STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215083	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroline Nursing and Rehab	520 Kerr Avenue Denton, MD 21629

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on a complaint, review of medical records, and staff interview, it was determined facility staff failed to notify a resident's representative when a resident had a medication change. This was evident for 1 (Resident #7) of 15 residents reviewed for complaints during a Recertification/Complaint survey. The findings include: On 11/20/2024 at 8:00 AM, a review of complaint #MD00193361 revealed Resident #7 was started on a new Medication (Mirtazapine, also known as Remeron) but facility staff failed to notify the Resident's Representative (RP). Mirtazapine is a medication used to treat depression and is sometimes used to help with sleep and to increase appetite for people who are not depressed. On 11/20/2024 at 8:24 AM, Review of Resident #7's clinical records revealed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with medical diagnoses that included but not limited to Major Depressive disorder, Alzheimer's disease, Dysphagia following Cerebral Infarction, Feeding difficulties, and Atrial Fibrillation. On 11/20/2024 at 10:13 AM, in an interview with Resident #7's RP (the complainant), s/he stated that staff did not usually notify them of changes unless s/he asked. S/he confirmed that they were not notified at the time the Resident was started on Mirtazapine. On 11/20/2024 at 10:52 AM review of physician orders for May 2023 revealed the following: -Mirtazapine Oral Tablet 7.5 mg, Give 1 tablet by mouth at bedtime for Insomnia/depression start date 5/2/2023 and discontinued on 5/7/2023. -Remeron Tablet 15 MG, Give 15 mg by mouth at bedtime for appetite stimulant start date 5/9/2023 and discontinued on 5/16/2023. On 11/20/2024 at 10:57 AM, a review of the Medication Administration Record (MAR) for May 2023 revealed Resident #7 was given Remeron (Mirtazapine 7.5 mg) 1 tablet by mouth at bedtime on 5/2/2023 through 5/6/2023 for Insomnia/depression. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/2024 at 11:17 AM, a review of change in conditions forms from May 2023 was completed. There was no change in condition form/family notification for when Resident #7 was started on Mirtazapine (Remeron). On 11/20/2024 at 11:49 AM, a review of nurses' progress notes from May 2023 through June 2023 was completed. There was no documentation that Resident #7's RP was notified when the resident was started on Mirtazapine. However, there was documentation instructing staff to Please notify family when resident has changes to his/her medication dated 5/7/2023 at 10:03 and on 5/7/2023 at 10:30 Please be advised this nurse d/c Mirtazapine as ordered by Dr. per daughters request .Please also alert daughters when any medication changes or gets added. On 11/22/2024 at 9:06 AM, in a follow up interview with the Director of Nursing (DON), she stated that the expectation was that when any resident was started on a new medication, the nurse would notify the resident's family/RP by phone and/or leave message for RP to call the nurse if they did not answer the phone. She added that the nurse will then document in the progress notes that RP was notified. Surveyor shared concerns regarding facility staff not providing documentation that Resident #7's RP was notified when they started the resident on Remeron in May 2023. DON stated that she has instructed the nurses that family has to be called for everything, no exception. However, DON did not provide any documentation to show that the resident's RP was notified when they started him/her on Mirtazapine (Remeron).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45131 Based on a review of the facility self-report, record reviews, resident interview, and staff interviews, it was determined that the facility failed to ensure residents were free from verbal abuse. This is evident for 1(Resident #63) of 10 residents reviewed for abuse during the recertification/complaint survey. Findings include: On 11/15/2024 at 10:50 AM, a review of a Facility Reported Incident (FRI) submitted to the Office of Health Care Quality (OHCQ) revealed that, on 8/21/24 at 6:30 PM, Resident #63 was verbally abused by a Geriatric Nurse Aide (GNA), and that incident was reported to the facility by another resident's family member. The report revealed that the GNA stated to Resident #63 If you yell at me again, I am going to make you sit in that chair all night. The complainant stated that Resident #63 had been yelling to get into bed. On 11/15/2024 at 10:50 AM, a review of the initial FRI report form revealed that the facility's corrective action was the termination of the alleged perpetrator, Staff #38. A review of the Employee Status Change form confirmed her termination as of 8/23/2024 due to verbal abuse. On 11/18/2024 at 10:46 AM in an interview with Resident #63, the surveyor spoke with the resident who was lying in bed, awake and alert to self. The resident stated that he/she just had a shower and felt very good. The resident was asked about the event of 8/21/2024 and initially the resident stated that he/she did not remember; however, when the surveyor mentioned the allegation of verbal abuse and the threats of leaving him/her in the chair all night, the resident stated that they vaguely remembered. When asked if the employee has returned to her room since the incident, he/she stated no, I asked for her not to come back to my room. The resident was unable to provide any additional details related to the alleged incident. On 11/18/2024 at 11:50 AM, in an interview with the Nursing Home Administrator (NHA), she was asked about the facility's abuse reporting process. The NHA stated that they would first remove the residents from the situation, and the accused staff would be suspended pending further investigation. She stated that the investigation would be conducted and documented using the initial report forms and that follow-up forms would subsequently be submitted to OHCQ electronically. The surveyor asked about further investigation and conducting interviews with other residents, the NHA stated that it was clear cut that Staff #38 did make the inappropriate comments. A resident's family member overheard the verbal assault and Staff #38 confirmed the statement made to the resident. When asked about the interviews conducted with the witness, the NHA clarified the witness note written/dated 8/22/2024 by pointing to the statement on the facility reported incident form submitted to OHCQ and stated she confirmed what was in that report. On 11/18/2024 at 12 PM Staff #38 employee files were requested. On 11/18/24 at 12:21 PM A review of Staff #38 employee files revealed that Staff #38 had their initial abuse training in August 2023. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/2024 at 12:44 PM, a licensed practical nurse (LPN)'s progress notes on 8/21/2024 at 6:35 PM revealed that Resident #63 showed no physical or behavioral changes after the incident. The supervisor and DON were notified of the allegation and Staff #38 was sent home immediately. On 11/18/2024 at approximately 12:44 PM, additional documents were provided by the facility, including a typed and signed statement by the NHA, dated 11/18/2024. The typed and signed statement revealed that there were no residents or staff members who witnessed the incident, but due to the presumed reliability of the witness, a decision was made to terminate Staff #38, and the employee did not dispute making the inappropriate comment. On 11/21/2024 at 12:35 PM, the surveyor notified the DON about the above-mentioned findings, and she acknowledged the findings.

