STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215085	A. Building B. Wing	11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Park Healthcare	3330 Wilkens Avenue Baltimore, MD 21229

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45733 Based on interview and record review, it was determined that the facility failed to honor the resident's right to participate in family events outside the facility. This was evident for 1 (Resident #46) out of 1 resident reviewed for resident rights. The findings include: On 10/13/23 at 09:50 AM during an interview, Resident#46 stated that he/she requested a Leave of Absence (LOA) on two different occasions: 8/25/23 & 9/5/23, however, only the first one was approved for 8/25/23 from 7:00 AM until 11:00 AM. Resident #46 followed the facility policy and filled out both requests 4 days prior to the requested leave. He/she remembered making the requests to staff at the third-floor nurse's station. An interview was conducted on 10/13/23 at 11:32 AM with the Unit Manager (Staff #3) who confirmed that he received both of Resident # 46's LOA requests. He stated that LOA requests were normally approved by him unless there was a medical risk concern, then it was forwarded to the physician for review. Furthermore, due to facility applied the Leave of Absence policy under therapeutic Bed Hold Day so the request was also forwarded to the Business Office Manager (Staff #44). On 10/13/23 at 11:40 AM Interview of Staff #44 revealed she had a conversation with Resident #46 that LOA was limited to 18 calendar days in a year. However, Resident #46 only had 2 requests, each was a 4-hour absence. Additionally, Staff #3 reported that the resident's LOA paper was lost in the chart so he could not provide any documentation. On 10/16/23 at 08:30 AM, an order page for 8/25/23 from the Primary Physician (Staff #50) stated, may to LOA for 4 hours (7A-11A) with his father. There was no documentation on 9/5/2023' of the LOA request from Staff #50. A phone interview was conducted on 10/16/23 at 09:51 AM with Staff #50 regarding LOA process, she stated normally it was for therapeutic events like medical appointments that were approvable. When asked about residents' family or community activities LOAs, she indicated all Long-Term Care residents' requests were okay to approve by the unit managers, but other residents' requests had to be reviewed by her. She reviewed them while on site because floor nurses normally altered her. She had no recollection of this resident's LOA request on 9/5/2023, she planned to provide that information in person later. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/23 at 8:50 AM the surveyor requested an interview with Staff #50 and requested that the 9/5/2023 LOA documentation be provided. On 10/19/23' at 9:30 AM the surveyor notified facility staff that no 9/5/2023 LOA documentation was provided to support the denial.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, reviews of a closed record, a staff interview, it was determined that a resident was not given an admission contract. This was evident for 1 (Resident #141) of 112 intakes reviewed during an annual certification survey. The findings include: Review of complaint MD00175504 on 11/02/23 revealed an allegation Resident #141 had been admitted to the facility for over a month without an admission contract. A review of Resident #141's closed medical record on 11/02/23 failed to reveal any documentation Resident #141 had received an admission contract. Resident #141 was admitted to the facility on [DATE]. Resident #141 was transferred to another long-term care facility on 02/18/22 per her wishes. In an interview with the facility, on 11/20/23 at 11:50 AM, the administrator stated that he was unable to locate a completed admission contract for Resident #141 after being admitted to the facility and couldn't answer why the contract had not been issued.

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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. 18819 Based on reviews of a facility reported incident and staff interview, it was determined that a staff member removed money from a resident's account without the resident's permission. This was evident for 1 of 112 intakes reviewed during an annual recertification survey. The findings include: Review of facility reported incident MD00184909 on 11/01/23 revealed details that staff member #87 was asked by Resident #144 to go buy him some cigarettes on 10/22/22. In addition to buying the smoking materials, staff member #87 also withdrew $40 dollars cash. Review of staff member #87's written statement, dated 11/03/22, staff member #87 admitted that Resident #144 had not given her permission to remove an additional $40 cash from the debit card account on 10/21/22. Review of Resident #144's written statement, Resident #144 stated that he had not given staff member #87 permission to withdraw an extra $40 cash from his account. Resident #144's statement also indicated that Resident #144 confronted staff member #87 on 10/21/22 about the $40 removed from the account. Resident #144 informed the facility administrator that the staff member returned $25 and stated that she spent the rest of the money on food because she was hungry. Resident #144 told staff member #87 that she should have asked him first. In an interview with the facility Director of Human Resources (HR) on 11/14/23 at 3:15 PM, the HR Director confirmed the facility substantiated the allegation of misappropriation of funds and terminated staff member #87 on 11/03/22.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 14894 Based on clinical record review, review of facility abuse investigations, and staff interview it was determined that the facility staff failed to ensure allegations of abuse were reported to the state agency. This was evident for 3 (#150, #22, and #90) out of 30 residents reviewed for abuse. The findings are: 1. A review of intake MD00188656 was started on 10/20/23 at 11:11 AM. A review of the nursing progress notes dated 1/31/23 at 2:59 PM revealed that Resident #150 alleged that someone struck him/her really hard in the face during the middle of the night and returned later to kiss him/her on the cheek. The resident later alleged a dog tried to bite him/her. A review of the facility investigation revealed that a nurse (Staff #21) was informed on 1/31/23 of the allegation by the resident. Staff #21 said she observed no signs or symptoms of injury. She said she then told the unit manager (Staff #86) the same day. Further review revealed that the incident was not reported to the state agency until 2/5/23. This surveyor interviewed the Administrator on 10/20/23 at 10:54 AM. The incident was summarized and explained to the Administrator. The resident alleged that they were slapped on 1/31/23. The resident told the nurse who then passed the allegation to the unit manager. The allegation was not reported to the state agency until 2/5/23. He acknowledged the details and showed a printout of the email confirmations of their self-report. The printout showed that both the initial and final reports were emailed on 2/5/23. 44440 2. On 10/2/23 at 12:37 PM, the surveyor reviewed Resident #22's medical record. The review revealed that Resident #22 was admitted to the facility in early 2023. Further reviewed revealed Resident #22 had a scheduled appointment at an outside facility on 6/1/23 and left with transportation at 11:30 AM. The surveyor reviewed a progress note written by Social Services Staff #14 on 6/1/23 that stated Staff #14 received a call from an outside provider regarding Resident #22. The caller informed Staff #14 that Resident #22 did not want to return to the facility and felt like he/she was being mistreated at the facility. On 10/3/23 at 2:06 PM, an interview with the Nursing Home Administrator (NHA) was conducted. The NHA stated he did not report this allegation. 45733 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Facility self-report file review on 10/16/23 at 11:01 AM revealed on 9/14/2023 approximately 5 PM, facility staff at the nurse's station on the 3rd floor were made aware of an abuse incident involving Resident #90. However, the State Agency was not notified until 9/14/2023 at 9:39 PM, more than 4 hours later. Nursing home facilities are required to report allegations of abuse to the State Agency no later than 2 hours after the abuse allegation was made or was observed. This did not occur.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review, review of facility investigations, and staff interview it was determined that the facility staff failed to ensure allegations of abuse are thoroughly investigated and accurately reported with inclusion of details such as but not limited to reported injury and witness statements. This was evident for 12 (#119, #161, #165, #365, #374, #22, #42, #115, #63, #369, #70, and #128) out of 30 residents reviewed for abuse. The findings include: 1. A review of Resident #119's clinical record on 10/12/23 revealed that the resident had an incident on 5/3/22 at 11:30 AM. A review of the facility's investigation revealed that the facility reported the incident to the state survey agency but failed to include that the resident suffered an injury. This surveyor interviewed the Administrator on 10/18/23 at 10:20 AM. He was informed that the incident was reported but the facility failed to mention that the resident suffered an alleged injury as a result of the incident. Explained to the Administrator that an alleged injury is an important detail to include in all injury and abuse reports. 2. A review of two Facility Reported Incidents (FRI's) -- MD00181020 and MD00181170 were started on 11/6/23. The FRI's involved Resident #161's allegations of physical and sexual abuse, respectively. The review of the two investigations revealed that neither had witness statements. This surveyor interviewed the Administrator on 11/16/23 at 1:12 PM. The Administrator was informed of the importance of having witness statements from the alleged victim, any alleged perpetrator(s), and witnesses or potential witnesses. The Administrator expressed his understanding of the importance of obtaining witness statements. 3. This surveyor started a review of intake MD00175238 on 10/17/23 at 11:30 AM. A review of Resident #165's clinical record revealed Resident #165 was in their bedroom on 4/8/22 when the roommate's daughter went to the nursing station to accuse the resident of stealing her relative's tv remote which has been missing for 4 weeks. The daughter then went into the room and yelled at Resident #165. Resident #165 started to cry and turned on the cell phone to record the incident. The resident's spouse was called, and the spouse called the police. Resident #165's spouse came to the facility on [DATE] at 10:30 AM to request a room change. The facility had already begun the process of moving the roommate. The spouse also reported that a Roku box had been taken as well. The spouse reported the alleged theft to the police. The roommate's daughter was also an employee (receptionist), so she was suspended and then terminated. The daughter could still visit her relative. No evidence that she was escorted to the unit when she visited and/or prevented from entering Resident #165's room was found. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 10/25/23 at 1:40 PM. This surveyor explained the findings to him. He said he understood the daughter took the remote from out of Resident #165's hand and shared with me that he did not believe the daughter went onto the floor after the incident. He then showed me a laptop with a record of all the employees who signed in and out of the facility during the weeks after the incident. He shared that staff are not required to sign in if the facility is not on COVID outbreak status. He stated that he is looking at changing the system so that all staff are required to check in regardless of COVID status. The Administrator stated on 10/25/23 at 2:09 PM that he talked with the other receptionists, but they did not remember if the alleged perpetrator ever went to floor as visitor. He could not provide evidence that the resident was protected throughout the investigation. . 4. This surveyor started a review of intake MD00182919, which involved an allegation of abuse of Resident #365, on 11/1/23. The facility investigation was requested on 11/2/23. This surveyor interviewed the Administrator on 11/7/23 at 11:17 AM. He was asked if he had a copy of the investigation. He said he looked on Thursday, Friday, and over the weekend. He said he could not find it. He verified the date of the alleged incident with me and said he would look at the computer scans one more time. The Administrator was interviewed on 11/8/23 at 12:39 PM. He confirmed that he had no evidence of an investigation. He called the previous administrator, Staff #52, who said she remembers the incident and stated that the alleged perpetrator was suspended. The Administrator provided proof of the suspension but not the actual investigation. 