STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215084	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patapsco Healthcare	9109 Liberty Road Randallstown, MD 21133

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 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. 50904 Based on a review of facility investigative material and interview with facility staff, it was determined that the facility failed to ensure that residents remained free of abuse. This was evident for 1 (Resident #151) out of 2 residents reviewed for abuse during the survey. The findings include: The facility's investigation related to facility reported incident MD00198074 was reviewed on 09/24/24 at 12:10 PM. The review revealed that the facility incident report indicated that on 10/03/23, a nurse that was assigned to the floor had made an allegation to the Director of Nursing of staff-to-resident abuse. The incident also stated that Geriatric Nursing Assistant (GNA) #57 was in the hallway collecting all the trays, and Resident #151 had a plate full of food. He/she was taking it down the hallway and the GNA #57 asked the resident, Can I have the plate please, and h/she ignored the GNA. GNA#57 repeated herself and grabbed the plate. Then, the resident took a handful of food and put it down GNA #57's shirt. The GNA said that it was her instinct to get the resident off her, so she pushed the resident off and the resident fell . The alleged incident occurred on 10/03/2023 and the Director of Nursing, DON was notified at 01:31 PM while the Administrator was informed at 2:00 PM and the initial report was sent to the state agency. On the same day, the facility also notified the law enforcement agency, ombudsman and physician. The GNA was suspended immediately pending further investigation and was terminated verbally on the same day. GNA#57 was also reported to the board of nursing. The final investigation report was sent to the State agency on 10/10/2023. On 09/24/24 at 1:10 PM in an interview with Human Resource Manager Staff #32, when surveyor asked why GNA #57's employment was terminated, she stated that GNA #57's employment was terminated because of a substantiated allegation of abuse. She stated that termination of the alleged staff member was done verbally after the staff admitted that she pushed the resident. She also added that a termination letter was not given because the investigation was completed almost immediately after the incident, and she provided a copy of the timesheet for that day which revealed that GNA #57 clocked out at 2:30PM on 10/03/2023 and did not work afterwards.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21859 Based on medical record review and interview with facility staff and resident family members, it was determined that the facility failed to maintain accurate Controlled Drug Receipt/Record/Disposition and an environment that was free of misappropriation of property. This was evident during the review of 2 of 8 (Resident # 101, #104) residents reviewed during the survey. The findings include: A controlled drug log is delivered with the controlled medication. The log is completed as the medication is administered and once the medication is completed the form goes into the resident's medical record. Each form is designated to the packet of medications that it was delivered with. On a controlled drug log, the date the medication is delivered, the resident name, medication, amount that is delivered, dosage, and administration orders are all noted at the top of the form. As medication is administered, staff are to document date/time, dose, amount wasted if applicable, administered by, and amount remaining. Once a medication has been administered in its entirety, staff need to reorder the medication, and a new Controlled drug log will also be delivered with the corresponding medication. 1. Facility reported incident MD00204258 was reviewed on 9/19/24 at 10am. According to the facility's investigation, on 4/1/24 RN (Registered Nurse) staff # 54 notified the Nursing Supervisor staff #57 and the physician at 10:30am, and the (DON) Director of nursing (staff # 2) at around 1:35pm, that resident #101 asked for PRN (as needed) medication oxycodone 15mg and it was noticed that the medication and medication count log was not on the medication cart. According to the facility investigation on 4/1/24 during an interview with the night shift (11pm-7am) nurse RN (staff #55) stated she received 30 (15 milligram) tablets of Oxycodone for resident #101 from pharmacy on 3/31/2024 in which she placed the new blister package (medication) in the narcotic box along with placing the log in the narcotic book. According to staff #55, Resident #101 had two tablets left in the previous blister pack in which during her shift on 3/31/24 at approx. 5:45pm and 9:50pm Resident #101 received the medication. Once the blister pack was completed, she stated she updated the narcotic book with the updated narcotic count. Staff #55 stated that she properly completed the narcotic count with the oncoming day shift (7am-3pm) nurse RN (Agency nurse) staff #56; However, review of the Narcotic count sheet revealed that staff #54 completed the narcotic count with the oncoming day shift staff #56. Continued review of the facility investigation revealed during an interview with Resident #101 on 4/1/24. The resident stated s/he received Oxycodone oral tablet 15mg last on 3/31/2024 around 9:50pm. Throughout the night s/he slept and did not request another dose until 4/1/24 dayshift approx. 