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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. 45131 Based on record reviews and staff interviews, it was determined that the facility failed to timely report verbal abuse to the State Survey Agency and other agencies as required by law. This is evident for 1 (Resident #63) of 9 residents reviewed for facility reported incidents during the recertification/complaint survey. Findings Include: On 11/15/2024 at 10:50 AM, a review of a Facility Reported Incident submitted to the Office of Health Care Quality (OHCQ) revealed that a self-report for verbal abuse against Resident #63 was submitted to OHCQ on 8/22/2024 at 4:09 PM; however, this alleged incident was witnessed by another resident's family member who notified the supervisor of the incident on 8/21/2024 at 6:35 PM. On 8/21/24, it was alleged that Resident #63 was verbally abused by a Geriatric Nurse Aide (GNA). On 11/15/2024 at 11:50 AM, in a Nursing Home Administrator (NHA) interview, the NHA confirmed verbal abuse and as a result, Staff #38 was terminated on 8/23/2024. The surveyor asked the NHA about the reporting time for abuse to the State Agencies and she stated they notify the required agency within 24 hours for any issues. On 11/19/24 at 1:31 PM, a review of the facility's abuse policy revealed that reports of allegations or suspected abuse, neglect or exploitation are to be reported immediately to Administrator, other officials and State Survey agency through established procedures. On 11/21/24 at 12:35 PM, in a Director of Nursing (DON) interview, the surveyor informed the DON that the facility failed to report abuse allegations within the 2-hours after the allegation was reported to the facility and the DON acknowledged the findings.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 43096 Based on the record reviews and interviews, and observations, it was determined that the facility failed to thoroughly investigate an abuse allegation. This is evident for 5 (Resident#232, #235, #63, #32, #7) of 38 residents reviewed during the recertification/complaint survey. The findings include: 1)On 11/13/23 at 3:30 PM, the surveyor reviewed one of the facility's incident reports, MD00198830. The incident report stated that Resident #235 reported to his/her family member that a same-gender staff had sexually assaulted him/her; the reporter described when they did a skin check on 10/20/2023, the incident occurred. The facility's investigation had a written statement from the nurse who conducted a skin assessment upon Resident #235's admission. Also, there were five written statements from staff: three Geriatric Nurse Aides, one other Licensed Practical Nurse, and one statement without the name of the person who wrote it. However, the facility's investigation did not have additional documentation to identify who was involved in this incident. Also, no interviews were documented with Resident #235 and other residents. During an interview with the Nursing Home Administrator (NHA) on 11/13/24 at 4:04 PM, she stated that Resident #235's family member initially reported this incident to the police, and then the facility started investigating it. The NHA said, We interviewed Resident; the details were included on the follow-up incident report form. She confirmed no formal documentation regarding Resident #235's statement. Also, the NHA verified that the facility did not obtain any interviews with other residents. 2)On11/14/24 at 9:50 AM, a review of the facility's incident report, MD00180232, revealed that on 3/06/22, Resident #232 reported to a nurse that an African American male nurse tried to attack him/her last night. Further review of the facility's investigation revealed four staff witness statements on 3/07/22 with their name (however, the statements did not contain their titles). Also, there were no interviews with other residents. On 11/14/24 at 11:17 AM, the surveyor asked the Nursing Home Administrator (NHA) about who wrote the witness statements. She provided each one's title: three were written by Licensed Practical Nurses, and one by Geriatric Nursing Aide. Also, the surveyor asked the NHA how the facility identified staff who were pointed out by Resident #232 as the perpetrators. The NHA said, I was not here when the incident occurred. But I will find who was involved in this incident by the staffing sheet. Also, the NHA explained that the facility should obtain interviews with other residents whenever there is alleged abuse. The NHA verified that the schedule sheet for 3/06/22 and/or any supportive documentation to identify who was involved in this incident was not presented in the facility's investigation packet, and there were no other residents' interviews. The NHA validated the above concerns. 45131 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3)On 11/15/2024 at 10:50 AM, a review of a Facility Reported Incident (FRI) submitted to the Office of Health Care Quality (OHCQ) revealed that a verbal abuse allegation was made by another resident's family member. The FRI stated that on 8/21/24, Resident #63 was verbally abused by a Geriatric Nurse Aide (GNA) of the facility. The complainant reported that she overheard Staff #38 was telling Resident #63 If you yell at me again, I am going to make you sit in that chair all night. According to the complainant Resident #63 had been yelling to get into bed. On 11/15/2024 at 10:50 AM, a review of the facility's investigation folder revealed that the facility failed to conduct a thorough investigation as evidenced by the following: 1.There was no documented evidence that an interview was conducted with the alleged victim or other residents within the facility whom she provided personal care to. 2.There was no documented evidence that the facility conducted interviews with any other staff members or other potential witnesses. 3.There was no documentation to support that the facility reported the allegation of abuse to law enforcement. 4.There was no documentation to support that the facility reported the GNA conduct to the Maryland board of Nursing Licensing Board. On 11/18/2024 at 11:50 AM, in a Nursing Home Administrator (NHA) interview, the surveyor asked if law enforcement was notified of the abuse allegation and the NHA stated they did not notify the police of verbal abuse, what Staff #38 said didn't rise to the occasion to report the issue. When asked about the investigation she stated that Resident #63 was not alert and oriented, and her understanding was that she didn't really know what took place. She stated that they didn't interview any other residents because it was clear cut when a resident's family witnessed the assault and reported the incident. The NHA also stated that during an interview with Staff #38, she admitted that she made the alleged statement to the resident. The surveyor asked if the Resident's family was notified of the issue and the NHA stated, I believe the social worker notified the family, but I am not sure. On 11/18/2024 at 12:00 PM, in an interview with the NHA, the surveyor requested documentation to support that the family was notified of the incident; however, the documentation was not provided. On 11/19/2024 at 7:52 AM, during an interview with the administrator, she was asked what the procedure was for reporting an allegation of abuse and she stated that she thought it was 24 hours like she used to do in Pennsylvania state. A copy of the abuse education attendance was asked for and reviewed. 11/19/24 01:31 PM, a review of the facility's abuse policy revealed that the report allegations or suspected abuse, neglect or exploitation should be reported immediately to the Administrator, other officials and State Survey agency through established procedures. 11/21/24 12:35 PM in an interview with the Director of Nursing (DON), the DON was informed about the above-mentioned findings, and she acknowledged that the reporting to the licensing board was not done, the allegation was not reported to law enforcement and she was made aware that a thorough investigation was not completed by the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50904 4)On 11/19/2024 at 07:05 AM, review of Intake MD00211710 from 11/13/2024 regarding the facility's reported incident investigation concerning allegation of abuse revealed that: On 11/13/2024, The facility notified the state agency office that a facility staff overhead Resident # 32 telling a state surveyor that he/she had been abused and also stated he/she did not know by whom, when, or what they looked like. The staff heard him/her add that they got into a shoving match with them. The staff then heard that he/she didn't get his/her damn lunch. On 11/15/2023, the Nursing Home Administrator conducted interviews with five staff members who typically work on the unit regarding their knowledge of any incidents involving the resident and other residents or staff in recent days. They all responded that they had no knowledge of it. The Administrator also interviewed five other residents who stated that they were being treated well. On 11/18/2024, The facility sent a follow-up investigation report form to the state agency stating that the allegation was not verified. The form stated that there was no indication of abuse and Resident #32 does not have the mobility to get out of bed and shove another person. 11/19/2024 8:13 AM, In an interview with the Unit Manager, Staff #35, she was asked how she heard about the abuse allegation. She stated that it was reported to her by a Geriatric Nursing Assistant (GNA) who had stated that she overheard Resident #32 saying to the state surveyor that he/she had been abused. When she was asked for the identity of the GNA, she stated that she did not remember who told her about the conversation. She added that she wrote up a statement on the day the GNA told her but did not include the name of the GNA because she did not remember the person. 11/19/2024 8:37 AM When the Administrator was informed about the interview with the unit manager (Staff #35), she stated that the unit manager seemed forgetful due to recent medical condition. She stated that it did not occur to her that the GNA's identity was unknown. She told the surveyor she would interview everyone who worked on the floor on the day of the alleged incident. At 4:06 of the same day, she informed the surveyor that all the staff denied telling the unit manager about any incident. She also added that she should have asked for the identity of the staff who heard the conversation for proper interview during the investigations. 51128 5)On 11/13/24 at 10:15 AM, a review of the facility's incident report, MD00181023, revealed that an investigation was initiated and was ongoing on 5/2/2022 for a verbal abuse incident between Geriatric Nurse Aide (GNA # 45) and resident #7. The investigation stated that Resident #7 told the Registered Nurse (RN# 46) that GNA # 45 spoke to him/her in an inappropriate tone. Resident #7 reported that the older-looking female said, If you want to get in bed, you will stand up. A review of the investigation folder included a progress note written by RN #46 on 4/25/2022 at 15:22 PM, which documented that Resident#7's family called to report that he/she was very upset that a caregiver did not help assist him/her back to bed at the time she/he requested. RN #46 offered to talk to Resident #7, but the family said Resident #7 had threatened to leave the facility if staff came to talk to her about the incident. RN #46 documented that she spoke to the caregiver, GNA #45, and to see written note. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After further review of the incident folder, there was no written note from RN #46. The investigation summary written by the NHA on 5/2/22 documented that an interview was completed between Resident #7, GNA #45, and a witness, GNA #47. The NHA concluded that there was no deprivation by the GNA for care and Services, the GNA will be reinstated and complete 1:1 customer service education upon return to the facility. The incident folder did not have a witness statement from GNA#47 and no documentation of 1:1 customer training. On 11/18/24 at 11:45 AM, the Nursing Home Administrator (NHA), staff #1, was interviewed. When asked about the missing documents, the NHA stated that she was not the NHA when this incident was reported or investigated and could not find any further documentation. Although the abuse could not be substantiated, the facility staff failed to provide the missing documents for a thorough investigation of the incident. On 11/18/2024 at 11:45 AM, the NHA and the DON were informed that this was a concern.