5. This surveyor started a review of intake MD179333 on 10/30/23. A review of the facility investigation and Resident #374's clinical record revealed the resident alleged that the nurse supervisor (Staff #70) allegedly pointed her finger at the resident and then hit the resident's nose and face x2. The resident then allegedly fell as a result. The facility called the police and the state survey agency on 6/21/22. Further review revealed that there were four witnesses, but they were not interviewed. Staff #70 was suspended for 5 days. The Administrator was interviewed on 10/31/23 at 10:20 AM. He said the incident was initially reported but the final report was not sent to the state survey agency. The Administrator returned on 10/31/23 at 12:32 PM. He confirmed that the facility has no record of an interview with the resident, the alleged perpetrator, or the witnesses. He said he could not provide proof that the alleged perpetrator was suspended. The nursing coordinator for the 3rd floor nursing unit (Staff #3) was interviewed on 11/1/23 at 1:15 PM. He said he was coming off of the elevator and saw what happened. The resident had the right hand on a cane and a pill crusher in the left hand. Resident was trying to hit the nurse. When the resident swung down with the pill crusher it hit the nurse's hand and this caused the resident to fall. He said the nurse never hit the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44440 6. On 10/2/23 at 12:37 PM, the surveyor reviewed Resident #22's medical record. The review revealed that Resident #22 was admitted to the facility in early 2023. Further reviewed revealed Resident #22 had a scheduled appointment at an outside facility on 6/1/23 and left with transportation at 11:30 AM. The surveyor reviewed a progress note written by Social Services Staff #14 on 6/1/23 that stated Staff #14 received a call from an outside provider regarding Resident #22. The caller informed Staff #14 that he/she did not want to return to the facility and felt like he/she was being mistreated at the facility. On 10/3/23 at 9:39 AM, the surveyor conducted an interview with Resident #22. During the interview Resident #22 stated he/she had received better care at a different facility but had no personal concerns now. Resident #22 stated when he/she returned to the facility the facility did not interview or follow up with him/her as to why he/she did not want to return. On 10/3/23 at 1:45 PM, the surveyor interviewed Staff #14. During this interview Staff #14 described the steps taken when she is aware that a resident is reporting being mistreated. Staff #14 stated she would let the Administrator aware, separate and protect a resident from the perpetrator and an investigation would be started. Staff #14 recalled getting the phone call from the outside provider about Resident #22 and remembers she notified the Nursing Home Administrator NHA) and Director of Nursing (DON). She reports thinking they did an investigation. On 10/3/23 at 2:06 PM, an interview with the NHA was conducted. The NHA stated he did not report this case or do a formal investigation. The NHA stated he remembered he reached out to Resident #22's family member to understand why Resident #22 did not want to return and the family member stated the resident felt like he/she was being treated like a child. The NHA confirmed he never followed up or investigated the concern of mistreatment Resident #22 had when he/she returned to the facility. 7. On 10/3/23 at 2:00 PM, the surveyor requested the facility's investigation report from an alleged incident of abuse the facility reported on 5/13/22. On 10/18/23 at 9:44 AM, the surveyor followed up with the Nursing Home Administrator (NHA) and requested the investigation report. The NHA stated he was unable to find the investigation but would continue looking. On 10/12/23 at 11:03 AM the surveyor conducted an interview with Resident #42. Resident #42 was not able to provide any information on the alleged abuse from over a year prior. On 11/16/23 at 1:47 PM, the surveyor conducted a follow-up interview with the NHA where he confirmed no investigation report was found for Resident #42. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 10/19/23 at 11:33 AM, the surveyor reviewed an investigation report from an incident that occurred on 5/14/23 between Resident #115 and #63. The report stated that the two residents were found in an altercation out on the smoking patio. No injuries were reported or found on assessment, and the police were called. In the investigation the facility was unable to determine how the Residents got out onto the smoking patio that allowed them to be unsupervised. On 10/19/23 at 11:35 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During this interview he stated that there would have been an assigned person to monitor the smoking area but only during assigned smoking times. He further stated there was no staff supervising at the time of the incident and was not sure if this took place during a scheduled smoking time or the residents got the code to the smoking patio and let themselves out. The NHA agreed that the facility failed to interview the staff that was scheduled to supervise smoking that day to better understand how the residents were allowed to smoke unsupervised. 37277 9. On 10/13/2023 at 8:30 AM, a record review revealed that a Facility Reported Incident (FRI) regarding Resident #369 was received by the Office of Healthcare Quality (OHCQ) on 6/6/2022 at 1:47 PM. In the FRI, the facility reported that per Resident #369, on 5/23/2022 a Geriatric Nursing Assistant hit his/her hand. On 10/13/2023 at 9:30 AM the facility's investigation was requested by the Surveyor. On 10/16/2023 at 11:00 AM, when asked about the investigation, the Nursing Home Administrator (NHA) stated that he is still trying to locate the file. On 10/17/2023 at 11:50 AM, the NHA admitted he cannot find the file. 10. On 10/20/2023 at 8:30 AM, a record review revealed that a FRI regarding Resident #70 was received by the OHCQ on 7/14/2022 at 1:57 PM. In the FRI, the facility reported that on 7/13/2022 Resident #70 went out the front door. On 10/20/2023 at 10:35 AM, the facility's investigation was requested by the Surveyor. On 10/23/2023 at 10:30 AM, when asked about the investigation, the NHA admitted it is one of several investigations he can't find. 11. On 10/24/2023 at 1:45 PM, a record review revealed that a FRI regarding Resident #128 was received by the OHCQ on 9/08/2022 at 10:50 AM. In the FRI, the facility reported that Resident #128 reported $40.00 went missing. On 10/25/2023 at 8:00 AM, the facility's investigation was requested by the Surveyor. On 10/26/2023 at 11:45 AM, Staff #39, a Regional Nurse, stated that the investigation could not be found.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 14894 Based on clinical record review, review of a complaint, and staff interview it was determined that the facility failed to ensure proper planning on an issued 30 day discharge. The findings were evident for 1 (#165) out of the 140 residents that were part of the survey sample. The findings are: A review of Resident #165's clinical record on 10/19/23 to investigate intake #MD00175238 revealed that on 8/3/22 a meeting was held with the Ombudsman, the resident, and the resident's spouse. The resident had been caught smoking in an inappropriate place with the potential of harm to self and to others. The resident and spouse had been warned before but the resident is impulsive without regard to safety of self or others. The spouse understood why a 30-day involuntary discharge was issued secondary to facility not being able to accommodate the resident's need to smoke. Resident requested a facility with more opportunities for smoking. Spouse will call other facilities near home and facility said they would call facilities in the city. Spouse agreed to the discharge. Further review revealed the resident was still in the facility after the 30-day involuntary discharge was issued. Another meeting was held with the resident and spouse on 3/2/23. The spouse was notified of the resident smoking. Spouse agreed to work on getting the resident discharged within the next two weeks. A care conference meeting was held on 3/14/23. Resident attended with spouse, rehab nursing, a member of the business office, a service coordinator from the wavier program (a government program where an individual receives needed care at their home), the Administrator, and a friend of resident. During the meeting the Administrator told the spouse that a safe place to live must be in place for the discharge to occur. Spouse announced that the resident was going to be discharged to an occupied apartment with a roommate who would be the caregiver. Potential roommate was called, and he informed the team that the rental office has not yet approved. The Administrator informed the spouse that the correct steps need to be followed for a safe discharge. The Social Worker tried to explain the benefits of continuing the waiver process. The spouse stood and announced the resident was leaving against medical advice. They both left the facility. The Social Worker (Staff #14) was interviewed on 10/19/23 at 10:29 AM. She said when a resident smokes in the facility they go on contract. Activity staff put them on the contract. If resident violates the smoking agreement, then the contract starts and activity enforces. Social work handles contracts for physical aggression. Rescinded 30-day notices are kept in the business office. The Administrator was interviewed on 10/19/23 at 1:30 PM. He said he checked with the business office and there were no 30-day discharge notices on record. I informed the Administrator that a 30-day discharge was noted in the clinical record. He said he would check with the corporate lawyers. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator returned to the survey team meeting area on 10/19/23 at 1:42 PM. He stated a 30-day discharge was not given because resident left discharged against medical advice (AMA). This surveyor said the 30-day notice was issued earlier in the resident's stay and then he was shown where it mentioned the 30-day discharge in the care plan. He replied that it might have been for a different resident. I read it to him to show it was not likely to be someone else's. He replied understood. He also said he has a phone call into the lawyers. The Administrator supplied an email chain on 10/20/23 at 11:34 AM. The email chain implied that there were two involuntary discharge notices, but neither was in the clinical record. Email chain states the second one was rescinded about the time of actual discharge.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation, record review, resident interview, and staff interview, it was determined that the facility failed to ensure a care plan was developed for a resident who was an active smoker upon the completion of resident's comprehensive assessment at admission and failed to review, to revise a resident's care plan after a quarterly assessment, to ensure that care plan meetings took place in a timely manner, to ensure a Power of Attorney (POA) was invited to a care plan meeting. This was evident for 6 (Resident #109, #10, #371, #33, #39, and #67) of 12 residents reviewed for care plan timing and revision. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. This helps to evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. 1a. On 9/27/2023 at 8:55 AM, surveyors observed Resident #109 in his/her room. Resident #109 stated I'm going out to smoke. On 9/27/2023 at 9:39 AM, Activity Assistant, Staff #11, provided the surveyors with a copy of a document titled Resident Smoking revised 2/22/2021, a section under, Policy Explanation and Compliance Guidelines which stated in section: 6). All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment 7). Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10). All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. On 9/27/2023 at 12:50 PM, review of resident #109's electronic medical record established that Resident #109 had diagnoses, including but no limited to chronic respiratory failure, COPD (chronic obstructive pulmonary disease: inflammatory lung disease that causes obstructed airflow from the lungs), fracture of vertebrae, traumatic brain injury, high blood pressure, malignant neoplasm of lung, falls, tobacco use, and substance abuse. On 10/4/2023 at 7:00 AM, Licensed Practical Nurse (LPN), Staff #6, informed surveyors that the resident was discharged [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2023 at 9:30 AM, during review of Resident #109's electronic medical record, surveyors discovered a MDS focus note dated 8/25/2023 at 11:33 AM, written by Resource MDS Coordinator, Staff #28, revealed that the resident was a current smoker. On 10/16/2023 at 9:45AM, review of resident's MDS (Minimum Data Set) dated 8/29/2023, revealed that Resident # 109 was cognitively intact, needed limited assistance with mobility, occasionally used a walker or cane at times for mobility, had pain, shortness of breath with exertion and when lying flat, and used tobacco. Continued review of electronic medical record showed that on 8/22/2023 at 1:15PM Resident #109's smoking assessment was completed. It revealed that the resident was an unsafe smoker with some weakness noted and supervision was required during smoking. The assessment also stated that Resident #109 appeared to have physical limitations which interfered with the ability to perform safe smoking techniques. On 10/17/2023 at 12:30 PM, review of Resident #109 care plans from 8/22/2023 through 10/3/2023, concluded that there was no care plan for smoking initiated. On 10/18/2023 at 7:45 AM, surveyors conducted an interview with Unit Coordinator, Staff #21. During the interview, Staff #21 stated that a smoking assessment is completed by the nurse on admission to determine the smoking parameters for a resident who smokes. Staff #21 also stated that there should be a care plan created for a smoking resident. If the smoking assessment reveals that the resident is an unsafe smoker, they may go to the smoking area with an aid for assistance and that should be included in the care plan. On 10/27/2023 at 11:30 AM, the surveyor expressed the concerns with Regional Director of Clinical Operation (RDCD), Staff #39 and the Administrator. 1b. On 10/19/2023 at 7:13 AM, Surveyors noted a diagnosis of pneumonia as an active condition on the Quarterly MDS assessment dated [DATE] for Resident #109. On 10/19/2023 at 10:10AM, review of Resident #109's electronic medical record, surveyors note a chest x-ray to be completed 9/1/2023 at 3:18 PM to rule out pneumonia ordered by Physician, Staff #50. During further review of records, surveyors discovered a note created by Staff #50, on 9/5/2023 at 11:30 PM establishing the chest x-ray confirmed pneumonia and that Resident #109 will start on antibiotics as treatment for 7-10 days. On 10/19/2023 at 10:50AM, surveyors note that the MDS assessment history reflected that a quarterly MDS assessment including pneumonia was completed on 9/14/2023. Surveyors discovered that there was no documentation to indicate that Resident #109's care plan was revised based on the diagnosis included in the quarterly MDS assessment. The identified concerns were reviewed with the interim Director of Nursing (DON), the Administrator, and the Regional Director of Clinical Operations (RDCO) throughout the survey process and at the exit conference on 11/20/2023. There was no documentation provided to surveyors regarding initiation and implementation an updated care plan for Resident #109. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37277 2. On 09/27/2023 at 10:20 AM, Resident #10 reported that he/she was not told when the last care plan meeting was scheduled and had been trying to schedule a care plan meeting. A subsequent record review revealed that the last care plan meeting was held on 03/14/2023. On 10/05/2023 at 10:39 AM, an interview with Staff #14, a social worker, revealed that care plan meetings are supposed to be scheduled 7 days after admission, quarterly, and if there is a significant change. On 10/12/2023 at 11:45 AM, Resident #10 reported that he/she was still trying to have a care plan meeting scheduled. At 1:15 PM this was brought to the attention of Staff #14 from the social work department. 14894 3. A review of Resident #33's clinical record on 9/27/23 revealed care plan meetings have not been held for the resident for the past year. The Social Work Director (Staff #14) was interviewed on 10/3/23 at 1:46 PM. Staff #14 said she is responsible for planning the care plan meetings. She keeps sign-in sheets from the meetings in her office. She looked for sign-in sheets for the resident but could not find any. She confirmed that the resident's brother has requested to be invited to care plan meetings on numerous occasions. 4. Resident #39 was interviewed on 09/27/23 at 08:17 AM. Resident stated that he/she doesn't go to the meetings because they used to invite the residents but not anymore. A review of Resident #39's clinical record on 9/27/23 revealed that there was no evidence that the resident has been invited and/or attended any care plan meeting. The Social Work Director (#14) was interviewed on 10/3/23 on 1:46 PM. Staff #14 said she is responsible for planning the care plan meetings. She keeps sign-in sheets from the meetings in her office. She looked for sign-in sheets for the resident but could not find any. 5. Resident #67 was interviewed on 9/28/23 at 8:10 AM. The resident stated that they did not know what a care plan meeting was. A review of the resident's clinical record revealed that there was no evidence that the resident had been invited to a care plan meeting since admission. The Social Work Director (#14) was interviewed on 10/3/23 on 1:46 PM. Staff #14 said she is responsible for planning the care plan meetings. She keeps sign-in sheets from the meetings in her office. She looked for sign-in sheets for the resident but could not find any. 47758 6. A medical Power of Attorney (POA) is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. During the review of a complaint by the surveyor on 10/19/2023 at 1:25 PM, the complainant reported that s/he was the POA for Resident #371 and was unable to participate in his/her care because the facility failed to discuss the resident's care plan and failed to return phone calls regarding the resident's care. Review of the medical records did not reveal documentation of care plan meetings or notifications to the POA for the care plan dated 10/9/21. On 10/20/23 at 9:00 AM, during an interview with the Regional Director of Clinical Operations (RDCO), the surveyor shared the concern that the POA had not been notified of the care plan meeting for Resident #371 and requested a copy of notification and the care plan meeting notes. During an interview on 10/20/2023 at 12:58 PM, the RDCO stated the facility is not able to provide POA notification of a care plan meeting for the care plan dated 10/9/21 or notes from the meeting and the facility would start tracking care plan meetings and notifications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure that 1) prescribed medications are correctly transcribed and administered, 2) insulin sliding scale parameters were included on the medication order for a resident receiving insulin, 3) report changes in baseline conditions and health concerns verbalized by residents. and 4) to create a new medication order in the resident's electronic record, once the order had been changed, and facility staff administered narcotics with conflicting orders. This was evident for 1) 2 (Resident # 39 and #46) of 6 residents investigated during the medication administration and investigative portion of the survey, 2) 1 (Resident #39) of 6 observed during the medication administration task portion of the survey, 3) 3 out of 3 monthly Dialysis Communication Logs reviewed during the survey, and 4) 1 Resident (#93) identified in 2 out of 3 narcotic binders reviewed during medication storage observations. The findings include: Polyneuropathy is a condition in which a person'ss peripheral nerves are damaged. It affects the nerves in your skin, muscles, and organs. When these nerves are damaged, they can't send regular signals back to your brain. Insulin is an essential hormone that helps your body turn food into energy and controls your blood sugar levels to keep them in the normal range of 70 mg/dl and 100 mg/dl. A sliding scale varies the dose of insulin based on the blood glucose level. The higher your blood glucose the more insulin you receive. Dialysis is a process that helps with the removal of waste products from the blood normally done by the kidney. A Communication Log is a place to document important details of a resident's care and the action taken. 1. On 10/11/2023 at 8:33 AM, during the medication administration task, surveyors observed Licensed Practical Nurse, Staff #23, obtain Resident #39's blood sugar level. Surveyors noted that the resident was sitting up in bed with the tray table across the legs. The resident reported he/she had already eaten breakfast consisting of a biscuit, gravy, and orange juice. Staff #23 retrieved Resident #39's insulin pen from the medication cart. Staff #23 and surveyors reviewed Resident #39's medication administration record which revealed an order for 3 units of insulin to be given subcutaneously (insertion of medication beneath the skin by injection) three times daily with meals for Diabetes Mellitus. Surveyors discovered that there was no sliding scale. Diabetes Mellitus is a disease that affects how the body uses sugar- too much sugar in the blood. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2023 at 8:40 AM the surveyors interviewed with Staff #23. Staff #23 stated that, residents receiving insulin are usually on a sliding scale. Staff #23 informed surveyors that she would call the doctor to inquire about why there was no sliding scale order. On 10/11/2023 at 12:35 PM, surveyor interviewed with Physician, Staff #50. During the interview, Staff #50 stated that, residents on insulin are usually on a sliding scale. The surveyor informed Staff #50 that the surveyors and the assigned nurse, Staff #23, could not locate the sliding scale insulin for Resident #39. Staff #50 stated she would look into it and get back with surveyors. A follow-up interview with Staff #50 was conducted 10/13/2023 at 11:06 AM. Staff #50 states, All residents receiving insulin should be on a sliding scale. Resident #39 should have a sliding scale. The pharmacy recommends that we keep the residents receiving insulin on a sliding scale for 2 weeks. I like to keep them on a sliding scale at a low dose because they (residents) like to eat snacks and the snacks increase their (residents ') blood sugars. I ordered the sliding scale for Resident #39. On 10/13/2023 at 12:10 PM, review of Resident #39's medical records showed an order for insulin with a sliding scale created on 10/12/2013 at 11:30 AM. The identified concerns were reviewed with the Director of Nursing and Administrator throughout the survey and again at 12:30 PM on 11/17/2023. 3) During initial tour of the unit on 9/27/2023 at 9:05AM, surveyors observed Resident #517 sitting up in bed, sweating heavily with hair and shirt wet, head bent while rubbing the back of neck, and restless in bed. Surveyors also noticed a CVC (central venous catheter: an access used for administering medications) in his/her left chest and AVF (arteriovenous fistula: dialysis port) in his/her right upper arm. Surveyors conducted an interview with Resident #517 on 9/27/2023 at 9:09 AM. The surveyors asked how he/she was feeling and he/she responded by saying I'm so hot. The resident said he/she was in pain. Surveyors asked where the pain was located, and the resident stated the pain was in the back of his/her neck where he/she recently had surgery. Surveyors asked the resident how he/she would rate the pain from 0-10 pain scale (0 being no pain and 10 being the worst pain). The resident was unable to verbalize the severity of pain but surveyors observed the resident was sweaty and grimacing. On 9/27/2023 at 9:14 AM, surveyors notified the Unit Manager, Staff #1, of resident's condition. Surveyors observed Staff #1 knock on Resident #517's door and then enter the resident's room. Staff #1 placed the resident's breakfast tray on the bedside table and raised the head of the bed. On 9/27/2023 at 9:50 AM, review of Resident #517 electronic medical records revealed that the resident was admitted on [DATE] with diagnoses that included, but no limited to, end stage renal disease (kidney disease), dependence on renal dialysis, osteomyelitis (bone infection), hypoglycemia, laminectomy due to fusion of spine, and chronic postprocedural pain. The admission assessment dated [DATE] showed that the resident was cognitively intact, alert, and able to make his/her own decisions. On 9/28/2023 at 8:33 AM, during record review, it was noted that Resident #517 was transferred from the Dialysis Clinic within the facility to the hospital 9/27/2023 at 11:05 PM. A nursing progress note, written by Staff #1 on 9/27/2023 at 10:35 AM, stated that Resident #517 was transferred to the hospital emergency room due to hypoglycemia (low blood sugar). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/2023 at 8:40AM, surveyors toured the unit and observed random dialysis communication binders, located on a desk at the nurses' station. A communication binder for Resident # 517 was not located during the tour. Staff #1 was at the nurses' station when surveyors asked Staff #1 where Resident #517's Dialysis Communication form was located and Staff #1 replied, I will look for it. The form was never located while surveyors were on the unit with Staff #1. On 9/28/2023 at 2:29 PM, during an interview with Staff #1 and the interim DON, Staff #1 revealed that the resident was sweating a lot, she got him/her some juice, and he/she drank a little. Staff #1 informed surveyors that she sent the Dialysis Communication form with Resident #517 when he/she went to dialysis on 9/27/2023. Staff #1 presented the surveyors with a copy of Resident #517 ' s Dialysis Communication Form. Surveyors, Staff #1, and the interim DON reviewed the form and discovered the form was incomplete. The form did not include the resident ' s current health status (at the time of transfer from the unit to the Dialysis clinic). The interim DON and Staff #1 confirmed that the form did not include the important information needed to transfer Resident #517 to the dialysis unit. On 9/29/2023 at 7:00AM, Surveyors conducted an interview with the Dialysis Post-Acute Services Nurse, Staff #74. During the interview, Staff #74 revealed that GNA (Geriatric Nursing Assistant), Staff #13, brought the resident to the dialysis clinic unexpectedly on 9/27/2023 at 10:00AM. Staff #74 went on to say that Resident #517 was drooling, non-verbal, shaking, diaphoretic (sweating heavily), soaking wet, unstable, and did not look well. Resident #517 could not communicate with me and the resident never received dialysis that day. He/she did not come to the dialysis clinic with his/her dialysis communication form. Surveyors showed Staff #74 a copy of the form that Staff #1 provided to surveyors on 9/28/2023. Staff #74 confirmed that the dialysis communication form did not come with the resident that day. Staff #74 let surveyors know that the dialysis staff do not have access to the facility ' s electronic medical record for residents, so the dialysis communication form is how nursing staff and dialysis staff would communicate resident care before and after dialysis. On 9/29/2023 at 10:27AM, surveyors reviewed the facility ' s Dialysis policy. The policy states that nursing staff will provide a report to the dialysis provider regarding the resident ' s condition and treatment provisions each dialysis treatment day, and as needed. On 9/29/2023 at 10:53 AM, Surveyors interviewed Staff #13 who revealed, she usually informs the nurse when she ' s taking the resident to dialysis. Resident # 517 didn't have a dialysis binder available. On 10/3/2023 at 9:30 AM, surveyors interview the Unit Coordinator, Staff #21 who stated that the Dialysis Communication Form should be filled out entirely especially the areas pertinent to the residents condition before being transported to the dialysis center. If there is a change in condition observed, it is to be included on the form to inform the dialysis staff. The sending nurse should sign off on the form and send the form to the Dialysis Clinic with the resident. The identified concerns were communicated to the interim DON and Administrator throughout the investigation and again at 12:30 PM on 11/17/2023. 42828 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the Narcotic Binder on 10/12/2023 at 9:18 AM, revealed a Medication Monitoring Control Record with pharmacy label for Resident #93 that included an order written on 6/14/2023 by Physician's Assistant, Staff #56, that read: Give [opioid] 5 mg (milligram), 1 tablet by mouth, every four hours, as needed for pain. During record review in the presence of Staff #25 on 10/18/2023 9:25 AM. the medication monitoring control record for Resident #93 showed that, daily from 10/11/2023 through 10/16/2023, facility staff documented administering 2 tablets of {opioid} 5 mg, to Resident #93 for a total of 15 doses administered. On 10/18/2023 at 9:30 AM, further investigation into Resident #93's medical record revealed an order in PCC (the electronic medical record) that read: Give {opioid}10 mg (milligram), 1 tablet by mouth, every four hours, as needed for pain. On 10/18/2023 at 9:50 AM interview was conducted with Staff #25 in the presence of the interim DON. Staff #25 stated the Physician's Assistant, Staff # 56, changed Resident #93's {opioid order} and he {staff #25} wrote on the {opioid} label Direction change, 2 tablets every four hours. On 10/18/2023 11:30 AM, the interim DON submitted documents to surveyors titled, One on One Education and Controlled Substance Administration and Accountability policy with signatures listed from all Unit Managers and various licensed nurses as having received the education. An interview was held on 10/26/2023 AM with Staff #56, which revealed the expectation was that the medication would not be wasted because if she had changed the order in the electronic record, the pharmacy would've taken too long to deliver the medication and it didn't make sense to waste it. The nurses are to follow the medication orders in PCC. A subsequent interview was conducted with the Regional Director of Clinical Operations, (RDCO) on 10/26/2023. The RDCO confirmed that medication orders between the resident's electronic record and the medication monitoring control record were to be the same. The RDCO provided surveyors with a document titled One on One Education with the topic: When orders are placed in PCC, the old orders need to be discontinued. This includes pain medications and other medications. The educator was listed as the Medical Director and the document was signed by Staff #56. The interim DON, RDCO and Administrator were made aware of the identified concerns throughout the survey and again at survey exit. 37584 5a. A review of the resident's Medication Administration Record (MAR) on 11/2/23 at 08:00 am revealed an admission order dated 06/22/23 for Gabapentin Oral Capsule 100 MG (Gabapentin) Give 1 capsule by mouth one time a day every Mon, Wed, and Fri for nerve pain; To be given after dialysis. However further review of the monthly MARs showed that Resident #46 had received Gabapentin 3 out of 7 days per week since their June 2023 admission. Further review of the Gabapentin monthly administration record found 74 missed doses from June 24, 2023, through November 3, 2023. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident #46's physician (staff # 50) on 11/02/23 at 10:15 AM it was revealed that it was expected that all admission orders are reviewed at least twice, once by nursing and the other by a physician. Staff #50 added that the nursing staff reviews can be completed with the physician over the phone. According to Resident # 46's Nursing Unit Coordinator (staff#3) during an interview conducted on 11/03/2023 at 1:45 PM, he performed daily reviews and reported any discrepancies he found to the residents' physician and the Director of Nursing. He also indicated that it was his responsibility to oversee physicians' order management and monitoring by daily progress notes and physicians' order reviews that included a review of all new admissions' documentation to ensure orders are written and transcribed accurately and administered to residents accordingly. This was conducted through the reviews of all MARs and Treatment Administration Records and provided notifications to pharmacy for needed corrections associated with them. He also provided staff education as needed. During the interview he confirmed he knew Resident #46. When asked he stated he have been doing the reviews but never found any issues with Resident #46's medication orders. During the interview staff #3 reviewed Resident #46's admission order for Gabapentin and the transcribed administration instructions on the June 2023 - November 2023 MARs shared by the surveyor. Staff #3 acknowledged that the admission orders for the Gabapentin's, administration, and the monthly MARS transcriptions were inaccurate, should have been reviewed, and verified by the resident's physician before transcribed and checked by nursing for accuracy before administrating the medication to the resident. He also acknowledged the undetected inaccurate orders and MARs for Resident #46 caused continuous medication errors that resulted in the 74 missed doses from June 2023 through November 2023. During a follow-up interview with staff # 50 on 1/07/23 at 2:00 PM, when asked she stated staff #3 had made her aware of the inaccurate order and dosage frequency transcription errors for Resident #46's Gabapentin medication. 5b. Record reviews that involved intake # MD00196805 was conducted on 11/07/23 at 11:47 AM. Review of the intake revealed Resident #46 expressed concerns of multiple episodes of high blood pressure that had not been addressed by staff. The medical record review revealed that Resident #46 was admitted to the facility with diagnosis that included high blood pressure (aka Hypertension or HTN), and kidney failure requiring dialysis. Further review showed Resident #46 had weekly dialysis treatments in a satellite dialysis center located in the facility scheduled for Mondays, Wednesdays, and Fridays weekly. Review of the Medication Administration Record (MAR) revealed a physician order dated 06/23/23 for a 30 mg tablet of the medication Nifedipine was to be given by mouth four (4) times a week to help control the resident's HTN. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Dialysis Center Nurse (staff #74) on 09/29/23 at 9:43 AM she stated that Resident #46 was scheduled for dialysis treatments every Mondays, Wednesdays, and Fridays. She added since the dialysis staff do not have access to the facility's residents' electronic medical records, Each resident has a Dialysis Communication Form completed for every visit to the dialysis center. On the form, the resident's nurse would complete the top portion titled Pre-Dialysis (PD) information. The middle section titled Dialysis Center Information (DCI) was completed by the dialysis nurse. The bottom section titled Post-Dialysis Information (PDI) was completed by the unit nurse upon return from dialysis. She said that all 3 entries required the licensed nurses to include important information that ensured the resident's physical condition was monitored before, during, and after dialysis and all identified problems were reported to the resident's physician for further investigation. The information included the current blood pressure reading, (BP) heart rate (Pulse), respirations (breaths taken per minute), body temperature and any complaints of pain. Staff # 74 added that the forms were kept in a binder at the nurses stations on the unit. On November 7, 2023, at 10:30 AM, a review of Resident #46's Dialysis Communication Binder was conducted for the months of July 2023 through October 2023. A review of August 2023 forms revealed that on August 7, 2023, staff # 74 indicated the resident's blood pressure at the dialysis center was recorded at 181/103. The nurse also indicated that the resident complained of a headache at a level 5 out of 10. (0 meaning no pain and 10 meaning the worst pain) Further review of the 8/7/23 report showed that the unit nurse's post - dialysis documentation indicated the resident's BP was 139/84 and reported a headache at a level of 10 out 10. (Blood pressure is measured using two numbers: The first number, called systolic blood pressure, measures the pressure in your arteries when your heart beats. The second number, called diastolic blood pressure, measures the pressure in your arteries when your heart rests between beats. Blood pressure is considered high (stage 1) if it reads 130/80. Stage 2 high blood pressure is 140/90 or higher. A blood pressure reading of 180/110 or higher more than once, is considered an hypertensive crisis.) Further review of the August Communication Forms revealed 7 out of 7 visits to the dialysis center the resident BP was recorded between 139/84 and 181/103. Further review found that on August 9, 18 and 25, all three BP readings on the communication forms were between 139/84 and 181/103. On August 14, it indicated 2 BP readings between 139/84 and 181/103. Additional review of the August log indicated Resident #46 complained of a headache 5 of the 7 visits and headache with body pain on August 14. However, there was no documentation found to support that the resident's physician was notified of the abnormal blood pressures or the complaint of headaches or body pain. During a brief interview with Resident #46's primary physician (staff #50) on 11/02/23 at 10:15 AM she stated that on 08/17/23, she visited the resident at their request to discuss their concerns. Resident #46 spoke of multiple occurrences of elevated high blood pressure readings with occasional head and body aches which had recently increased in frequency and intensity. She added that there was a review his current blood pressure but was unable to confirm his concerns, so she ordered for nursing staff to record his blood pressures every shift for a few days to validate the resident's concerns and determine if any adjustments in the resident's blood pressure medication regimen was needed. A record review for Resident #46 conducted on 11/02/23 at 12:15 PM revealed a progress note written by staff #50 that confirmed the 08/17/23 visit with Resident #46 and his/her expressed concerns regarding their blood pressure. However further record review failed to show any additional blood pressures were recorded that day or instructions parameters given to increase the number of BP readings for the resident were added. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the August 2023 Treatment Administration Records (TAR) failed to show any requests for vital sign monitoring for Resident # 46. Further review of the TAR shows the resident's vital signs were discontinued on 08/17/2023 and no new order for vital signs were found. During an interview with Resident #46's Nursing Unit Coordinator (staff #3) on 11/03/2023 at 1:45 PM, he stated that although the order for vital signs were discontinued, the nursing staff conducted daily screens of the residents that included blood pressure records. However, a review of the blood pressures recorded on the July 2023 and October 2023 TARs with staff #3 failed to correlate with the BPs recorded on communication forms. Further review found BPs readings on the TARs that warranted physician notification, but no documentation was found or presented to indicate that this was done. A review of the August 2023 Medication Administration Record for Resident #46 conducted on 11/02/23 at 1:30 PM indicated that on 08/18/2023, the 06/22/23 order for Nifedipine Extended Release (ER) was changed from 30mg one time a day every Tuesday, Thursday, Saturday, and Sunday to Nifedipine ER 30 mg one time daily. Further record review by surveyor found no documentation to support that an order was placed to monitor the frequency of elevated blood pressures, or guidance to determine reportable abnormal blood pressure readings to the physician nor any additional blood pressure readings were conducted. A review of Resident 46's September 2023 Dialysis Communication Forms indicated that 6 of 6 dialysis treatment visits the resident's BPs was recorded between 143/81 and 194/88. On 9/29/23 all three recorded BPs were 155/86 and 164/88. On 09/01/23 the Dialysis Center BP was recorded as 152/90 and the Post Dialysis BP was recorded as 148/96. Further review found 4 of 6 visits failed to indicate a pre or post dialysis BP readings were recorded. On 9/20/23 no pre or post dialysis BP readings were indicated on the form. Review of October's Dialysis Communication Forms indicated that 7 of the 7 dialysis treatment visits Resident #46' blood pressure was recorded between 150/90 and 166/101. On October 18, and 20, 2023, all 3 recorded BPs were between 152/84 and 160/94 and on 10/27/23 the dialysis center's BP was recorded as 166/101, with a complaint of a headache at a level of 6 out of 10 and the resident's post dialysis BP was recorded as 156/82 for the resident. Further record review failed to show that staff #50 was notified of the BP readings recorded after she adjusted Resident #46's Nifedipine administration frequency on 8/18/23. During the 11/03/2023 at 1:45 PM interview with staff #3, he stated he conducted daily reviews of progress notes, followed-up on new admissions, and physician order changes to ensure orders are written and transcribed accurately and administered to residents accordingly. Noted discrepancies were referred to the physician and Director of Nursing (DON). He conducted any needed documentation follow ups, pharmacy notifications, and provided nurse education. The reviewed information is discussed in daily meetings in-person or by phone call with nurses on the unit, the DON, the Administrator, and others as determined. When asked by surveyors, who was responsible for the review of the facility's Dialysis Communication Forms, he shared that his responsibilities included a daily review of the facility's Dialysis Communication logs and the recurrent Medication and Treatment Administration Records monthly and periodic changes that occurred in between. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When Staff #3 was asked what would you consider to be an example of an elevated blood pressure reading, he responded in general BP baseline for all residents: are between 130 - 140 and post dialysis 120. Low BPs are common with dialysis residents. Surveyors asked what he expected the nurses response to be if a resident's BP is over or under the baseline blood pressure. Staff #3 replied that the nurse would attend to the patient. Check if resident was medicated if not administer and recheck the BP. If not medicated notify the MD (Medical Doctor) and document the incident in the electronic health record. He added it is also his responsibility to read the pre and post dialysis notes and communication forms, for any change in condition, and follow-up on documentation related to reports, and any reporting and communications from dialysis. During the interview he confirmed he knew Resident #46. When asked he stated he have been doing the reviews but never found any issues with Resident #47's communication log reviews. The surveyor showed the progress note documented on 8/17/23 that involved the conversation between staff #50 and the resident who stated had expressed multiple concerns to staff regarding elevated BP levels and the surveyor's concerns noted during the record reviews. Staff #3 responded that the COVID-19 assessments included the BP checks and would have been documented there. On 11/03/23 at 2:15 PM, a review of the COVID-19 assessment screenings for Resident #46 was conducted. Review of August through October 2023 assessments revealed sixteen (25) incidents an automated exceeded 139 systolic thresholds alert was triggered related to the resident's recorded BP readings submitted by nursing staff. Further review found no evidence that the alerts were reported to Resident #46' physician or associated documentation to support that the BPs were addressed.

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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. 14894 Based on clinical record review, resident interview, and staff interview it was determined that the facility staff failed to ensure residents' discharge goals are evaluated and planned. This was evident for 3 (#71, #165, #46) of the 7 residents reviewed for the discharge process. The findings include: 1. A review of Resident #71's clinical record on 10/31/23 as part of the investigation for intakes #MD00181160, #MD00183249, and #MD00190405 revealed that on 11/18/21 the Social Worker met with the resident to discuss progress in the facility as well as plans for discharge. The resident expressed a desire to return to the assisted living facility the resident occupied prior to admission to the nursing home. The Social Worker wrote This writer will follow up with this resident as needed. On 4/17/23 at 4:12 PM the Social Worker (Staff #14) wrote a social services progress note. The note says, Resident's son has been visiting and care plan meeting is scheduled for 4/20/23 to discuss discharge plans. The resident again expressed a desire to return to the community as expressed to the interdisciplinary team. This desire is reflected in the care plan goal to return to community setting such [as] an apartment in the community through [the] Waiver [program] upon discharge. The care plan was initiated on 6/4/23. A care plan goal was also created [Resident] will verbalize understanding of discharge plans and how to achieve goal. The goal was initiated on 6/4/23. The resident was still in the facility during the recertification survey. The Administrator was interviewed on 11/16/23 at 1:20 PM. We discussed that the resident has been requesting to be discharged since admission. Administrator could not explain why discharge has not happened. Mentioned there have been staffing changes over the years. He said he would review the resident's request for discharge with the interdisciplinary team. 2. A review of Resident #165's clinical record as part of the investigation for intake #MD00175238 was reviewed starting on 10/19/23. The facility Social Worker, the Ombudsman, the resident and the resident's spouse met on 8/3/22. The reason for the meeting was the resident had been caught smoking in inappropriate places. Resident and spouse had both been informed of the facility's concern. Resident was reported as being impulsive. Options were discussed including but not limited to increasing smoking times. The resident was issued a 30-day involuntary discharge as the facility could not accommodate the resident's need to smoke when the resident wants to smoke. Resident requested going to a location that would allow more opportunities to smoke. Resident rejected the nicotine patch. Spouse agreed to call facilities close to them and the Social Worker would call facilities in the community. They agreed the resident needed close supervision by staff. Resident would not identify who supplied the smoking materials. Spouse is in agreement to transfer to facility offering more smoke options. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker wrote a note on 3/2/23 at 6:22 PM that she informed the spouse that the resident was still having smoking issues and that the case worker was working with spouse on discharge plans. A discharge care plan meeting was held on 3/14/23 at 8:15 PM. Resident, spouse, friend of the resident, a Service Coordinator from the community waiver program, and facility staff attended. Administrator communicated the need for a safe discharge. Spouse communicated that arrangements for moving into an efficiency apartment that was already occupied were made. Administrator advised spouse to follow the correct steps to ensure a safe discharge for the resident. Social Worker tried to explain that it would be better to continue to keep resident on waiver where resident would be eligible for benefits. Spouse disagreed with the need to maintain resident on waiver program. Spouse was reminded it was still the facility responsibility to make sure resident is discharged to a safe location. Spouse disagreed and at this point informed team he/she was taking resident against medical advice (AMA). Spouse was made aware this would not be a safe discharge as nothing was in place such any medications or a wheelchair. Spouse left the facility with the resident. A review of the facility AMA form revealed that the resident and spouse refused to follow waiver program process. Spouse wanted the resident to discharge to a studio apartment where the resident would not be on the lease. It was not clear that the spouse and resident were thoroughly educated on the discharge process prior to the meeting. The Social Worker (Staff #14) and the Administrator were interviewed on 10/19/2023 at 10:29 AM. If a resident smokes in the facility they are provided a behavioral contract. Activity puts them on contract. Smoking agreement if violated then the contract starts, and Activity enforces. Social work handles contracts for physical aggression. Rescinded 30-day notices are kept in business office. Administrator kept referring to their lawyers and that they did not like the language in the 30-day notice. The Administrator was interviewed on 10/19/2023 at 1:30 PM. He said he checked with the business office and there was not a 30-day discharge notice issued for this resident. This surveyor said it is mentioned in the chart and he said he would check with the corporate lawyers. The Administrator was interviewed on 10/19/2023 at 1:42 PM. He stated a 30-day was not given because the resident left AMA. This surveyor said the 30-day notice was given earlier in the resident's stay, and then I showed him where it was in a care plan. He replied that it might have been for a different resident. I read it to him to show it was not likely to be someone else. He replied understood. He also said he has a phone call into the lawyers. The Administrator supplied on 10/20/23 at 11:34 AM an email chain. Resident appears to have been issued two 30-day discharges. Neither of the discharge notices were present in the chart. Email chain says the second 30-day discharge had been rescinded about the time of actual discharge. 45733 (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 10/13/23 at 09:50 AM an interview was conducted with Resident #46, he/she complained why am I still here? Resident #46 met with the Social Worker Staff #14 for a safe discharge request and had not heard back from her in terms of securing an outpatient dialysis center in his/her community for 3 times per week hemodialysis as soon as possible. On 10/13/23 at 10:20 AM, in reviewing the social worker's notes, no documentation was found to support Resident #46's request was in progress. During an interview on 10/13/23 at 10:39 AM with staff #14 revealed she was too busy and had not even started making any contact to outpatient dialysis centers near Resident #46's home. On 10/19/23 at 12:11 PM an interview was conducted with Staff #14 and Social Worker's Assistant (Staff #64) revealed no progress was made to secure an outpatient dialysis center. Staff #64 stated she filled out the Metropolitan Transportation Authority (MTA) transportation ride request for to and from the future dialysis center only. Metropolitan Transportation Authority (MTA) the public transport agency in the metropolitan areas.