10:30am. At that time the nurse advised Resident #101 he had to contact the physician because he did not see the medication. According to the investigation the resident received three 5mg tablets of oxycodone at 10:45am. During an interview with the DON and the Administrator on 9/19/24 at 3pm the findings were verified. The Administrator stated after reviewing the camera footage the conclusion was that Agency staff #56 removed the oxycodone medication from the medication cart and the medication count sheet from the medication book. She stated all nurses that were involved in this incident were terminated and Agency staff #56 was reported to the board of nursing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49304 2. Resident #104's resident representative was interviewed on 9/17/24 at 11:48 AM. He/she stated the resident's top and bottom dentures have been missing for about one year. Resident #104's resident representative stated in a meeting with the Ombudsman, the facility said he/she had canceled Resident #104's dental insurance. Resident #104's resident representative stated they never canceled the dental insurance and was then given a packet from the facility of forms to fill out. When the resident representative contacted the dental insurance company from the packet, they were told the dental insurance company was not contracted with the facility. After that, the resident representative reported speaking to Unit Manager (UM#24) along with forwarding him the email from the dental insurance company. The resident representative reported that UM #24 stated he shared that information with the Nursing Home Administrator (NHA) who said she would look into it, but the resident representative has not heard anything since. During the interview, the resident representative also stated that Resident #104 has been missing his/her hearing aids for about 8 months and this concern was shared with Resident Success Manager #29. Resident #104's resident representative stated they were his/her only pair so he/she should be eligible for a replacement. Review of the medical record for Resident #104 on 9/17/24 at 2:10 PM revealed Resident #104 with a documented Brief Interview for Mental Status (BIMS) of 1 out of 15, which indicates the resident had severe cognitive impairment. Further review revealed the resident had multiple diagnoses including dementia and a care plan that documented Resident #104 had the potential for oral/dental health problems related to edentulous (having no teeth) status. Documented interventions in the care plan included to monitor/document/report as needed any signs and symptoms of oral/dental problems needing attention and to provide mouth care. Continued review of the medical record revealed a care conference note dated 4/19/24 that stated, quarterly care plan meeting was held with resident and Power of Attorney (POA) at bedside. POA expressed her concern about denture she had reported two months ago, and she needed a response from facility administration. Facility administrator agreed to follow up and update her. Further review revealed an Attending Physician Request for Services/Consultation for Resident #104 for denture fitting from Medical Doctor #71 with UM #24 as the nurse who took the order, dated 6/7/24, and a Hearing Aid/Assistive Listening Device Delivery Receipt & Purchase Agreement that documented a left and right hearing aid were delivered to the facility on [DATE]. On 9/18/24 at 1:25 PM in an interview with Geriatric Nursing Assistant (GNA #60) she stated she is Resident #104's GNA and confirmed Resident #104 used to have dentures on the top. She also confirmed that Resident #104 had hearing aids and stated, they each had a small loop and were on a wire to keep them from getting lost. One morning, GNA #60 went to provide Resident #104's care and one was missing. Then GNA #60 went on vacation and came back, and the other one was missing. When GNA #60 asked other staff about the hearing aids, she reported everyone said something different, but the hearing aides were gone. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 9:37 AM Unit Manager (UM#24) and the Director of Nursing (DON) were interviewed. During the interview, UM#24 stated the resident did have dentures when he started working at the facility about 1 year ago and that the GNAs would clean Resident #104's dentures. He also confirmed Resident #104 had hearing aids and it has been since about October 2023 that they did not have them. The DON stated when she started working at the facility, facility staff confirmed that Resident #104 had dentures, but she had never seen the resident with dentures. The DON then stated the resident's representative canceled his/her dental insurance, so when the facility was trying to get them replaced, he/she did not have insurance and the resident's representative had to reapply for dental insurance. Finally, the DON stated we do need to follow up with the dental provider from the packet not being contracted with the facility, but everything else was followed up on. At the time of survey exit, Resident #104 still did not have dentures or hearing aids.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863 Based on surveyor review of a facility reported incidents, review of medical records, and family and staff interviews, it was determined that the facility failed to report and submit facility related incident reports (FRI) to OHCQ related to injury of unknown origin, serious bodily injury, elopement, misappropriation of resident property and potential employee related abuse towards a resident within the required two-hour framework and failed to submit a follow up investigation report within 5 days. This was evident 9 (Resident #131, #133, #117, #78, #104, #89, #144, #145, #139) out of 38 facility reported incidents reviewed during the survey. The findings include: The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, serious bodily injury, and misappropriation of resident property are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report). 