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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. 50904 Based on an interview with a resident, a record review and interview with facility staff, it was determined that the facility failed to ensure comprehensive care plans were developed and implemented. This was evident for 3 residents (Resident #11, Resident # 57 and Resident # 247) out of 38 residents reviewed for developing the comprehensive care plans during the Medicaid/Medicare recertification survey. The findings include: 1)On 11/12/24 at 1:19 PM during the initial screening of the residents, Resident #11 stated that he/she does not participate in any activity within the facility and would like for activity staff to visit him/her in the room so that he/she can know about the kind of activity that he/she could be a part of. On 11/13/24 at 02:57 PM, the surveyor reviewed Resident #11's electronic records for an activity care plan. The care plan did not show any focus, goals or interventions for the resident's activity while in the facility. On 11/13/24 at 03:12 PM, in an interview with the Activities Director (Staff #6), she was asked about how activities were done with residents who were bed-bound. She stated that she does one-on-one visits. When she was asked about the activities done with Resident #11, she stated that the facility has not yet started an activity with the resident and that she stated that the resident has not been getting activities except the sunshine visits. When she was asked about what sunshine visit was, she stated it was a process where daily activities schedules were handed over to the residents. She stated that the activity at the moment favors the resident who can move about in their wheelchairs or be able to walk with little or no assistance. On 11/14/24 09:57 AM The Director of Nursing was informed about Resident #11's desire to participate in activities in the facility while in his/her room. She confirmed that the resident did not have a care plan in place for activities. 49409 2)On 11/13/2024 at 2 pm, a record review of the Minimum data set (MDS) from 09/11/22 reflects that resident #57 had an active diagnosis of PTSD. A review of the Hospital records from 09/06/2022 confirms that the resident had a diagnosis of PTSD. The care plan for resident #57 revealed that the care plan was initiated on 09/14/2022 and revised on 07/12/2023. The facility failed to initiate the care plan with appropriate interventions to provide comprehensive care. On 11/14/24 at 09:57 AM, reviewed with the Director of Nursing, and he/she acknowledged the missing care plan to address PTSD and any interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3)On 11/13/24 at 10:15 AM, interview with resident # 247 and a record review of the care plan dated 11/04/2024 revealed that the facility failed to develop care plan interventions for hemodialysis care. On 11/13/24 at 02:17 PM, the surveyor conducted an Interview with registered Nurse # 51, which revealed that the Nursing leadership did the care plan documentation. On 11/14/24 09:57 AM the surveyor reviewed the missing interventional plan with The Director of Nursing (DON). DON acknowledged that leadership initiates and updates the care plans and missing care plan interventions for hemodialysis.

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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. 42507 Based on complaints, observation, record review, and interview, it was determined the facility staff: 1) failed to revise and update resident care plans to reflect accurate and current interventions, and 2) failed to have timely care plan meetings with a resident and/or resident representative. This was evident for 6 (#38, #68, #63, #19, #37, #241) of 38 residents reviewed during a recertification/complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Care conferences are usually held on a regular basis, often quarterly, but can be scheduled more frequently if needed based on the resident's condition. The Minimum Data Set (MDS) is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is a standardized assessment tool to comprehensively evaluate a resident's health status, functional abilities, and needs. It is the foundation for creating a personalized care plan that drives care rendered by the healthcare team within a nursing facility. 1) On 11/13/2024 at 10:51 AM, during initial pool screening, surveyor observed Resident #38 in bed with bed in low position and fall mats on the floor on both sides of the resident's bed. In an interview with the resident s/he noted that they had fallen in the last couple of months. On 11/21/2024 at 10:35 AM, a review of fall risk assessments completed using the Morse Fall scale on admission and each time the resident had a fall revealed Resident #38 was at high risk for falls (scores ranged from 80 (on 5/23/2023) to 50 (on 6/10/2024). On 11/21/2024 at 11:05 AM, review of Resident #38's care plan revealed a care plan focus for [Resident's name] is (Moderate) risk for falls r/t Impaired Cognitive impairment, CVA initiated on 4/19/2023 with revision on 11/17/2024. Goals and Interventions/Tasks included but not limited to Resident is to have a two person assist with transfers. However, the care plan was not updated/revised to include high risk for falls (based on recorded Morse fall risk assessments) and/or actual falls. The interventions were not resident centered and was not updated/revised to capture the resident's current status. The interventions did not include fall mats found in resident's room, no bed in low position, place personal items within reach, etc. On 11/21/2024 at 11:42 AM, a review of progress notes revealed the following documentation on 6/10/2024 at 8:49 AM by the IDT (Interdisciplinary Team): IDT review completed for Fall on 6/10/24-- Resident has had multiple falls due to being non-complaint with calling for assistance. Resident has no complaints of pain or discomfort, no injuries noted, resident was looking for the cat that was running loose in his room. CP in place, appropriate. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of progress notes revealed staff documentation that Resident #38 fell in the facility on 5/15/2024, 5/18/2024, and 5/20/2024 respectively. On 11/21/2024 at 1:15 PM, an interview was conducted with E-Wing Unit Manager (UM #15): UM #15 confirmed that Resident #38 had fallen a couple of times while in the facility. Surveyor reviewed resident's care plan with UM #15 who verified that there was no care plan focus for actual fall. Surveyor further reviewed the resident's documented Morse fall risk assessment scores with UM #15. She verified and confirmed that the lowest score was 50, which was high risk for falls. UM #15 acknowledged that the care plan did not captured the resident's high fall risk and/or actual falls. On 11/22/2024 at 8:50 AM, in an interview with the Director of Nursing (DON), she stated she was aware that the resident had fallen in the facility a couple of times. Surveyor reviewed Resident #38's care plan with DON who confirmed that Moderate risk for falls should have been changed to high risk for falls as the resident's lowest Morse fall risk score was 50. DON confirmed that the resident's Care plan should have been revised/updated to reflect a focus on actual fall with interventions. DON added that should have been done during their last IDT meeting. However, the DON stated that she was going to look at Resident #38's care plan and do a complete update and add/remove some of the interventions that were not pertinent to the resident such as two person assist with transfers. 44441 2)On 11/20/24 at 11:50 AM, review of a complaint incident MD00202140 had that resident #241 had multiple falls and had to be sent out to the hospital for evaluation for fall injuries. Further review of the medical records on 11/20/24 at 12:00 PM revealed that resident had an unwitnessed fall on 12/25/22 with no injuries. Resident #241 fell again on 1/17/23 and had to be sent out to the hospital for evaluation due to injuries. On 1/19/23, the Resident fell again and was sent out to the hospital emergency room for evaluation. Review of the care plan with initiation date of 10/2/22 had: Resident is at risk for falls related to (r/t) Impaired safety awareness/cognitive loss due to CVA, Epileptic Seizures. Further review did not show that the resident's actual fall was captured or that the care plan was updated to include the actual falls even though the care plan was revised on 1/17/23. In an interview with Staff #19 a unit manager on 11/20/24 at 1:13 PM, he was asked who was responsible for updating the care plans and he said it was the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). He said care plans are updated when there was a change in the residents' condition and that updates are implemented right away. He was asked about residents at fall risk that sustained actual falls. He stated that their care plans should have been updated to reflect the actual fall. On 11/20/24 at 1:34 PM, the DON was made aware that the fall care plan was not updated to reflect the actual falls and that this was a concern. 