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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** 14894 Based on clinical record review, review of complaint intakes, observation, and staff interview it was determined that the facility staff failed to ensure residents received quality care regarding, but not limited to, medication administration, catheter care, conduct and document accurate nursing assessment, promptly identify and intervene for an acute change in a resident's condition and to provide an emergency medication (Glucagon) timely to a resident (Resident #108) with a finger stick result of 41mg/dl. This was evident for 10 (#121, #161, #364, #381, #63, #16, #517, #162, #131, and #108) out of 140 residents in the survey sample for the annual recertification and complaint survey. The findings include: 1. A review of Resident #121's clinical record on 10/30/23 as part of the investigation into intake #00191930 revealed the resident had a follow up Angiogram (a scan that shows blood flow through circulatory system) scheduled for 1/23/23 at a hospital. The resident was unable to go to the appointment because the resident requires ambulance transportation and transfers using a Hoyer lift which was broken at the time of the appointment. The appointment was rescheduled for 2/6/23. A review of the resident's Medication Administration Audit Report (MAAR) on 11/17 and 11/18/23 revealed that the resident had several medications administered outside of the prescribed time. The resident was admitted on [DATE]. The resident was prescribed Lidocaine patches (treats pain) for both knees to be applied at 9:00 AM but they were not applied until 11:26 AM. Metoprolol (blood pressure medication) was ordered for 9:00 AM but not administered until 11:27 AM. Clopidogrel (prevents clotting) was ordered for 9:00 AM but not administered until 11:26 AM. Triumeq (treats HIV) was ordered for 9:00 AM but not administered until 11:27 AM. The third floor Unit Manager (Staff #3) was interviewed on 11/3/23. He stated it is his responsibility to follow-up on new admissions, and to ensure orders are written/transcribed accurately. 2. Resident #161's clinical record was reviewed on 11/14/23 as part of the investigation into intake #MD00177440. The resident was admitted on [DATE] but medications were not started until 12/30/21 and were administered 2-4 hours past the ordered time. Prednisone 10 mg (treats inflammation) and Zyprexa 5 mg (helps mental health) were ordered to be administered at 8:00 AM but were not administered until 12:16 PM. Metoprolol 50 mg (blood pressure medication) was ordered to be administered at 9:00 AM but not administered at all. Medications ordered to be administered at 9:00 AM but not administered until 12:16 PM: Multi Vitamin, Folic acid 1 mg, Vitamin D3, Apixaban 5 mg (anticoagulant), Depakote 250 mg (treats bipolar disorder), Senokot 1 tab, Haloperidol 5 mg (treats mood), Hydroxycholoroquine 200 mg (treats Lupus), FerrouSul 325mg, Docusate 100 mg, and Nifedipine 90 mg (treats hypertension). Levothyroxine (treats thyroid) 25 mcg ordered to be administered at 10:00 AM but not administered until 12:17 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator informed of findings on 11/17/23 at 1:30 PM. No evidence provided prior to exit. 3. Resident #364's clinical record was reviewed on 11/8/23. Resident was admitted on [DATE] at 9:30 AM. Some medications were not administered until later in the day or not until 10/1/22. Resident's physician ordered Albuterol (treats asthma) 2 puffs twice a day and Fluticasone (treats asthma) 2 puffs twice a day, both ordered for 8:00 AM and 8:00 PM but neither administered on 9/30/22. Metanx (treats diabetes) 1 capsule twice a day was ordered to be administered 9:00 AM and 5:00 PM but not administered on 9/30/22. Cefepime (treats osteomyelitis) 1 gm was ordered to be administered every 6 hours and was administered at 12:00 PM but not at 8:00 PM on 9/30/22. Administrator informed of findings on 11/17/23 at 1:30 PM. No evidence provided prior to exit. 47758 4. During a review of the June 2021 Medication Administration Record (MAR) on 10/17/23 at 8:10 AM, the surveyor identified that Resident #381 had missed 107 out of 870 medication doses documented as administered on the MAR. This was indicated with a blank space for the date and time the medication was to be administered. On 10/17/23 at 1:26 PM, the surveyor interviewed the Regional Director of Clinical Operations (RDCO) regarding the concern of Resident # 381's missing medication doses from June 2021. She stated that she would investigate and get back to the surveyor. During an interview on 10/18/23 at 7:44 AM the RDCO stated that she reviewed the progress notes, but she was not able to find documentation of refusal in Resident # 381's progress notes from the missing doses in June 2021 and that staff would be trained on the proper documentation of medication administration. 44440 5. On 11/8/23 at 3:30 PM, the surveyor reviewed Resident #63's medical record. The review revealed a change in condition note written on 11/7/23 by Registered Nurse Staff #31. The note described the nurse gave Resident #63 his/her Methadone (a medication given to help Substance Use Disorder) at around 10:30 AM. It further described that the medication appeared to be due to be given in the Electronic Medication Administration Recorded (eMAR). After the administration of Methadone, the nurse then realized that the previous shift signed out the medication in the logbook, stored where the medication was located but not in the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/9/23 at 2:07 PM, the surveyor interviewed Staff #31. In the interview Staff #31 stated she was orientating a new nurse, and the new nurse informed me that she had given the Methadone that was due for Resident #63. Staff #31 stated, when she reviewed the medication change of custody record for Resident #63's Methadone she discovered that Resident #63's Methadone had already been documented as taken from the supply on 11/7/23. Staff #31 stated the new nurse failed to sign out the medication on the medication chain-of custody record when she took the Methadone. Staff #31 stated they asked Resident #63 if the previous nurse had given the medication but Resident #63 could not recall if he/she had received a dose earlier in the day. She further stated, the physician was notified, and the Resident was monitored with no issues. Staff #31 reported she provided education to the new nurse that at the time Methadone is removed to be given, staff needs to endorse that the medication was taken on the chain of custody form and when removing the medication, to verify the time the last dose was removed on the chain of custody form. On 11/17/2023 9:49 AM, the surveyor interviewed the 3rd floor Unit Manger Staff #3. During this interview Staff #3 confirmed that when Methadone is taken for administration the staff is expected to sign the medication chain of custody record as well as document the medication was administered in the eMAR. At this time the surveyor reviewed Resident #63's medication chain of custody record. The record indicated on 11/7/23 two doses were signed out on a medication that was to be given daily. The surveyor interviewed the Nursing Home Administrator (NHA) on 11/16/23 at 1:47 PM. During the interview, the surveyor informed the NHA of the concern related of Staff not following medications administration practices. 37277 An indwelling urinary catheter (Foley) is a tube that drains urine from the bladder into a bag outside the body. It is held in place in the bladder by a balloon. 6. On 09/29/2023 at 9:53 AM, Resident #16 was observed to have a Foley catheter. Per resident, in April, he/she had a urinary tract infection. He/she stated, it went to my blood. On 10/02/2023 at 8:08 AM, a medical record review revealed that Resident #16 had gone out to the hospital in March. From the time the resident returned from the hospital on 3/23/23 to the time the resident went back out to the hospital on 04/16/2023, there were no active orders for Foley catheter care/maintenance. Foley catheter care/maintenance orders would have been necessary to guide the nursing care. It is the standard of practice to have orders in place instructing nursing to maintain the Foley catheter. Maintaining the catheter includes, but is not limited to, checking placement and for drainage. Additionally, there were no progress notes during this time that indicated Foley catheter care was being performed. A review of hospital notes dated 04/17/2023, revealed that Resident #16's condition was due to septic shock and a urinary tract infection. Regarding the Foley catheter, he/she was found to have incomplete drainage given inappropriate foley catheter plaent. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/2023 at 10:16 AM, the Director of Nursing (DON) acknowledged there should have been orders for catheter care/maintenance. Per the DON, ultimately it would have been the nurses' responsibility to ensure those orders were in. 49148 7. On 9/27/2023 at 9:09 AM, during a tour of the unit, surveyors observed Resident #517 sitting up in bed, sweating heavily with hair and shirt drenched, head bent while rubbing the back of neck, and restless in bed. Surveyors noticed a CVC (central venous catheter: an indwelling tube into the vein used for medications) in his/her left chest and AVF (arteriovenous fistula: dialysis port) in his/her right upper arm. During an interview with Resident #517, surveyors asked how he/she was feeling. Resident #517 responded by saying I ' m so hot. The resident ' s speech was slurred and hard to understand during the conversation. At 9:14 AM, Surveyors expressed concerns to Unit manager #1 regarding Resident #517 ' s condition. On 9/27/2023 at 9:50 AM, review of Resident #517's electronic medical records confirmed that the resident was admitted on [DATE] with diagnoses that included, but was not limited to, end stage renal disease (kidney disease), dependence on renal dialysis, osteomyelitis (bone infection), laminectomy, fusion of spine, heart failure, high blood pressure, hypoglycemia, severe protein calorie malnutrition, chronic hepatitis C, and chronic postprocedural pain. The admission assessment dated [DATE] showed that the resident was cognitively intact, alert, and able to make his/her own decisions. On 9/28/2023 at 8:33 AM, during record review, surveyors discovered a nursing progress note written by Staff #1 on 9/27/2023 at 10:35 AM stating that Resident #517 was being transferred to the hospital emergency room due to hypoglycemia (low blood sugar), shortly after being taken to the dialysis clinic within the facility. Staff #1 noted the resident to be diaphoretic (sweating heavily), shaking, and unable to speak clearly, with a low blood sugar reading. On 9/28/2023 at 1:49 PM surveyors conducted an interview with the Interim Director of Nursing (DON). Surveyors expressed the concern that Resident #517 was visibly unstable before being sent to the dialysis clinic and then transferred to the hospital as a result. An interview with Staff #1 on 9/28/2023 at 2:29PM, revealed that she was aware that the resident was unstable during her encounter with Resident #517 on 9/27/2023 at 9:14AM. Staff #1 stated that she was aware the resident was hypoglycemic, but did not check the resident's blood sugar before sending him/her to dialysis. She stated that she was made aware of Resident #517's condition from the dialysis clinic and asked to retrieve the glucagon emergency kit for the resident. from the medication cart and told to Licensed Practical Nurse (LPN) # 104 to administer it to the resident. Staff #1 did not go to the dialysis clinic to assess the resident while he/she was there. The Interim DON was present during the interview with Staff #1. The interim DON informed the surveyors that in an emergency, nurses can give glucagon and then request an order from the physician later. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/2023 at 7:00AM, Surveyors conducted an interview with Dialysis Post-Acute Services Nurse, Staff #74. During the interview, Staff #74 revealed that Geriatric Nursing Assistant (GNA), Staff #13, brought Resident #517 to the dialysis clinic unexpectedly on 9/27/2023 at 10:00AM. Staff #74 stated that the resident was on the schedule for 9/27/2023 at 1:00PM.Staff #74 stated that Resident #517 was drooling, non-verbal, shaking, diaphoretic (sweating heavily), soaking wet, unstable, and did not look well, and could not communicate with her. Staff #74 asked Staff #13 does the nurse know he/she looks like this? Staff #13 stated Yes. Staff #74 informed us that she was able to get the resident to the hemodialysis chair with assistance, obtain vital signs and a blood sugar level. The blood sugar level was so low that it would not register on the glucometer. Staff #74 gave the resident glucose gel to help increase blood sugar. The blood sugar check 15 minutes after administration of the gel and the level still didn't register. Staff #74 called the nursing unit to ask Staff #1 for an emergency glucose kit. Licensed Practical Nurse (LPN), Staff # 104 arrived at the dialysis clinic with the glucose syringe and administered the medication to the resident. Physician # 103 arrived at the dialysis clinic about 10:45AM and assessed the resident. Resident #517's blood sugar was checked after 10 min and registered at 68. Staff #74 rechecked Resident #517 blood sugar 2 more times and both readings were low. 911 was called and the resident was transferred to the hospital. The resident never received hemodialysis that day. Staff #74 stated she notified Staff #1, Administrator, and Interim DON of Resident #517's condition while at the dialysis clinic 9/27/2023 at 10:00AM. On 9/29/2023 at 7:45 AM, during review of Resident #517's electronic medical record, surveyors discovered a daily nursing charting assessment dated [DATE] at 1:53PM. The assessment revealed that Staff #1 inaccurately assessed changes in level of consciousness, orientation, cognition, or communication status. On 9/29/2023 at 10:34 AM, Surveyors interviewed Resident #517 in his/her room. Resident #517 stated that he felt queasy, threw up, and broke out into a sweat on 9/27/2023. The resident stated he/she told the nurse. Resident #517 was unable to recall leaving his/her room and going to the dialysis clinic. On 9/29/2023 at 10:53 AM, surveyors interviewed Staff #13. Staff #13 stated that she was instructed to take the resident to dialysis by Staff #1. Staff #13 said that the resident was very sweaty and unsteady during transfer to wheelchair. Staff # 13 told Staff #1 of Residents #517's condition before she left the unit. Staff #13 stated that she usually takes the residents to dialysis with a dialysis communication form, but Resident #517 did not have one. The identified concerns were reviewed with the Administrator and Interim DON throughout the investigation and on 11/20/2023 at 12:30 PM. 18819 The findings include: 8. A review of Resident #162's closed medical record on 10/26/23 revealed that Resident #162 had been admitted to the facility on [DATE] with diagnoses that included: metabolic encephalopathy, liver abscess, diabetes, substance abuse disorder, and sepsis. Resident #162 was discharged on [DATE]. A review of Resident #162's physician admission orders, dated 09/28/23 at 10:05 PM, revealed the following medication orders: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Ceftriaxone, 2 Grams, IV, every day for 4 days. Did not receive a dose until 10/01/23. 2) Fluticasone Nasal Spray, 2 sprays each nostril, every day, for Allergies. Did not receive a dose until 10/01/23. 3) Lasix, 20 mg, orally, every day, for edema. Did not receive a dose until 09/30/23. 4) Insulin Detemir, 7 units, subcutaneously, at bedtime. Did not receive a dose until 10/01/23. 5) Levocetirizine, 5 mg, orally, every day, for antihistamine. Did not receive until 10/01/23. 6) Methadone, 35 ml (70 mg), orally, every day, for drug therapy. Did not receive a dose until 09/30/23. 7) Montelukast Sodium, 10 mg, orally, every day, for COPD/asthma. Did not receive a dose until 09/30/23. 8) Cipro, 500 mg, orally, twice a day for 21 days, for liver abscess. Did not receive a dose until 10/01/23. 9) Albuterol Inhaler, 2 puffs, 4 times a day, for shortness of breath/wheezing. Did not receive a dose until 10/01/23. 10) On 10/12/23 at 5:19 PM, Permethrin 5 % cream, apply to full body, every day for 14 days. For insect bites. Never received an application. 11) The staff also failed to order the medication Narcan as needed. The resident has a history of substance abuse disorder and was receiving the medications Methadone for addiction and Oxycodone for pain. In a telephone interview with the facility pharmacy manager on 10/27/23 at 10:37 AM, the facility pharmacy manager stated that the pharmacy did receive Resident #162's admission medication requests on 09/28/23. On 09/29/23 all of Resident #162's medications were placed in a profile only status as the facility nursing staff, when ordering, did not request the medications to be sent. The pharmacy staff placed Resident #162's medications into the system so the nurses can see the MAR in the resident's record. On 09/30/23, medications were still in a profile only status until one of the facility nurses called and requested the pharmacy to send the medications. 9. A review of Resident #131's closed medical record on 10/27/23 revealed that Resident #131 had been admitted to the facility on [DATE] with diagnoses that included: end stage renal disease on hemodialysis, opioid abuse, anemia, GERD, atrial fibrillation, and blindness. Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #131's physician orders, dated 02/12/22, revealed orders to administer the medication, Midodrine, HCL, 5 mg, orally, every 8 hours as needed, hold the medication for a systolic blood pressure greater than 130 mm/Hg. Review of Resident #131's medication administration records (MAR) from 02/12 through 07/28/22, failed to reveal the nursing staff had administered a single dose to Resident #131. February 2022, 9 AM Systolic BP readings included: 02/14 - 126, 02/15 - 127, 02/18 - 117, 02/20 - 110, 02/21 - 118, 02/22 - 108, 02/23 - 119. February 2022, 5 PM Systolic BP readings included: 02/12 - 113, 02/13 - 104, 02/14 - 126, 02/15 - 127, 02/17 - 122, 02/18 - 128, 02/19 - 113, 02/21 - 120, 02/22 - 121, 02/23 - 128, 02/24 - 129. April 2022, 9 AM Systolic BP readings included: 04/01 - 127, 04/06 - 127, 04/08 - 122, 04/10 - 127, 04/14 - 124, 04/19 - 125, 04/21 - 129, 04/22 - 128, 04/29 - 128, 04/30 - 121 April 2022, 5 PM Systolic BP readings included: 04/02 - 125, 04/03 - 127, 04/07 - 127, 04/10 - 127, 04/13 - 127, 04/14 - 124, 04/19 - 127, 04/22 - 127, 04/29 - 128, 04/30 - 121, 04/31 - 125. Further review failed to reveal that staff were monitoring Resident #131's blood pressures at 1 AM nor did the nursing staff sign off they had administered a dose of Midodrine at 1 AM (every 8 hours) from 02/12 through 07/28/22. Further review of Resident #131's closed medical record revealed a physician progress note, dated 07/12/22, and nurse practitioner notes, dated 05/16/22 and 05/24/22, all indicating Resident #131 was receiving the medication Midodrine every 8 hours and withholding the medication for a Systolic Blood Pressure greater than 130 mm/Hg. Further review of Resident #131's closed medical record revealed a care plan for the indication of hypotension related to end stage renal disease that was initiated on 02/12/22. 10. Review of complaint MD00199200 on 11/07/23 revealed an allegation the nursing staff failed to accurately assess and intervene when Resident #108 had a change in condition. When 911 staff arrived at approximately 8:10 AM, 911 staff arrived, the facility staff reported to the 911 staff that there was nothing wrong with Resident #108. 911 staff spoke with the facility nurse and requested recent vital signs for Resident #108 and was informed that Resident #108's vital signs were fine. Unable to locate a recent of vital signs, the facility nurse obtained a new set of vital signs. 911 indicated Resident #108's vital signs were reported as: blood pressure 87/45, heart rate 50, respiratory rate of 22, and a finger stick glucose reading of 45 mg/dl. Resident #108 was moved to a stretcher and sent to the emergency room . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #108's medical record on 11/07/23 revealed that Resident #108 was admitted to the facility on [DATE] with diagnoses that include but not limited to anemia, bacteremia, psychoactive substance use, arthritis, and streptococcal sepsis. Resident #108's attending completed a MOLST form on 07/24/23 that indicated Resident #108 wants to be a Full Code and also wanted all life sustaining procedures. On 11/06/23 at approximately 8 AM, Resident #108's family member phoned 911 due to a change in condition in Resident #108's level of consciousness. In an interview with staff member #98 on 11/07/23 at 10:45 AM, staff member #98 stated she arrived on the second floor at approximately 7:30 AM and observed Resident #108's family member was in Resident #108's room. Staff member #98 stated that she was informed by the night shift nurse that Resident #108's family member wanted Resident #108 to be transferred to the emergency room but earlier Resident #108 had refused to go. Staff member #98 stated that 911 had arrived and requested a set of recent vital signs for Resident #108. Staff member #98 stated that she had to obtain a new set of vital signs on Resident #108 and documented: a blood pressure 85/63, pulse rate 65, oral temperature 97.8, and an Oxygen saturation 98%. Staff member #98 stated she also obtained a fingerstick glucose reading of 41 mg/dl. Staff member #98 stated that she went to get a dose of glucagon to administer to Resident #108 but there was none available on the first medication cart. Staff member #98 went to the second medication cart and was unable to find a dose of glucagon on the second medication cart. Staff member #98 stated that she was unsure if a dose of glucagon was available in the second-floor medication room. Staff member #98 stated 911 staff notified that they would address Resident #108's reading of 41 mg/dl and emergently transferred Resident #108 to the emergency room . Further review of Resident #108 medical record failed to reveal a nursing assessment and a set of vital signs prior 911 intervention and being taken emergently to the emergency room .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 44440 Based on review of medical records, facility policies, facility investigation reports, interviews, and observations, it was determined that the facility failed to: 1. Assess known smokers on admission, re-assess residents deemed as safe smokers after they were found to be unsafely smoking, and adequately supervise residents while smoking. 