1. On 09.20.24 at 09:49 AM the surveyor reviewed MD00203928 related to Resident #131. On 09.23.24 at 09:39 AM the administrator stated that she would look for the documentation related to the Resident #131's documented left breast hematoma. On 09.20.24 at 11:00 AM the surveyor reviewed the reviewed the electronic medical record and reviewed the change in condition completed on 02.27.24 and 03.05.24 related to the resident's left breast hematoma of unknown origin. Resident # 131 was originally found to have left breast hematoma on 02.27.24 via a change in condition progress note and reported still present on 03.05.24. The initial facility incident report was dated 03.25.24 which was beyond the required timeline for submission and final facility incident report was dated 04.02.24. 2. On 09.19.24 at 11:00 AM the surveyor reviewed MD00195697, related to Resident #133. The Resident #133 eloped from the facility through a resident window on 08.16.23 on or about 9:30 PM. The Resident #133 was a [AGE] year-old, BIMS of 15, and who had been receiving intravenous (IV) antibiotics via an IV (PICC) line. The resident was ambulatory, alert and oriented times three according to the medical at the time of the elopement. However, the initial facility incident report (FRI) was submitted to OHCQ via email on 08.17.23 by the former administrator, staff # 5 which was beyond the required timeline for submission. The final facility incident report was submitted on 08.23.23 at 10:56 PM by staff #5 per the documentation provided by the facility on 09.24.24 at 08:42 AM. 3. On 09.21.24 at 4:00 PM the surveyor reviewed MD00206525, related to Resident #117 who currently resided in the facility. The resident accused GNA # 60 of throwing a food tray onto the resident's overbed table and called the resident a derogatory name on 06.08.24. The accusations were substantiated, and the employee was terminated. The facility incident report was not submitted to OHCQ until 06.11.24 by the current administrator. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The surveyor discussed the concerns related to the late submission of facility related reports with the administrative staff on 09.24.24 and 09.25.24 as well as during the surveyor exit interview on 09.26.24.

49304

4. The facility's investigation related to facility reported incident MD00201088 was reviewed on 9/26/2024 at 7:26 PM. In the investigation, it stated staff found Resident #78 unresponsive. Further review of the initial report documented 12/31/23 at 2:00 PM as the date and time when staff became aware of the incident, 12/31/23 at 3:00 PM as the date and time the administrator was notified of the incident, and 1/1/24 at 5:00 PM as the date and time the initial report was submitted. The initial report was submitted 27 hours after facility staff found the resident unresponsive.

On 9/27/24 at 1:26 PM in an interview with the Administrator she stated the latest the incident should have been submitted to the state agency was 12/31/24 at 5pm and confirmed the initial report was submitted 1/1/24 at 5pm. When asked if it was submitted in the required 2 hour time frame, she stated, No.

5. On 9/26/24 at 5:52 PM MD00199215 facility investigation was reviewed. In the investigation, it stated staff found Resident #78 unresponsive. The initial report documented 11/5/23 at 10:30 PM as the date and time when staff became aware of the incident, 11/6/23 at 10:00 AM as the date and time the administrator was notified of the incident, and 11/6/23 at 9:15 PM as the date and time the initial report was submitted. The initial report was submitted 23 hours after facility staff became aware of the incident.

6. On 9/17/24 at 11:48 AM in an interview with Resident #104's resident representative he/she stated Resident #104's top and bottom dentures have been missing for about one year.

On 9/17/24 at 2:10 PM review of the medical record revealed Resident #104 with a documented Brief Interview for Mental Status (BIMS) of 1 out of 15, which indicates the resident has severe cognitive impairment. Further review revealed the resident has multiple diagnoses including dementia. Continued review of the medial record revealed a care plan that documented Resident #104 had the potential for oral/dental health problems related to edentulous (having no teeth) status. Documented interventions included to monitor/document/report as needed any signs and symptoms of oral/dental problems needing attention and to provide mouth care.

On 9/18/24 at 1:25 PM in an interview with Geriatric Nursing Assistant (GNA #60) she stated she is Resident #104's GNA and confirmed Resident #104 used to have dentures on the top.

The Unit Manager (UM#24) and the Director of Nursing (DON) were interviewed on 9/23/24 at 9:37 AM. During the interview, the UM#24 stated the resident did have dentures when he started about 1 year ago and that the GNAs would clean the dentures. Furthermore, the DON stated when she started working at the facility, facility staff confirmed that Resident #104 had dentures. The DON confirmed that Resident #104's missing dentures were not reported to OHCQ.