45131 3)On 11/12/24 at 1:50 PM, in an interview with Resident#63, the resident stated that he/she was not included in the care planning meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 at 9:42 AM, a review of Resident #63 record revealed the following deficient practice: A review of the MDS/comprehensive assessments revealed a MDS was completed on 6/29/2023; however, there was no documented evidence that the facility conducted an interdisciplinary care plan within 7 days after the completion of a quarterly comprehensive assessment. The documentation provided showed that the next care plan meeting was completed on 9/12/2023. A review of the resident record revealed that the care plan meetings were conducted prior to the MDS assessments. On 9/23/2023 the MDS assessment was completed, however, the care plan meeting was completed on 9/12/2023 and on 12/27/2023 the MDS assessment was completed; however, the care plan meeting was completed on 12/19/2023. On 11/15/2024 at 10:23 AM, in an interview with the regional social worker (Staff #20), the surveyor requested documentation to support that the care plan meetings were completed within 7 days after the MDS assessment. Staff # 20 stated that the documents would be provided, if available. On 11/15/2024 at 10:56 AM, in an interview with Staff #20, she stated that there was no additional documentation found to explain why the care plan meetings on 9/12/2023 and 12/19/2023 were conducted before the MDS assessments were completed. She also confirmed that there was no documentation to support that Resident #63's care plan meeting was conducted in June 2023, after the MDS assessment. On 11/18/2024 at 02:45 PM, in an interview with the Director of Nursing (DON), she was made aware that after the MDS assessment on 6/29/23, the next care plan meeting was not completed as required. She stated that she would check with the MDS nurse. On 11/18/2024 at 3:14 PM in an interview with the regional social worker, she re-stated they were unable to locate the documents and had no clue why they were not completed. She also acknowledged that the care plan meetings were conducted early, and she was not sure why it was done before the MDS assessments. 4) On 11/12/2024 at 2:39 PM, in an interview with Resident #68, the resident stated he/she was not always included in his/her care planning. On 11/15/2024 at 9:45 AM, a review of Resident #68 records revealed that the resident or resident representative was not present for 3 of 6 care plan meetings conducted between October 2023 and October 2024. On 11/15/2024 at 10:23 AM, in an interview with the Regional Social worker (Staff #20), the surveyor requested additional care plan meeting documentation for the care plan meeting, and she stated that the information will be provided if available. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/2024 at 12:35 PM, in an interview with the DON, the surveyor asked the DON about the attendance of Resident #68's or their resident representative to each care plan meeting. The DON was informed of the findings, and she stated that the resident had a legal guardian, and the guardian should be in attendance to all the care plan meetings. She stated that the care plan meetings are not usually conducted without the residents or their representative present. The DON stated that Resident #68 sometimes will refuse to attend but the representative should be in attendance, either by phone or in person. The surveyor requested documentation that the guardian or resident participated in the meeting and the DON stated that she will check but she was not sure if the documentation was available. The documentation was never provided to the surveyor as requested. The DON was made aware of the above-mentioned concerns during the interview process. 51128 5)On 11/12/24 at 11:49 AM, during an interview with resident #19, the resident stated that his/her sister had phone conversations with the facility concerning his/her care but did not know how often. A review of the medical records on 11/14/2024 at 1:08 PM revealed that the care conferences on 4/30/24, 11/2/23, and 9/14/23 were held earlier than the MDS dates 5/18/24, 11/11/23, and 8/11/23. Furthermore, an MDS was completed on 7/24/2024, but there was no documentation of a care conference until 10/2/2024. 6)On 11/12/24 at 02:52 PM, an Interview with Resident #37 stated the resident had a care plan meeting in October and was unaware of any other care plan meetings. A review of Resident #37's medical records on 11 /18/2024 at 9:04 AM revealed that a Care Conference was documented on 1/29/2024 held at 10:30 AM, a sign-in roster on 10/22/2024 at 11:00 AM and no documentation for a care conference following MDS dates 4/20/2024 and 7/21/2024. In an interview on 11/15/2024 at 09:30 AM with the regional Social Worker (staff #20), was asked how often care plan meetings were held for residents. She stated that the MDS guides the care plan updates, which are documented 7 days after the MDS completion dates, and that care conferences are held annually, quarterly, and when there is a significant change. On 11/15/2024 at 10:20 AM, Staff #20 could not provide further documentation of care plans for residents #19 and #37. She stated that she could not locate further documentation of the care plan or care conferences in the PCC (electronic medical cloud) system. Staff # 20 was made aware that this is a concern. On 11/22/2024 at 09:00 AM, in an interview with another surveyor, the Director of Nursing (DON) stated that when the system popped up for the care plan due time, she let the department know they should do the care plan. The DON further stated that she is not sure about the MDS vs. Care plan timing. The DON was made aware of the concern then and acknowledged the issue with care plans.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 50904 Based on record review and interview with the facility staff and residents, it was determined that the facility staff failed to provide an activities program to meet the needs and preferences of residents. This was evident for 1 (Resident #11) of 6 residents reviewed for activities during the Medicare/Medicaid Recertification survey. The findings include: On 11/12/24 at 1:19 PM, during the initial screening of the residents, Resident #11 stated that he/ she does not participate in any activity within the facility and would like for activity staff to visit him/her in the room so that he/she can know about the kind of activity that he/she could be a part of. On 11/13/24 at 03:12 PM, in an interview with the Activities Director (Staff #6), she was asked about how activities were done with residents who were bed-bound. She stated that she does one-on-one visits. When she was asked about the activities done with Resident #11, she stated that the facility has not yet started an activity with the resident and that she stated that the resident has not been getting activities except the sunshine visits. When she was asked about what sunshine visit was, she stated it was a process where daily activities schedules were handed over to the residents. She stated that the activity at the moment favors the resident who can move about in their wheelchairs or be able to walk with little or no assistance. On the same day at 03:27 PM, Resident #11's three-month activity log was reviewed and it showed the initials of the activity staff on days that the resident read, watched the television and played puzzled games. At 03:32 PM, when she was asked about the initials on the activity dates when the activity did not take place, the Activities Director stated that activities staff document, by using their initials, whatever they saw the resident doing at each moment they pass by or dropped off the daily activity schedules. She also added that the log didn't document what activities were provided to the resident but what the resident's personal activity at the time of sunshine visits. She added that her plans going forward with residents who were bed-bound would be to have a weekly in-room activity with the resident. She stated that each weekly one-on-one visit would be maximum or 15 minutes and added that notes would be put in the binder just as the activities staff are doing for residents who can get out of their rooms. She confirmed that these activities were not currently being provided. On 11/14/24 at 09:57 AM, the surveyor informed the Director of Nursing about the concern regarding the failure to provide activities for Resident #11. She confirmed that the resident had not been participating in activities nor has he/she been doing in-room activity with staff but was not aware that a care plan was not in place. She stated that going forward, the resident would have a one-on-one visitation by the activity personnel.

