 AM in an interview with the DON, she confirmed the finding that facility failed to provide a minimum of 3 hours of bedside care for 27 of the 60 days from 11/08/24 through 1/08/25. When asked if she had additional evidence, she said she had none and knew the PPD was deficient with state regulation. On 1/17/25, prior to the exit conference, an interview with the Chief Operating Officer was conducted. He said that he was also aware of the PPD deficiency. 4). State regulations at 10.07.02.64 C state The nursing home shall establish a quality assurance committee that includes at least: (1) The nursing home director of nursing; (2) The nursing home administrator; (3) A social worker; (4) The nursing home medical director; (5) A dietitian-nutritionist; and (6) A geriatric nursing assistant at the nursing home. On 1/16/25 at 9:42 AM the Facility Administrator provided Quality Assurance Performance and Improvement (QAPI) attendance sign-in sheets for January 2024 through December 2024. A review of these documents revealed that the committee met monthly and that the social worker failed to attend 2 out of 12 meetings, and the dietician and geriatric nursing assistant failed to attend 11 out of 12 meetings. On 1/17/25 at 8:23 AM in an interview, the Chief Operating Officer (COO) and the DON acknowledged that the QAPI committee lacked attendance of the required participants. On 1/17/25 at 10:51 AM, a surveyor informed the DON that the lack of attendance by required participants failed to meet the Maryland State requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51489 Based on observations, interviews and record review, it was determined that the facility failed to maintain complete, accurate and legible medical records. This was evident for 3 (#26, #36, #12) out of 35 residents reviewed during the survey. The findings include: On 1/8/25 at 11:00 AM, an observation of a plastic medicine cup with many pills sat on top of Resident #26's bedside table. On 1/8/25 at 11:10 AM, in an interview with Staff #7, a Licensed Practical Nurse (LPN) stated, that the resident takes them when s/he wants to. I can't make her/him take them. On 1/8/25 at 11:15 AM, the surveyor observed Staff #7 instructed the resident to take the medications that sat on the bedside table. On 1/8/25 at 11:25 AM, in a brief interview, Staff #7 reported that medications were documented as given when brought into the room. I don't know what time s/he takes the medications. On 1/13/25 at 5:18 PM, in an interview with the Director of Nursing (DON), she reported that the facility did not have a process to know when Resident #26 took the medications. She stated, There's no way of telling when. The nurse documented as given when the meds were taken into the room. On 1/14/25 at 9:34 AM, a record review of the Medication Administration Record (MAR), showed that the morning medications were signed off as administered at 8:00 AM. On 1/16/25 at 11:59 AM, a record review of the Medication Administration Policy revealed that medications should be administered within 1 hour time frame unless otherwise specified and enhancing therapeutic effect of meds, preventing potential interactions, and honoring the resident's choices. On 1/17/25 at 8:10 AM, in an interview, the DON stated, I expect medications to be signed off after they are ingested, not when left at the bedside. Surveyor shared concerns that Resident #26's medical record does not accurately represent or reflect when medications were received. 51712 2) On 1/8/25 at 4:53 PM, a review of medical records showed that Resident #36 had a change in condition note started on 10/5/24 by nurse Staff #28, indicating an issue with the resident's eye. The note indicated the primary care provider was notified on 10/5/24 at 11:21 AM, but the area of the note for recommendations by the provider was noted to be blank. The note was closed and signed by the Director of Nursing on 10/7/24 at 1:11 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 9:20 AM, the surveyor reviewed with DON the concern regarding the 10/5 change of condition note that failed to include the physician response or that the responsible party was notified. Also noted that the note was initiated by nurse #28 and closed by the DON. DON indicated that she would follow up. On 1/10/25 at 9:36 AM, the DON provided no additional information regarding the change in condition note for Resident #36. The DON reported there was a fax to the physician, but there was no response. 3) On 1/10/25, a review of the paper chart for Resident #12 revealed that the primary care physician was handwriting the monthly visit progress notes. The surveyor was unable to read all of the physician's documentation. On 1/10/25 at 1:49 PM, the surveyor asked the nurse (Staff #30) to read the note for clarity. The nurse was unable to read the majority of the notes. On 1/17/24 at 12:17 PM, the surveyor reviewed the concern with the DON regarding ensuring medical records were legible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45139 Based on observation, interview, and pertinent document review, it was determined that the facility failed to: 1) ensure a glucometer was adequately disinfected between different resident uses in a manner that met minimum standards and minimized risk for the infectious spread of blood-borne pathogens, and 2) ensure that Infection Prevention Control Program (IPCP) policies and procedures were reviewed at least annually. This was evident for 1 Resident (# 26), in a random observation during a recertification/complaint survey. The findings include: Blood glucose meters are portable devices that measure blood glucose levels and aid in diabetes self-management. Healthcare providers use these types of devices in a variety of clinical settings. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. 