50457

(continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On 09/17/24 at 12:52 PM, during the review of MD00208860, the report revealed that an alleged incident involving abuse of Resident #89 occurred on 8/10/24. The incident was never reported to the state agency. On 09/23/24 at 06:45 AM, the Administrator #1 provided the surveyor with a copy of grievance documents related to the incident involving Resident #89. The Administrator #1 stated that this was the only file concerning the incident and confirmed that no investigation had been conducted. When the surveyor inquired about the reason for not investigating, the Administrator #1 explained that they did not know why it had not been done. 8. On 09/18/24 at 2:35 PM, during a review of investigation MD00198955 and review of facility self-report form, it revealed an alleged incident of staff abuse involving Resident #144 occurred on 10/25/23 at 5:00 PM. The incident was reported to the state agency on 10/25/23 at 8:19 PM. Upon further review of the facilities investigation, there were no evidence that the required five-day follow-up report had been completed. On 09/24/24, 09/25/24, and 09/26/24 the surveyor requested the facility's five-day follow-up investigation report involving Resident #144 from the Administrator #1. On 9/26/24 the Administrator #1 explained that the report had been completed by the previous Administrator, but they were unable to locate the follow-up investigation report. 9. On 9/20/24 at 12:47 PM, during a review of investigation MD00200065 and review of the facility's self-report form, it was revealed that an alleged incident of staff abuse involving Resident #145 occurred on 11/29/23 at 12:30 PM. The incident was report to the state agency on 11/29/23 at 9:44 PM. Further review of the facility's investigation showed that the follow-up investigation was not submitted until 12/6/23 at 9:24 PM. 50904 10. A review of intake MD00197034 was started on 09/24/2024 at 9:20 AM revealed that on 09/15/2023, Resident #139's daughter had called the facility and reported to the Administrator that the hospital had informed her that Resident #139 had a fractured rib. The facility also added that on initial investigation no one saw the resident fall and that the resident was currently in the hospital; however, staff were made aware of the occurrence to ensure that it did not happen upon the resident's return. The resident did not return to the facility. A record review of the facility's investigations showed that the resident went to the hospital on 09/11/2023 for being lethargic and hypoxic, however, staff had observed that the resident had bruising and swelling on the face before the hospital transfer. The facility conducted an interview on the staff members who worked with the residents on 09/10/23 and they all stated that they did not observe any bruising or swelling on the face. The facility's staff conducted interviews with the staff members who worked with the resident on 09/11/2023. The following statements were included in the facility's investigation: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensed Practical Nurse (LPN) Staff #55 stated that at approximately at 8:15 AM on 09/11/2023 while making his round, he observed Resident #139 lying in bed, alert and easy to arouse He also stated that the resident's left eyelid appeared a little swollen with no sign of distress, breakfast was served and he/she ate about 25% of his/her meal, Geriatric Nursing Assistant (GNA) assisted with Activities of Daily Living (ADL) after breakfast and resident was sitting at the edge of the bed. He added that at 11:40 AM, GNA #56 notified him that the resident was not looking well. He went to assess the resident and found him/her lethargic.He took his/her vital signs. He informed the nurse practitioner who saw the resident and ordered that resident's vital signs be repeated and ordered that resident be transferred to the nearest emergency room via 911. GNA Staff #56 in her statement to the facility on [DATE] stated that while she was helping an agency GNA Staff #25 to receive the report for the shift, they checked Resident #139 and he/she was seen tucked in bed, facing the windows with covers up to his/her shoulder. She added that it was not a little further after breakfast that the nurse told her that he was writing a change of condition on the resident's eye. GNA Staff #56 stated that she went to check on the resident, pulled the covers and noticed that the resident had bruises on his/her eyes, and his/her eyes were also swollen, and his/ her face was sealed shut. She also added that the resident's face was swollen from his/her eyes down to their neck and was not talking or responsive. GNA #56 stated she ran to liberty to get a nurse, and they began care. On 09/24/2024 at 11:57 AM, during an interview with GNA Staff #25, he was asked about the incident with Resident #139. He stated that his shift started from 7-3pm on 09/11/23 and as he was doing his rounds at the beginning of the shift with GNA staff #56, he said he noticed that the patient had bruises and he notified the nurse immediately. He added that the nurse told him to wash the resident up and get him/her ready for transfer to the hospital. On 09/25/2024 at 10:58 AM, the surveyor asked for a copy of the facility's assessment of the resident after the bruising and swelling was observed but the facility stated that they did not have documentation of the assessment after the incident. On 09/25/2024 at 12:09 AM, the Administrator notified the surveyor that she was informed that the hospital