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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. 43096 Based on the medical record review, resident interview, and staff interview, it was determined that the facility failed to 1) ensure that a resident (Resident #244) received appropriate care regarding dysphagia by failing to supervise and/or assist with feeding, and additionally develop a care plan for dysphagia and 2) ensure adherence to the prescribed frequency and medication administration time (Resident #37, #14). This was evident for 3 (Resident #244, #37, #14) of 38 residents reviewed during the recertification/complaint survey. The findings include: Oropharyngeal dysphagia, also known as transfer dysphagia, is a condition that makes it difficult to move food or liquids from the mouth into the esophagus. 1)On 11/21/24 at 8:50 AM, a review of complaints revealed that Resident #244's family members reported they observed the resident in August 2022 with partially chewed food on his/her lap, stuck to the side of his/her face, and food stuck in the roof of his/her mouth. They also added that they removed hardened food from the roof of Resident #244's mouth and cheek after numerous attempts. The surveyor reviewed Resident #244's medical records on 11/21/24 at 9:00 AM. The review revealed that the resident had a Speech Therapy consultation upon their admission on 7/15/2022 for dysphagia and was discharged from Speech Therapy on 7/22/22 with the recommendation of supervision/assistance at mealtime. On 11/21/24 at 9:00 AM, a review of Resident #244's MDS (Minimum Data Set: a part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 7/21/22 revealed that the resident required extensive assistance for eating. Further review of the Geriatric Nurse Aide (GNA) task for August 2022 revealed that ADL (activities of daily living) eating coded x for 8/01/22- 8/03/22, blank for 8/05/22-8/6/22, 0- independent for 6 times, 1- supervision for one time, 4- total dependence for 3 times from August 1st2022 to August 12th 2022. During an interview with the Speech therapist (Staff #29) on 11/21/24 at 10:16 AM, the surveyor reviewed Resident #244's speech therapy discharge summary dated 7/22/22 with Staff #29. She said, I was not here that time, but the documentation showed that the resident required supervision or assistance for dysphagia to prevent aspirations. Also, she confirmed that the therapy team discussed residents' issues with nursing departments when they needed further care for their health condition. During an interview with Geriatric Nurse Aide (GNA #30) on 11/21/24 at 11:35 AM, she stated that if she assigned any resident who needed supervisor or assistance for feeding, she was supposed to monitor them while eating and check their appearance to make sure no left-over food around them including in the mouth for their safety. On 11/21/24 at 11:40 AM, the surveyor reviewed Resident #244's care plan. The care plan did not have anything for the resident's dysphagia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 11/21/24 at 11:45 AM, the DON informed that Resident #244's GNA task review revealed that the resident's eating was not supervised or assisted, which was not followed by the Speech Therapist's recommendation. Also, there was no care plan for dysphagia. The DON confirmed that the care plan should be developed for their dysphagia. She validated the concerns. 51128 2)During an interview with Resident #37 on 11/12/24 at 2:44 PM, the resident stated that he/she filed a grievance on 7/2024 concerning his/her Finger sticks performing time and medication not being given on time. The medical record for resident #37 was reviewed on 11/14/2024 at 12:34 PM. The review revealed a physician's order for blood sugar to be checked before meals and bedtime and for insulin to be administered based on the parameters of the blood sugar readings. A review of the medication administration record revealed that on 7/16/2024, the blood sugar check was scheduled for 5:30 PM but was documented at 7:02 PM. Additionally, the blood sugar scheduled for 9 PM was documented at 10:57 PM and the resident's blood sugar level was documented at a high of 300. On 11/15/2024 at 10:09 AM, a review of the grievance packet outlined the investigation conducted by the Nursing Home Administrator (NHA) concluded that the nurse administrated Resident #37's medication on 7/16/24 verified that the insulin was administered late. An Interview with a nurse (staff #3) was conducted on 11/15/2024 at 10:32 AM. Staff #3 stated that he obtained Resident #37 blood glucose levels before the resident ate his/her dinner meal. Upon returning to give insulin coverage to the resident, Resident #37 was not in the room. Staff #3 stated that he did, in fact, administer the insulin late. 3) An interview was conducted on 11/14/24 at 2:55 PM with Resident #14, who stated that all his/her evening and night medications were administered earlier than scheduled. The resident stated that receiving his/her medications at that time caused him/her not to be able to sleep. A review of the medication administration records on 11/20/24 at 09:01 AM identified that on 10/11/2024, Resident #14's medication scheduled for 3:00 PM, 5:00 PM, 7:00 PM, 9:00 PM, and 10:00 PM were all administered at 3:44 PM. On 11/22/24 at 08:26 AM, an Interview was conducted with Licensed Practical Nurse (LPN #18) concerning the time periods of medication administration. LPN #18 stated that most medications were given at 10 AM and 10 PM at 1/2 hour before or 1/2 hour after the scheduled time.

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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. 49409 Based on a complaint, observation, resident and facility staff interviews, and medical record review, the facility failed to prevent new pressure ulcers and document weekly skin and wound assessments for residents with pressure ulcers. This was evident for 1 (Resident # 246) out of 2 residents who were reviewed for pressure ulcer prevention and treatment during the recertification/complaint survey. The findings included: A pressure ulcer, also known as a pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). An unstageable pressure ulcer is a type of bed sore that occurs when full-thickness skin and tissue are lost, but the extent of the damage is obscured by slough or eschar. On 11/14/24 at 01:56 PM, Interview with the resident # 246 revealed that the resident was told that he/she could not get out of bed due to the wound vac treatment. On 11/14/24 at 2:10 pm, an interview with GNA #52 revealed that resident #246 had not gotten a shower since he/she has been at the facility, but the resident can wash his/her upper body. On 11/14/24 at 1:30 pm, a medical record review revealed that the weekly skin assessments for three weeks on 10/24/24, 10/31/2024, and 11/14/24 were not documented. On 11/19/24 at 9:30 am a medical record review revealed that resident #246 had physician orders to change wound vac dressing to sacrum on Tuesdays, Thursdays, Saturdays and PRN, and if unable to reapply wound vac, remove wound vac dressing and apply wet to dry dressing as needed. On 11/21/24 at 10:24 AM, an interview with the unit manager, staff #19, revealed that the wound vac dressing/sealing often came off, but only selective staff could assist with the wound vac. Most evenings and weekends, when dressing issues arise, the staff uses wet-to-dry dressing. The unit manager validated that the wound vac came off on 11/06/24 at 10 PM, and the staff had to wait until the next day to return the wound vac. On 11/21/24 at 11:26 AM, an Interview with the Registered Nurse, staff #50, stated that there were at least 3 occasions that the outgoing staff would give the report that the wound vac was off from the 3-11 shift and the 11-7 shift. On 11/21/24 at 11:26 AM, an Interview with the Nurse Practitioner, staff # 53, revealed that the resident was not seen by the wound care practitioner weekly. A new unstageable pressure ulcer developed and was noticed by the Nurse Practitioner/ wound care provider on 11/14/24. Staff # 53 had seen the resident three weeks prior to this visit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1:30 AM, a medical record review revealed that the weekly skin assessments for three weeks on 10/24/24, 10/31/2024, and 11/14/24 were not documented. On 11/21/24 at 12:00 PM an interview with the Director of Nursing (DON) confirmed that few nursing staff are good at managing wound vac care, and DON was planning to bring a provider to do an in-service on wound vac management and wound care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43096 Based on a review of the resident medical records and an interview with facility staff, it was determined that the facility failed to address a significant weight loss for the resident. This was evident for 1 (Resident #238) of 7 residents reviewed for nutrition during this survey. The findings include: During a review of complaints on 11/19/24 at 11:00 AM, it was noted that Resident #238 had significant weight loss from 8/05/22 (258.8 pounds via mechanical lift) to 8/18/22 (194.3 pounds via mechanical lift): 64. 5 pounds, 24.9% loss, within 13 days. The following body weight was recorded on 9/02/22 as 198.3 pounds. A review of Resident #238's medical records on 11/19/24 at 11:15 AM revealed that the previous dietitian (Staff #39) wrote a progress note on 8/29/22 as possible significant weight loss- requested reweigh. Recommendations: continue regular diet with mechanical soft/ honor food preferences as much as able/ encourage intake and assist as needed/ continue liquid protein/ re-evaluate weight when reweight is available. However, there was no additional documentation from the dietitian or nursing staff to notify providers and family members regarding Resident #238's significant weight loss. On 11/19/24 at 12:06 PM, an interview was conducted with a dietitian (Staff #23). Staff #23 explained that a difference of more than 5 pounds in residents' body weight would be noted to nursing staff and ideally reweighted within 24 hours. She also said, Significant weight loss should be reported to the provider and their family member and discussed in our weekly risk meeting. During an interview with a Licensed Practical Nurse (LPN #19) on 11/20/24 at 1:35 PM, he confirmed that nursing Aides would check residents' body weight and report them to nurses. LPN #19 said, Any issue regarding body weight would be discussed with the provider and be documented in a progress note. In an interview with the Director of Nursing (DON) on 11/20/24 at 1:59 PM, she stated that she expected residents reweight to perform as soon as possible. The DON recalled that Resident #238 had significant weight loss since the resident was not eating well when he/she had weight loss. The surveyor shared concerns regarding Resident #238's significant weight loss with delayed follow-up and no documentation on how they reported to the provider and family members. She validated the findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42507 Based on observation, medical record review, and interview, it was determined the facility staff failed to date and label oxygen administration equipment and maintain a nasal cannula in a sanitary manner to prevent potential infection . This was evident for 2 (#39, #74) of 3 residents reviewed for respiratory care during a recertification/complaint survey. The findings include: Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 11/12/2024 at 10:18 AM, the surveyor observed Resident #39 lying in bed. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to an oxygen concentrator set at 3LPM (liters per minute). The LPM oxygen flow rate of 3 indicates that 3 liters of oxygen should flow into the resident's nose in 1 minute. However, the oxygen tubing/ nasal cannula and humidifier bottle were not dated. When asked, the resident was unable to recall when the oxygen tubing was last changed. On 11/12/2024 at 11:12 AM, Licensed Practical Nurse, LPN #14 observed and confirmed that the Oxygen tubing and humidifier bottle were not dated. On 11/12/2024 at 11:24 AM, both the Assistant Director of Nursing (ADON) and E-Wing Unit Manager (UM #15) observed and confirmed that the Oxygen tubing and humidifier bottle were not labeled with date and time they were changed. UM #15 stated that the oxygen tubing and humidifier bottle should be labelled with the date it was changed. She added that night shift (11 PM- 7 AM) nurses were responsible for changing the Oxygen tubing. However, she proceeded to change the Oxygen tubing and dated the new tubing and humidifier bottle. During a review of Resident #39's medical record conducted on 11/14/2024 at 10:26 AM, surveyor noted an active physician orders dated 11/19/2023 to: Change O2 Humidification Bottle as needed, and Change O2 and Neb tubing as needed label with time, date and initials. On 11/14/2024 at 10:40 AM, review of Treatment Administration Record (TAR) for November 2024 did not reveal staff documentation that O2 and Neb tubing were changed, labeled with time, date, and initials, and/or O2 humidification bottle was changed as needed. On 11/14/2024 at 11:01 AM, a review of Resident #39's care plan reveal no focus on Oxygen therapy with goals and interventions/tasks. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/2024 at 3:54 PM, in an interview with the Director of Nursing (DON), surveyor reviewed resident's orders for Oxygen, staff documentation on the MAR/TAR for November 2024, oxygen care plan, and surveyor's observations on 11/12/2024. DON stated that she was aware of the staff not labeling the oxygen tubing/humidifier bottles. She verified and confirmed that facility staff were not documenting whether they were changing the Oxygen tubing and humidifier bottle. She stated that she was going to write up all the night shift (11 PM-7 AM) staff as they were responsible for changing the Oxygen tubing per facility policy. DON reviewed the resident's care plan and confirmed that it failed to address oxygen therapy. However, she stated that she was going to revise the care plan to reflect Oxygen therapy with specific goals and interventions. 45131 2) On 11/13/2024 at 11:14 AM, an observation of Resident #74's room revealed an opened oxygen tubing set laying on the bedside table, but it was not labeled, and the oxygen tank machine was off. The oxygen tubing set included a nasal cannula (a device with prongs that insert into a patient's nostrils). The prongs of the nasal cannula were in direct contact with the bedside table and was not protected from contamination. The nebulizer machine on the bedside dresser was attached to a face mask, which was also not labeled. The face mask was also out in the open, unprotected from the environment. On 11/13/2024 at 11:14 AM, in an interview with Geriatric Nursing Assistant (GNA)#25, the surveyor asked if the resident was still using oxygen, and she stated that Resident #74 was weaned off the oxygen. On 11/18/2024 at 10:42 AM, a second observation of the resident's room revealed the resident resting in bed on room air and breathing was unlabored. The oxygen tubing was now laying on top of the oxygen tank, still unprotected from contamination. The nebulizer mask (labelled 11/16/2024) was observed laying on top of the bedside dresser. The mask and tubes were still not stored in a sanitary environment. On 11/18/2024 at 10:43 AM, in an interview with Resident #74, the resident was resting in bed in room air, breathing unlabored. When asked if he/she was still using the oxygen, he/she stated occasionally. The resident stated the oxygen was last used yesterday. On 11/19/2024 at 9:48 AM, a review of the physician's order written on 9/23/2024 revealed oxygen at 3L continuously to keep O2 above 90% every shift. On 10/8/2024 a physician order stated, wean off of oxygen to try to keep sats 93% and above on RA every shift. On 11/19/2024 at 10:00 AM, a review of Resident#74's progress notes revealed that, on 11/16/2024, 3 liters of oxygen was administered due to low oxygen status; therefore, oxygen was in use intermittently. On 11/19/2024 at 11:06 AM, a third observation of the resident's room revealed that the resident's oxygen tubing was laying on the floor connected to the oxygen tank. The nebulizer mask was labeled for 11/16/2024 but the mask was laying on top of the side dresser. The surveyor's observation revealed that the respiratory care equipment was not maintained in a sanitary environment on 3 different occasions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/2024 at 11:06 AM, in an interview with Registered Nurse (RN)#15, RN #15 was shown the oxygen and nebulizer treatment tubing and she stated that the nebulizer tubing should be in a bag and labeled. She also acknowledged that the oxygen tubing was laying on the floor. She stated that the tubes should be labeled and stored in a clean bag when not in use. She stated that the tubing should be changed weekly on the 11pm-7am shift. On 11/19/2024 at 2:55 PM, in an interview with Licensed Practical Nurse (LPN) #32, she was asked about the resident's use of oxygen. LPN #32 stated that the resident was weaned off oxygen and she was unaware that Resident #74 was still using oxygen intermittently. She stated that the resident's oxygenation status was being checked every shift and that the resident was doing well on room air. LPN #32 was in charge of the resident's care and she was made aware of concerns found with the oxygen tubes and she stated that the tubes were changed and labeled. On 11/21/24 at 12:35 PM, in an interview with the Director of Nursing (DON), the surveyor informed the DON about the above-mentioned respiratory care findings. The DON stated that the facility's policy required that the oxygen tubes were changed every Thursday on the 11pm to 7am shift. She stated that the nurses were aware of the policy, and they will all be re-educated as a result.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 51128 Based on record review and interviews, it was determined that the facility failed to ensure that all nursing staff had competency evaluations. This was evident for six (Licensed Practical Nurses #19, #40, #41, Geriatric Nursing Aides #42, #43, and #44) of the six randomly selected nursing staff reviewed for competencies. The findings include: The American Nurses Association defines nursing competence as an expected level of performance that integrates knowledge, skills, abilities, and judgment. A review of the employee training files on 11/19/2024 at 9:39 AM revealed the following: 1. Licensed Practical Nurse (LPN) #19 was hired in May 2023. No competency evaluation was found for LPN #19 for 2023. 2. LPN #40 was hired on 10/09/2023. No competency evaluation was found for LPN #40. 3. LPN #41 was hired on 8/11/2022. No competency evaluation was found for LPN #41 in 2023. 4. Geriatric Nursing Assistant (GNA) #42 was hired on 12/27/2017. There were documented competencies for 4/2021 and 3/2022, but no competencies evaluation for 2023 for GNA #42. 5. GNA #43 was hired on 1/28/2013. Competency evaluation was found for 1/2020, 3/2021, 3/2022, but no competency evaluation was documented for 2023 for GNA #43. 6. GNA #44 was hired on 1/02/2023. No competency evaluation was found for GNA #44. On 11/19/2024 at 11:48 AM, the Staffing Coordinator (staff #24) was asked about staff training and competencies. She stated that during onboarding, the staff was given a packet of training to be conducted by the Assistant Director of Nursing (ADON) or Director of Nursing (DON), who was also responsible for competencies. An interview was conducted on 11/19/2024 at 4:08 PM with the ADON, who stated that competency training was not being done. On 11/22/2024 at 08:36 AM, the DON was made aware of staff competency training concerns.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 51128 Based on a review of employee records and interviews, it was determined that the facility staff failed to conduct performance reviews of Geriatric Nursing Assistants (GNAs) and Licensed Practical Nurses (LPN) at least once every 12 months. This was evident for 3 (GNA #42, #43, #44) and 2 Licensed Practical Nurses (#19, #41) of 6 randomly selected nursing staff records reviewed for annual training requirements during the recertification/complaint survey. The findings: On 11/19/20/24 at 9:39 AM, a review of randomly selected GNA's records revealed that GNA #42 was hired on 12/27/2017. Further review of his/her personal file failed to produce a record of his/her annual performance review. GNA #43 was hired in 2013, and GNA #44 was hired on January 2023, and their last documented evaluation was on 1/22. LPN #19 was hired on May 2023, LPN #40 on 10/9/2023, and LPN #41 in August 2022. There were no documented evaluations at the time of this record review. On 11/19/2024 at 3:47 PM, the surveyor requested copies of the annual evaluations for LPN #40, LPN#41, and GNA #44 from the Director of Nursing (DON). Without hesitation, the DON stated that she could not provide this information because the annual evaluations were not being done, and they have identified this as an issue that will be addressed at their Quality Assurance and Performance Improvement (QAPI). She was immediately made aware that this was a concern.