01/10/25 06:26 AM, Nurse Agency Staff #2 was observed measuring Resident #419's glucose levels utilizing a glucometer. On 1/10/25 at 6:32 AM, continued observation of Nurse Staff #2 revealed the Nurse Staff #1 exiting Resident #419's room with the glucometer in his hand and then he placed the glucometer on top of the med cart. The observation failed to reveal that the nurse disinfected the glucometer. The nurse then placed the glucometer in the right upper drawer of the med cart. Continued observation failed to reveal the glucometer was disinfected before being put in the drawer. On 1/10/25 06:33 AM, Nurse Staff #2 took the glucometer out of the med cart drawer and placed it on top of the med cart. The observation failed to reveal that the nurse had disinfected the glucometer. On 1/10/25 at 6:37 AM, Nurse Staff #2 was observed with the glucometer, dextrose sticks and lancet in hand(equipment used in measuring glucose). On 1/10/25 at 6:37 AM, Nurse Staff #2 reported that he was going into Resident # 26's room for glucose monitoring. The Surveyor delayed Nurse Staff #2 and stated that she observed that he did not clean the glucometer. The nurse then began to clean the glucometer with alcohol wipes. The nurse was asked if the facility's policy was to clean glucometers with alcohol wipes; he stated he thought so. The nurse said that he would like to verify this with his supervisor. On 1/10/25 at 6:41 AM, The Director of Nursing (DON) approached Nurse Staff #2 and the surveyor. The DON reported she thinks that they use the bleach wipes. The DON looked through the medication cart and failed to find any bleach wipes. The DON also functioned as the facility infection preventionist. The DON then went to get Super-Sani wipes from the nurse's station and provided them to the Nurse Staff #1 and advised him how to clean the glucometer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 6:41 AM, during a brief interview, the DON said that she was not sure if alcohol wipes were an appropriate disinfectant for the glucometer. The DON stated she would get back to the surveyor if the alcohol wipes were approved for cleaning the glucometer. On 10/10/25 review of the facility's policy, titled Obtaining a Finger Glucose Level, documented that the glucometers should be cleaned and disinfected between uses according to the manufacturer's instructions and current infection control standards of practice. On 1/10/25 at 7:11 AM, the DON reported that the manufacturer guidelines document that Super Sani-Germicidal Disposable wipes are to be used to clean the glucometers and alcohol wipes are not an effective disinfectant for the glucometers. On 1/10/25 at 7:11 AM review of the manufacturer guidelines for the glucometers used by the facility confirmed that Bleach Germicidal wipes and Super Sani-Germicidal Disposable wipes are two acceptable cleaning products and alcohol wipes are not effective disinfecting products for the glucometer. 51786 2) On 1/8/25 at 3:21 PM, as part of the infection control task for the recertification survey, the Director of Nursing (DON) was asked to provide the facility's infection prevention and control program documents to include policies and procedures. On 1/15/25 at 11:22 AM, the DON provided a binder titled Antibiotic Stewardship Program that contained IPCP standards, policies, and procedures. A review of these documents revealed policies for Pneumonia and Influenza that were revised in 2022, and the COVID-19 policy which was revised in 2021. On 1/15/25 at approximately 11:30 AM, in an interview with the DON, the outdated policies were reviewed with her and she was asked to provide evidence that the COVID-19, Pneumonia, and Influenza policies were reviewed and updated annually. On 1/15/25 at 11:59 AM, the DON submitted additional copies of policies and procedures, but a review of these documents indicated they were identical outdated policies as provided previously. On 1/16/25 at 11:50 AM, in another interview with the DON, she confirmed that the facility did not annually update the policies for Pneumonia, Influenza, and COVID-19.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 51786 Based on interview and record review, it was determined that the facility failed to provide the 2024-2025 COVID-19 immunization to residents and staff. This was evident for 1) five residents (Resident #3, #22, #63, #64, #269) of five residents, and 2) four staff (Staff #3, #24, #25, and #26) of five staff records reviewed for COVID-19 immunization during the recertification survey. The findings include: 1a) On 1/8/25 at 12:01 PM, an interview with Resident #22 was conducted and he/she stated that he/she requested the 2024-2025 COVID-19 vaccine but had not received the vaccine. On 1/9/25 at 3:47 PM, a review of Resident #22's health record failed to show that the resident received or refused the 2024-2025 COVID-19 vaccine. 1b). On 1/8/25 at 4:49 PM, an interview with Resident #3 was conducted and he/she stated that he/she requested the 2024-2025 COVID-19 vaccine but had not received the vaccine. On 1/9/25 at 3:51 PM, a review of Resident #3's health record failed to show that the resident received or refused the 2024-2025 COVID-19 vaccine. On 1/9/25, at 4:27 PM, a review of 3 other random residents' electronic health records revealed that Resident #63, Resident #64, and Resident #269 did not receive or refuse the 2024-2025 COVID-19 vaccines. On 1/15/25 at 1:53 PM, the Director of Nursing (DON) was asked to provide immunization records and/or declination forms for the following residents Resident #3, Resident #22, Resident #63, Resident #64, and Resident #269. On 1/15/25 at 3:05 PM, the immunization records were received and reviewed and failed to show that the 2024-2025 COVID-19 vaccine was provided to Resident #3, Resident #22, Resident #63, Resident #64, and Resident #269. On 1/15/25 at 3:53 PM, an interview with the DON was conducted. The DON stated that she was aware that Resident #3, Resident #22, Resident #63, Resident #64, and Resident #269 had not received the 2024-2025 COVID-19 vaccine. 2.) On 1/9/25 at 2:50 PM, the DON was asked to provide immunization records for 5 randomly selected staff members (Staff #3, #19, #24, #25, and #26). On 1/13/25 at 9:38 AM, the DON provided the requested staff immunization records. A review of these records revealed no evidence that the 2024-2025 COVID-19 vaccine was refused or provided to Staff #3, Staff #24, Staff #25, or Staff #26. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 11:45 AM, in another interview with the DON, she confirmed that Staff #3, Staff #24, Staff #25, and Staff #26 did not refuse and were not provided the 2024-2025 COVID-19 vaccine. On 1/17/25 at 12:21 PM in a follow-up interview with the DON, she said she had no further COVID-19 immunization evidence to provide.