had called the facility, and that investigation started after she was told about the fractured rib of the resident. She added that the resident was ambulatory. On 09/25/2024 at 2:44 PM, surveyor reviewed the facility's policy on reporting abuse and it showed Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury''. In an additional interview with the Administrator and the Director of Nursing at 3:04 PM of the same day, they were asked about the facility's policies and procedures on injury of an unknown origin and the Administrator stated that any injury of an unknown origin should be reported to the state agency within 2 hours because injury of unknown origin could be a form of abuse. They were made aware that the bruising and swelling incident was not reported to the state agency at all until after the resident's daughter had called to report Resident #139's fracture of the ribs which was four days after the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42782 Based on facility administrative and medical records review and interviews, it was determined that the facility staff failed to complete thorough investigations of an alleged resident to resident abuse incident, injuries of unknown origin and failed to maintain and provide investigation documentation of a facility reported incidents reported to the state agency. This deficient practice was evidenced in 4 of 38 facility reported incidents for residents (#67, #131, #72, #89) reviewed during the survey. The findings include: 1. On 09/18/24 at 1:31 pm the surveyor requested to review the facility report for MD00208358 associated with Resident #67. The surveyor provided the resident's name and date the alleged incident occurred to Administrator #1. On 09/23/24 at the surveyor requested to view the investigation for the self-report again. On 09/26/24 1:32 pm Administrator #1verbalized not being able to find the investigation associated with the self-report. On 09/27/24 at 3:28 pm Administrator #1verbalized they had been filing the self- reports. An investigation would start immediately after the allegation is made and he/she is responsible for maintaining the investigation in their office. 42863 2. Review of MD00203928 (FRI) and the MD00203241 on 09.17. 24 at 2:15 PM revealed the resident' family member was contacted by facility staff on 02.27.24 and on 03.05. 24 related to Resident #131's change in condition. The change in condition was related to a hematoma of the left breast, however the facility incident report was not initiated until 03.06.24. Further review of the hard copy radiology ultrasound results report by the surveyor on 09.23.24 at 07:03 AM revealed that on 03.05.24 at 21:34 the examination of Resident #131 revealed a ecchymosis, bruising, hematoma of the left breast, measuring 2.8x2.2 x1.6 cm. and routine screening was recommended. The resident was seen by the nurse practitioner, staff # 45 on 03.05.24 for a follow-up and management of the left breast hematoma. On 09.23.24 at 09:30 AM the surveyor interviewed the administrator and inquired whether the facility was aware of the requirement to report injuries of unknown origin to OHCQ within a two-hour time period. The administrator stated that the facility is now providing education to all clinical staff to report these types of incidents to administration as soon as they occur. The facility failed to initiate a thorough investigation in a timely manner and did not submit a facility incident report within the two -hour timeframe related to the injury of unknown origin to the OHCQ. Additionally, the facility failed to provide the surveyor with copies of the facility report related to MD00203928 prior to the surveyor's exit from the facility on 09.26.24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50385 3. On 9/18/24 at 04:29 PM, a review of facility reported incident MD00203897 was conducted. The incident report revealed that Resident #72 wandered into Resident #46's room and Resident #46 struck Resident #72 leaving a skin tear the size of quarter on the right cheek. On 9/19/24 at 9:30 AM, this surveyor requested for the facilities investigation from Administrator #1 regarding the incident on 3/21/24 relating to MD00203897. On 9/24/24 at 9:03 AM, this surveyor requested the facilities investigation relating to Resident #72 and Resident #46 from 3/21/24 for the second time. On 9/24/24 at 12:05 PM, an interview was conducted with Administrator #1. When asked if the facility had any record of the incident on 3/21/24, Administrator #1 stated that the facility had no investigation in their records. 50457 4. On 09/17/24 at 12:52 PM, during a review of complaint investigation MD00208860 it was revealed that an alleged incident occurred on 8/10/24, involving Resident #34 and Resident #89. Resident #89 expressed concerned about potential damage to their personal property. During an interview with Resident #89 on 09/20/2024 at 11:08 AM regarding complaint MD00208860, Resident #89 stated that Resident #34 made a false allegation to the police and facility, accusing Resident #89 of throwing yellow bodily fluids onto Resident #34. As a result of the allegations, Resident #89 reported that they were relocated to a new room. Resident #89 confirmed that their personal property was later returned undamaged. On 09/23/24 at 6:45 AM, the surveyor received a copy of the grievance documents related to the incident from the Administrator #1. The Administrator #1 stated that this was the only file concerning the incident and that no investigation had been conducted. When asked why the incident was