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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. 42507 Based on observation and interview it was determined facility staff failed to remove expired medications and patient supplies. This was evident on 2 of 4 nursing units and a central supply room observed during a recertification/complaint survey. The findings include: On 11/19/2024 at 11:35 AM, B/C-Wing med room was reviewed for medication storage and labeling in the presence of B-Wing Unit Manager (UM #19). Surveyor found the following expired supplies in the med room: - Derma Daily Moisturizing lotion with Aloe Vera: lot #20668A, Expiration date 07/24 - Derma Daily Moisturizing lotion with Aloe Vera: lot # 20520A, Expiration date 6/24 UM #19 confirmed the findings and immediately removed the expired supplies from the med room. On 11/19/2024 at 11:50 AM, surveyor reviewed medication storage and labeling for B-Wing OMNICELL room in the presence of UM #19. OMNICELL is a smart medical storage unit equipped with sensors and technology to monitor inventory, track expiration dates, and streamline medication management. The following expired medications were found in the refrigerator in the OMNICELL room: - Basaglar Kwik Pen (Insulin): lot #D557879C, expiration date 10/18/2024 - Basaglar Kwik Pen (Insulin): lot #D534923A, expiration date 8/3/2024 UM #19 confirmed the findings and stated that the expired Insulin pens were from their old pharmacy, Pharmscript. He immediately removed the expired medications from the refrigerator and stated that he was going to notify the Director of Nursing (DON). On 11/19/2024 at 12:00 PM, observation was made of the Central Supply room, in the presence of UM #19: The following items were found expired: - Two (2) bottles of sealed/unopened bottles of Stomahesive Protective powder: lot # 1L022, expiration date 11/01/2024. UM #19 verified and confirmed that the above listed items were expired and immediately removed them from the central supply room. On 11/19/2024 at 1:40 PM, surveyor reviewed D/E Wing med room for medication storage and labeling in the presence of E-Wing Unit Manager (UM #15). The following expired medications were found in the D-Wing Nurse Cart in the med room: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Three (3) vials of sealed/unopened Midazolam 10mg/2ml for Resident #35 found in the locked drawer of the nurse cart: Expiration date 4/1/2024. - One (1) bottle of Senna Syrup 8fl oz. (237ml) floor stock: Expiration date 4/24 - Four (4) Ondansetron 4mg tablets in a blister pack for Resident #49: Use by date 6/19/2024. On 11/19/2024 at 2:05 PM, surveyor reviewed medication storage and labeling for D-Wing CMA (Certified Medicine Aide) med cart in the presence of UM #15. The following floor stock was found expired in the med cart: - One (1) bottle of sealed/unopened Acidophilus lactobacilli Probiotic 200 capsules: Lot #363491, Expiration date 09/24. UM #15 verified and confirmed surveyor's findings regarding the above expired meds. She immediately removed the expired meds and stated she was going to discard them. On 11/20/2024 at 1:04 PM, In an interview with the DON, surveyor shared concerns regarding findings of expired meds/supplies during Medication Storage and Labeling review on 11/19/2024. DON stated she was going to follow up with the staff.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 45131 Based on complaint #MD00206921, complaint #MD00199493, resident interviews and staff interviews, it was determined that 1) the facility failed to provide sufficient food of adequate quality to meet residents' dietary needs and preferences which has the potential to affect all residents in the facility, and 2) the facility failed to ensure diabetic residents received snacks to meet their dietary needs which was evident in 1 (anonymous resident) of 3 Residents reviewed for meal accuracy during the recertification survey. The Findings Include: 1)On 11/12/2024 11:49 AM, in an interview with Resident#19, the resident stated that when he/she does not like the food served at the facility, he/she orders a salad or grilled cheese sandwich, but it was not always available. On 11/12/2024 01:52 PM, in an interview with an anonymous resident, the resident stated that residents were not provided with snacks. The resident also stated that some of the meals received were not the food choices on the menu that were filled out. On 11/13/2024 at 3:42 PM, in an interview with Resident #21, the resident stated that he/she was not given enough food and that the kitchen doesn't stick to the menu. Resident #21 stated that the dinner rolls were served very close to getting bad or old; they offered bread, but the edges were usually tough, and garlic bread was not available, and they will use slices of bread with garlic on them instead. She stated that the quality of food was not good. On 11/19/2024 at approximately 2:15 PM, a review of complaint #MD00206921, revealed the following statement, it is difficult to help the residents maintain a good quality of life when the corporate team will cancel food orders and we go without things like mayo, ketchup, tartar sauce, applesauce etc. They send the wrong meats and dietary has to scramble. On 11/21/2024 at approximately 9:00 AM, a review of complaint #MD0199493, revealed the following statement, my mother and the rest of the residents were being fed poor quality food. The food isn't the same as on the menus, and the cheese is hard and [moldy]. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/21/2024 at approximately 12:05 PM, in an interview with Staff #102, the staff revealed that the Food service department was responsible for ordering food supplies prior to the new management. The staff revealed that new management has provided the food service department with a preselected list of food items to choose from, and that the food must now be procured through an intermediate procurement company rather than straight from the food supplier. Staff #102 stated that the options being provided were bottom tier. Staff #102 stated that the food service department was unable to get certain food items; for example, if an item on the pre-selected list was not available, and a substitution was ordered from the approved substitution list, and that item was also unavailable, then the items would not be delivered to the facility, and the facility would not be notified of the issue. Subsequently, the posted menu items would be unavailable to the residents. Staff #102 stated that sometimes the food service staff members try to supply the residents' needs by going to a local grocery store; however, the local grocery stores were unable to supply the quantity of items needed for the facility and the residents' preferences were not met. On 11/22/2024 at approximately 11:30 AM, The Director of Nursing was notified of the above-mentioned findings, and she stated that the issues will be discussed with the food service department. 51128 2) On 11/12/24 at 02:47 PM, during an interview with an anonymous resident, the resident stated that she/he was not getting his/her diabetic snacks as scheduled. The medical record review on 11/14/2024 at 11:56 AM documented an order for the resident to receive a peanut butter and jelly sandwich (PBJ) and juice every evening shift related to his diabetic diagnosis. Further review of the Treatment Administration Record from August 2024 to current on 11/14/24 at 12:30 PM indicated no documentation of snacks was provided to the residents on 8/26, 9/13, 10/5, 10/10, 10/11, 10/12, and 10/20. Further review of the resident's progress note revealed that a nurse wrote a note on 11/2/2024 at 7:58 PM that no sandwiches were delivered from dietary. On 11/15/2024 at 10:30 AM, the beverage aide (staff #22) was interviewed. When the surveyor asked how the diabetic snacks were delivered to the unit, the beverage aide stated that all unit snacks were delivered to the nurse's station and put away by unit staff. She stated that snacks are delivered in the afternoon for the night and following morning and midday snacks. The beverage aide also said she was unaware of a list of residents who should get a diabetic snack and was unsure about individualized snacks. On 11/18/2024 at 10:48 AM, the Dietitian (Staff #23) was interviewed about diabetic snacks. She stated that there was a profile list of diabetic residents in the facility who got snacks. Snacks were individualized and delivered at 10 AM, 2 PM, and hours of sleep (HS). She stated that the nursing staff was responsible for documenting the administration of snacks to the residents and would notify the dietitian if snacks were not being delivered. The dietitian further stated that no tracker was in place to ensure snacks were delivered to the unit. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/18/2024 at 10:52 AM, the surveyor shared the concern with Staff #23, who acknowledged understanding and noted that the plan is to implement a tracking tool at the facility. On 11/22/2024 at 08:36 AM, the Director of Nursing (DON) was made aware of this concern.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45131 Based on the kitchen tour and staff, it was determined that the facility failed to ensure that stored food items were labeled and were not expired. This deficient practice has the potential to affect all residents in the facility. The Findings Include: During the initial kitchen tour on [DATE] with the Food Service Director (FSD, Staff #12), the following deficient practices were revealed: On [DATE] at 9:23 AM, observation of the walk-in refrigerator revealed: a large open container of salsa was dated [DATE] but also had a handwritten facility label of [DATE]; a large open container of sour cream best-by date of [DATE]; a 5lb bag of cubed potatoes unlabeled; a 2lbs of open pasteurized liquid eggs undated; and a bag of mixed salad open and undated. On [DATE] at 9:30 AM, observation of the walk-in freezer revealed the following items that lacked labels and were not dated: a bag of frozen pork patty; a bag of frozen rib steaks; a bag of Salisbury steak; a bag of frozen meatballs; 2 open bags of hot dogs; a bag of unknown meat; a ripped open bag of potato tots; 2 corn dogs; a bag of unknown red meat; a bag frozen soup; a bag of frozen pork; 3 open bags of frozen vegetables that were stored in a 20-gallon container. On [DATE] at 9:43 AM, observation of the dry storage room revealed: a large open undated bag of rice crispy treat cereal; a large undated open bag of cornflakes cereal; a large undated open bags of cheerios cereal; a 20 liter of plastic jar of rice, unlabeled and undated; an open 3lb bag of potatoes granules per Staff#12, and an unlabeled bag of croissants. During the tour, Staff #12 was interviewed about the findings in the dry storage, refrigerator, and freezer. The Staff #12 acknowledged that all items should be labeled and not expired. She removed items of concern that were identified during the tour. On [DATE] at approximately 11:30 AM, The Director of Nursing was notified of the above-mentioned findings, and she stated that the issues will be discussed with the food service department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215083	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroline Nursing and Rehab	520 Kerr Avenue Denton, MD 21629

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50904 Based on observation, review of resident medical records, review of facility policy, and interview with facility staff, it was determined that the facility failed to ensure that 1) physician's order for appropriate infection control signage with a COVID-19 positive resident was implemented, 2) follow-up tests were conducted for residents exposed to COVID-19, and 3) failed to ensure that a resident known to be positive for Covid-19 was isolated upon readmission as the resident was readmitted directly into original room with roommate.This was evident for 1 resident(Resident #55) out of 2 residents reviewed for Isolation precautions during the recertification/complaint survey. The findings include: On 11/13/24 at 08:29 AM, during a tour of the facility, the Surveyor observed an Enhanced barrier precaution sign on room D-5 and observed that there were two residents in the same room. On the same day at 08:40 AM, the surveyor asked Licensed Practical Nurse (LPN #14) why the door sign was there. She stated that Resident #55 was on enhanced barrier precaution due to being positive for COVID-19. She was further asked if the roommate was also positive for COVID-19 to which he responded with, No, just Resident #55 but that roommate (Resident #49) was just exposed. On the same day at 10:56 AM, the surveyor reviewed Resident #55 orders and it stated Strict Isolation: contact and droplet precautions in place, resident remains alone in room without roommate, all services and meals brought to resident's room every shift for 10 Days from 11/4/2024 to 11/14/2024. On the same day at 11:14 AM, the surveyor reviewed the facility's Infection Prevention Control Policy which showed that: COVID-19 Testing: a) Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. b) Asymptomatic residents with close contact with someone with SARS-Co V-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. On the same day at 11:30 AM, the surveyor reviewed Resident's #49's electronic health record and discovered that he/she was only tested on the first day(day 0) that the facility was aware of Resident #55's covid-19 status and was never tested on day 3 and day 5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 11:41 AM In an interview with the Director of Nursing (DON), she stated that Resident #55 had a headache on 11/04/2024, was sent to the hospital and returned to the facility with a COVID-19 positive status on the same day and was admitted to the same room he/she was in with /his/her roommate prior to going to the hospital. The DON explained to the surveyor that Resident #49 was tested for Covid-19, the result negative but that his/her daughter had requested for her parent and Resident #55 who was positive to Covid-19 and still in isolation to be together. When it was asked if it was a normal practice for the facility to have a covid positive resident and a covid-19 negative resident to be together in the same room, she stated the facility separates Covid-19 positive residents and exposed residents, and that it was the first time the facility did not separate such residents. When she was asked for proof of Resident's #49's request, she stated that it was not documented and that it was an oversight. When she was asked about the door sign that showed enhanced barrier precaution instead of contact and droplet precaution, she added that the Assistant Director of Nursing(ADON) should have changed the door sign to contact and droplet precaution, going by the attending physician's order and that it would be done immediately. When she was asked what the facility's standard of practice was in regards to testing a resident who was exposed to covid, she stated that such resident is tested on Day1, Day 3 and Day 5.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51128 Based on record reviews and interviews, it was determined that the facility failed to ensure that all Geriatric Nursing staff had competency evaluations. This was evident for three (Geriatric Nursing Aides #42, #43, and #44) of the three randomly selected nursing staff reviewed for competencies. The findings include: The Center for Medicare and Medicaid Services requires that nurse aides receive at least 12 hours of in-service training annually. This training should cover topics such as dementia management, resident abuse prevention, and other topics relevant to maintaining competency in their role. A review of the employee training files on 11/19/2024 at 9:39 AM revealed the following: 1. Geriatric Nursing Assistant (GNA) #42 was hired in December 2017. There were documented competencies for 4/2021 and 3/2022, but no competencies evaluation for 2023 for GNA #42. 2. GNA #43 was hired in January 2013. Competency evaluations were found for 1/2020, 3/2021, and 3/2022, but no competency evaluation was documented for 2023 for GNA #43. 3. GNA #44 was hired in January 2023. No competency evaluation was found for GNA #44. On 11/19/2024 at 11:48 AM, the Staffing Coordinator (staff #24) was asked about staff training and competencies. She stated that during onboarding, the staff was given a packet of training to be conducted by the Assistant Director of Nursing (ADON) or Director of Nursing (DON), who was also responsible for competencies. An interview was conducted on 11/19/2024 at 4:08 PM with the ADON, who stated that competency training was not being done. On 11/22/2024 at 08:36 AM, the DON was made aware of staff competency training concerns.