not investigated, the Administrator #1 responded that they don't know why. Review of the grievance documents on 09/23/24 at 6:45 AM, revealed a handwritten statement from Resident #34, police report number, admission records for Resident #34 and #89, room transfer and/or new roommate notice for both residents, and a psychiatric progress note for Resident #89. Additional documents included an interview with Resident #34 conducted by Resident Success Manager (RSM) #29 on 8/10/24 at 11:00 PM. Further review of grievance documents showed no written statement or interview from Resident #89 nor any statements from nearby residents or staff members. On 09/24/24 at 09:57 AM, during an interview with RSM #29 regarding the incident between Resident #34 and Resident #89, RSM #29 was asked about the process for handling resident grievances. RSM #29 explained that the incident occurred while they were out of the office. Upon their return on 8/11/24, they were asked to meet with Resident #34 to initiate a grievance process and submit the finding Administrator #1 and Director of Nursing #2, who would then address the concerns.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 42828 Based on medical record review and facility staff interview, it was determined that the facility failed to implement a discharge process that ensured a a resident received continuity of care at the proposed post-discharge facility. This was evident for 1 (Resident # 78) of 3 residents reviewed for discharge during the revisit survey. The findings include: Minimum Data Set (MDS)- The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. Activities of Daily Living, (ADLs), are the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring. The surveyor reviewed complaint MD00212969, which came into the Office of Health Care Quality on 12/27/24. The complainant alleged that Resident #78 was discharged from the facility on the evening of 12/26/24 without having an adequate discharge process in place. On 12/27/24 at 10 AM a review of resident #78's medical record revealed that Resident #78 was their own representative and was cognitively intact as per their most recent Minimum Data Set (MDS) assessment. The quarterly MDS showed Resident #78 was wheelchair bound, complete paraplegic and independent with all ADL's except showering. The assessment also revealed Resident #78 diagnoses included but not limited to Depression, Neurogenic bladder (requiring urinary catheterizations) and Schizophrenia. The classifications of medications captured on the assessment were: Antipsychotics, Antidepressants, Opioids, and Anticonvulsants. On 12/27/24 at 11:12 AM and interview was held with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). They were asked to provide evidence regarding the reason for the involuntary discharge and the documented discharge process for Resident #78 on 12/26/24. The NHA stated that Resident #78 was found to have smoking materials and cigarette smoke in his/her room on 12/19/24. The DON stated that Resident #78 violated his/her smoking contract and behavioral contract which was grounds for an involuntary transfer/discharge according to a Settlement Agreement dated September 17, 2024. The surveyors reviewed the smoking contract, behavioral contract, and the settlement agreement that resulted from a mediation held at the Maryland Office of Administrative Hearings on 9/17/24. On 12/30/24 1 PM, surveyors verbally expressed to the NHA and the DON the concern that there was a lack of documentation regarding Resident #78's transfer/discharge plan. There was no evidence to show the receiving facility was aware of the resident's transfer/discharge. There was no evidence to support that the facility confirmed that the resident's care needs were addressed/discussed at the receiving facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863 Based on observations, record reviews and interviews it was determine the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for the residents' highest practicable being. This was evident for 4 of 82 residents (Resident #27, #104, #61) reviewed during the survey. The findings include: 1. On 9/17/24 at 3:00 PM, in an interview with Resident #27's Power of Attorney (POA) he/she stated that they had requested Resident #27 have an evaluation to see if they could go from a pureed diet to a mechanical soft diet. Review of Resident #27's medical record on 9/17/24 at 3:10 PM revealed the resident had a Brief Interview for Mental Status (BIMS) of 5 out of 15, which indicated the resident had severe cognitive impairment. Further review of the medical record revealed the resident was diagnosed with dementia. On 9/19/24 at 1:40 PM in an interview with the Director of Rehabilitation #11 she stated that Resident #27 was referred to therapy for a swallow evaluation, but when the Speech Language Pathologist (SLP #33) attempted to do the evaluation, he/she refused. During the interview the Director of Rehabilitation #11 provided a copy of the Screen/Referral Form for Resident #27's swallow evaluation dated 8/28/24, signed by SLP #33, and that documented pt (patient) refused assessment despite education. On 9/19/24 at 1:44 PM review of the medical record did not reveal documentation of Resident #27's refusal nor documentation that Resident #27's POA was notified of the refusal. On 9/19/24 at 1:48 PM in an interview with Director of Rehabilitation #11 she confirmed there was no note from SLP #33 documenting Resident #27's refusal of the swallow evaluation. Furthermore, she confirmed his/her POA was not contacted and also confirmed there was no documentation that the POA was notified. During the interview when asked the expectation if a resident diagnosed with dementia and a BIMS of 5 refused care, she stated the proper parties are contacted so we can have what we need in place to properly treat the resident. Additionally, she stated this resident did not have the capacity to refuse treatment and we should have reached out and contacted his/her POA. On 9/23/24 at 12:00 PM in an interview with the Administrator she was asked if Resident #27's swallow evaluation was completed, and she stated she would let the surveyor know. On 9/23/24 at 1:45 PM in an interview with the Administrator she stated Resident #27's POA was not contacted after his/her refusal on 8/28/24, the swallow evaluation was not completed, and that a new swallow evaluation was scheduled where the POA would come to assist. 49304 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #104's resident representative was interviewed on 9/17/24 at 11:48 AM. He/she stated the resident's top and bottom dentures had been missing for about one year. Resident #104's resident representative stated in a meeting with the Ombudsman, the facility said he/she had canceled Resident #104's dental insurance. Resident #104's resident representative stated they never canceled the dental insurance and was then given a packet from the facility of forms to fill out. When the resident representative contacted the dental insurance company from the facility packet, they were told the dental insurance company was not contracted with the facility. After that, the resident representative reported speaking to Unit Manager (UM#24) and he stated this information was shared with the Nursing Home Administrator (NHA) who said she would look into it, but the resident representative had not heard anything since. During the interview, they also stated that Resident #104 had been missing his/her hearing aids for about 8 months and this concern was shared with Resident Success Manager #29. Review of the medical record for Resident #104 on 9/17/24 at 2:10 PM revealed Resident #104 with a documented BIMS of 1 out of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident was diagnosed with dementia. On 9/18/24 at 1:25 PM in an interview with Geriatric Nursing Assistant (GNA #60) she stated she was Resident #104's GNA and confirmed Resident #104 used to have dentures on the top. She also confirmed that Resident #104 had hearing aids and stated they each had a small loop and were on a wire to keep them from getting lost. GNA #60 advised one morning she went to provide Resident #104's care and one was missing and after she returned from vacation the other one was missing. When GNA #60 asked other staff about the hearing aids, everyone said something different, but they were gone. Continued review of the medical record revealed a care conference note dated 4/19/24 that stated, quarterly care plan meeting was held with resident and Power of Attorney (POA) at bedside. POA expressed her concern about denture she had reported two months ago, and she needed a response from facility administration. Facility administrator agreed to follow up and update her. Further review revealed an Attending Physician Request for Services/Consultation for Resident #104 for denture fitting from Medical Doctor #71 with UM #24 as the nurse who took the order, dated 6/7/24, and a Grievance/Concern Form dated 7/9/24, documented by Resident Success Manager #29 where the POA stated he/she has been asking for over a year about trying to get dentures for Resident #104. Furthermore, Hearing Aid/Assistive Listening Device Delivery Receipt & Purchase Agreement documented that a left and right hearing aid were delivered to the facility on [DATE]. On 9/23/24 at 9:37 AM Unit Manager (UM#24) and the Director of Nursing (DON) were interviewed. During the interview, UM#24 stated the resident did have dentures when he started working at the facility about 1 year ago and that the GNAs would clean Resident #104's dentures. He also confirmed Resident #104 had hearing aids and it had been since about October 2023 that she did not have them. The DON stated when she started working at the facility, facility staff confirmed that Resident #104 had dentures, but she had never seen the resident with dentures. The DON then stated the resident's representative canceled his/her dental insurance, so when the facility was trying to get them replaced, he/she did not have insurance and the resident's representative had to reapply for dental insurance. Finally, the DON stated we do need to follow up with the dental provider from the packet not being contracted with the facility, but everything else was followed up on. At the time of survey exit, Resident #104 still did not have dentures or hearing aids. 50457 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 09/17/24 at 12:24 PM, during the review MD00195230 revealed that an alleged incident involving Resident #61, and a broken oxygen tank that occurred on 8/6/23. On 09/19/24 at 9:08 AM, the surveyor observed Resident #61 sitting on the side of their bed with an oxygen concentrator infusing humidified oxygen at 2 liters via nasal cannula. Resident #61 reported a medical history of chronic obstructive pulmonary disease, asthma, being a former smoker, and asbestos exposure. When asked about an alleged incident in August of 2023 related to oxygen, the resident stated they did not recall much about the incident. They reported sitting on the side of the bed working with a geriatric nursing aide, then waking up in the hospital. Resident #61 mentioned they returned from the hospital with oxygen. On 09/19/24 at 10:07 AM, review of medical record progress note dated on 8/6/23 at 11:14 AM, revealed that resident was noted to have had a slight temperature around 6:28 AM. All vital signs were checked. Resident #61 was given as needed pain medication after he verbalized pain of 4 of their shoulder. Further assessment shows the temperature dropped and resident was found sleeping. Then the resident was found shaking in their room at around 8:33 AM and oxygen saturation level was around 89%. Fifth teen minutes later, the oxygen level was observed to have dropped to around 78%. The primary physician was called and reached around 9:33 AM. Emergency responders were called a few minutes later. The resident was taken out to the emergency department at around 9:50 AM. Resident #61's family member was called and informed at 9:51AM. On 09/19/24 at 10:34 AM, review of Resident #61 medication administration record and treatment administration record for July 2023 revealed an order for as needed supplemental oxygen 2-liter via nasal canula for chronic pulmonary disease. The medical record failed to show that Resident #61was given as needed oxygen as ordered by the doctor. After review of Resident #61's oxygen vital signs in August 2023, the records failed to include documentation of the resident's oxygen levels on 8/6/23. On 09/19/24 at 12:18 PM, during an interview with the DON #2 regarding the progress note from 8/6/23, the DON #2 stated that, based on the information documented in the medical record, the incident appeared to reflect no oxygen had been provided prior to the hospital transfer. The DON #2 stated that they were unable to identify any interventions that were implemented during the time Resident #61 was documented to have low oxygen levels.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385 Based on record review and staff interview, the facility failed to provide supervision to prevent a resident-to-resident altercations and to ensure residents were free of accident hazard devices. This was evident for 3 (Resident #72, #140, #34) of 6 resident's reviewed for supervision. The findings include: 1. On 9/16/24 at 02:51 PM, facility reported incident MD00203897 was reviewed. The facility reported a resident-to-resident interaction that happened on 3/21/2024. The report incident stated that Resident #72 wandered into Resident #46's room. Based on the incident detail, Resident #46 struck Resident #72 on the right cheek leaving a quarter size skin tear. On 9/18/24 at 4:27 PM, a review of Resident #72's progress notes was conducted. Review of Change of Condition Assessment note on 3/21/24 stated, [Resident #72] in wheelchair wandered to [Resident #46]'s room [ROOM NUMBER]A. [Resident #46] started yelling get out of my room and punched [Resident #72] on right side of cheek and obtained a superficial skin tear about a size of a quarter. Resident denies pain upon assessment. In the interventions section of the note it states, The two residents were separated immediately and are now being monitored. NP was notified and Bacitracin and Dry dressing was applied until healed. Called police to report the incident. [Police case #]: RP was notified as well. On 9/18/24 at 4:40 PM, Resident #72's care plans were reviewed. There was a care plan with a focus stating, [Resident #72] is an elopement risk/wanderer r/t patient's intrusive behavior and history of wandering into other patient's rooms. This care plan was created and initiated on 10/09/2023. Interventions of this care plan include, Monitor location. Document wandering behavior and attempted diversional interventions in behavior log. Redirect resident if resident is seen attempting to enter another resident's room. Resident to be redirected away to an alternate task On 9/24/24 at 12:05 PM, An interview was conducted with Administrator #1. When asked if the facility had any record of the incident on 3/21/24, Administrator #1 stated that the facility had no investigation in their records. 2. On 9/24/24 at 12:32 PM, a review of facility reported incident MD00206040 was conducted. The facility reported that Resident #140 went into Resident #71's room and was struck on the head by Resident #71 causing a laceration on the top of Resident #140's head on 5/24/24. On 9/24/24 at 2:16 PM, a review of Resident #140's care plan and interventions for wandering were reviewed. The focus of the care plan was, [Resident #140] has a behavior problem r/t Wandering the Hall Ways and intermittent screaming. 05/24/2024 - Resident wandered into another resident's room and was hit by the resident. On 9/24/24 at 2:30 PM, a review of the facility's follow-up report was conducted. The report stated that staff were educated on redirecting residents who were wandering into other residents' rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50458 3. On 09/16/2024 at 8:00 AM during observation rounds, Resident # 34 was observed with a microwave that was plugged into the wall and resting at the top of his/her bed. During interview with the resident on 9/16/24 at 8:15am s/he stated that the microwave was purchased to heat up food. The resident stated staff did not heat up his/her food when it is cold. On 9/16/24 at 12:30 PM, the surveyors, the Director of Nursing (DON), Administrator and the Maintenance Director went to Resident #34's room. The microwave was observed on the bedside table and removed by the Maintenance Director. The Administrator stated the resident was not to have a microwave located in his/her room.