2. Failed to prevent a Resident with documented unsafe use of smoking material from having smoking material in their room. 3. Failed to ensure that a resident's room was free from hazards. This was evident for 8 of 27 residents reviewed for smoking/accidents. (Resident #78, #41, #90, #63, #28, #463, #464 and, #368) The findings include: 1.) On 10/16/2023 at 10:32 AM, the surveyor reviewed Resident #78's safe smoking assessment completed on 5/4/23 and signed on 6/5/23. The assessment stated Resident #78 was a safe smoker but required supervision. On 10/16/2023 at 9:24 AM, the surveyor reviewed an investigation completed by the facility for an event that was reported to have happened on 6/1/2022. In the investigation report, the Nursing Home Administrator (NHA) states that a staff member, who was attempting to provide care for the residents, detected smoking activity due to an unpleasant odor emanating from the room. It further stated that Resident #78 was found smoking in his/her room. On 10/12/23 on 8:30 AM, the surveyor reviewed a progress note written by Licensed Practical Nurse (LPN) Staff #70. The note stated Resident #78 was educated on the risk of smoking in the room, specifically the risk of a fire and the potential result in death. The Resident verbalized an understanding and the note further stated that staff would encourage and support safe smoking in the right designated area. On 10/18/23 at 9:44 AM, the surveyor reviewed Resident #78's care plan. A care plan was initiated on 6/1/23 and stated, Resident #78 is a smoker and was found smoking in his/her room. The care plan was updated on 8/20/23, and included an incident on 8/6/23 where Resident #78 was reported smoking in his/her room and another incident on 8/20/23 where Resident #78 was observed smoking in another resident's room. It was updated again on 10/18/23 and stated Resident #78 was observed smoking in the room on 10/17/23. On 10/27/2023 at 11:09 AM, the surveyor conducted an interview with Regional Director of Clinical Operation Staff #39. During this interview Staff #39 stated that any resident that smokes within their room is considered an unsafe smoker. On 10/27/2023 at 11:55 AM, the surveyor showed staff #39 documentation that indicated Resident #78 was smoking in the room on several occasions and most up-to-date safe smoking assessment completed on 6/23/23 assessed Resident #78 as a safe smoker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/24/2023 11:39 AM, the surveyor conducted an interview with Resident #10. During this interview the surveyor noted an oxygen concentrator next to resident #10's bed. During the interview, Resident #10 confirmed that Resident #90 was his/her roommate and smoked in the room. Resident then stated a roommate after Resident #90 also smoked in the room and stated it was Resident #63. On 10/25/2023 3:12 PM, the surveyor reviewed a census report from the facility from September 2023. The review revealed that Resident #63 was roommates with Resident #10 after Resident #90 left. 4.) On 10/24/2023 11:39 AM, the surveyor Reviewed #63's medical record. The review revealed a care plan dated 7/29/23 that stated, Resident #63 has behavior issues, non compliance, and smokes in the room. Further review revealed Resident #63 was placed in the room with Resident #10 on 8/29/23. This was after Resident #10 was identified as being at risk due to non-compliance of smoking in the room by his/her previous roommate, Resident #90. On 10/24/23 at 11:40 AM, the surveyor reviewed a progress note written by LPN Staff #24 on 10/4/23 that stated Resident #63 was in the room with a group of friends smoking cigarettes behind closed doors. The whole room was smelling, and one could see smoke in the room and cigarette butts and ashes on the table. On 10/25/23 at 9:30 AM, the surveyor reviewed Resident #63's most up-to-date safe smoking assessment. The safe smoking assessment was dated 6/5/23 and indicated Resident #63 was a safe smoker requiring supervision. There was no safe smoking assessment documented after Resident #63 was noted to be smoking in his/her room. On 10/27/2023 at 11:55 AM, the surveyor showed Staff #39 the documentation from Resident #63 medical record where it was documented that the Resident was smoking in the room, however, the most up-to-date safe smoking assessment, completed on 6/5/23, stated Resident #63 was a safe smoker. 5.) On 10/25/23 at 9:24 AM the surveyor reviewed Resident #28's medical record. The review revealed that Resident #28 had a care plan that was created on 7/31/23 and stated Resident #28 was observed smoking again in the room despite education. Further review of Resident #28's medical records revealed the most up-to-date safe smoking assessment was completed on 6/3/23. In this assessment Resident #28 was considered a safe smoker, however in the personal protection section a comment was written stating, keep reminding that smoking is not allowed in the rooms. On 10/27/2023 at 8:54 AM, the surveyor interviewed Licensed Practical Nurse (LPN) staff # 21. During this interview staff #21 stated that on admission the nurses assess if a resident smokes. Staff # 21 stated this is done on admission and done quarterly as well. Staff #21 further stated that the computer can tell her when the assessment is due to be completed. She stated that if a resident is found to be smoking in their room, she would consider them an unsafe smoker. 6.) On 10/27/2023 at 9:24 AM, two surveyors made an observation on the 4th floor where there was a strong odor of cigarette smoke in the hallway. Both surveyors knocked and went into the room of Resident #464 and Resident #463, where the odor of smoke was amplified. The surveyors interviewed Resident #464 and Resident #463 in their shared room. Both Residents stated they were smokers but denied smoking in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/27/23 at 10:30 AM, the surveyor reviewed Resident #464's medical record. The review revealed that Resident #464 was admitted on [DATE]. No assessment was completed to evaluate the safety of the resident's smoking. On 10/27/23 at 10:33 AM, the surveyor reviewed Resident's #463 medical records. The review revealed that Resident #463 was admitted on [DATE]. No assessment was completed to evaluate the safety of the resident's smoking. On 10/27/23 at 9:32 AM, the two surveyors walked into the dining and activities room on the first floor. Within this room, the doors leading to the smoking patio were closed, and a cart was located next to the door. Several residents were outside smoking. No one was by the door. A person was noted to be across the room, turned away facing the vending machine on the opposite wall. On 10/27/23 at 9:33 AM, the person who was at the vending machine turned and walked over to the cart by the smoking patio and stated she was an Activities Assistant Staff #11. At this time the Restorative Aide, Staff # 68, assisted Resident #27 to the smoking area and asked Staff #11 for a smoking apron. Staff #11 opened the cart and gave Staff #68 a smoking apron for Resident #27. The surveyor asked Staff #11 if any of the Residents smoking out on the patio needed to be supervised. Staff #11 stated, all those Residents that were able to get to the patio themselves can account for themselves and do not require her supervision. She further stated, she is expected to supervise Resident #27. Staff #11 explained for any Residents to get out onto the smoking patio she would have to enter a code but they can let themselves back in by pushing a button that is located on the outside door. On 10/27/23 at 9:37 AM, both surveyors observed the courtyard smoking area. On 10/27/23 at 9:38 AM, the surveyor interviewed Resident #41. During this interview Resident #41 stated the burn holes on his/her sweatpants were from smoking but the pants were old and this happened a long time ago. After the interview the resident was observed throwing the lit end of his/her lit cigarette on the ground. On 10/27/23 at 9:52 AM, the surveyor walked inside from the smoking patio and reported to Staff #68, who was at the smoking cart, that that Resident #41 threw his/her lit cigarette butt on the ground. Staff #68 stated that Staff #11 had just walked away to get coffee started for the next Resident activity. She further stated she normally does not supervise smoking and then stated, I don't know what they do for smoking breaks. She followed up and stated, Staff #11 would be returning shortly. Staff #68 was observed walking out onto the smoking patio and talking to Resident #41. On 10/27/2023 11:09 AM, the surveyor conducted an interview with the Regional Director of Clinical Operation Staff #39. During this interview Staff #39 stated that any resident that smokes within the room is considered an unsafe smoker. She further stated the nurses are the ones that conduct the assessment and would assess using multiple factors to decide if a Resident was a safe smoker. She further stated that all residents should be monitored while smoking. The surveyor asked how it is communicated if a Resident is a safe smoker or requires interventions. Staff #39 stated if anyone is observed smoking within their room the staff should let leadership know, leadership should search the room with consent of the resident. If they object the police should be notified, however the police do not always respond to this type of request. Nursing should be documenting any unsafe smoking and documenting who they notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/27/23 at 11:50 AM, the surveyor conducted an interview with the Regional Director of Operations Staff #69. Present during the interview was the Nursing Home Administrator and Staff #39. Staff #69 stated that they often smell smoke in the building but have never seen a resident actively smoking. He further stated if we do see a resident smoking, we have a process in place and expect the process to be followed for all residents that are found smoking within the building. If we continue to suspect it, we give a behavioral contract and search the room. We also get the police involved if they refuse the search. If they continue to not follow the rules, we will give a 30 day notice and let the judge decide. He further stated however, sometimes when we do this and the judge decides they should be discharged , we still must keep them until we can establish a safe discharge and they would continue to reside here. The Administrator followed the interview by stating all Residents sign a smoking agreement when they are admitted and are aware of the smoking expectations. On 10/27/2023 at 11:55 AM, the surveyor showed the documentation from Resident #63, Resident #78 and Resident #28, where there was documentation of the Residents smoking in the room. At this time the Administrator confirmed that the smoking protocol was not followed for those residents. Staff #69 confirmed that if a resident smokes within the room they are considered to be an unsafe smoker. The surveyor followed up by and showed the Staff #69 the most up to date smoking assessments completed for these residents. Resident #63's most recent safe smoking assessment was completed on 6/5/23 and was assessed as a safe smoker with supervision. Resident #78's most recent safe smoking assessment was completed on 6/23/23 and was assessed as a safe smoker with supervision. Resident #28's most recent safe smoking assessment was completed on 6/3/23 and was assessed as a safe smoker with other in the comment. The surveyor also informed Staff #69 that there were two residents admitted in September that were documented as smokers and had no safe smoking assessment completed. On 10/27/23 at 12:11 PM, Staff #39 confirmed that education was needed to address non-adherence to the smoking policy, activities personnel should be educated on supervision and nursing needed to be educated on assessments. The Maryland Office of Health Care Quality (OHCQ) determined that these concerns met the Federal definition of Immediate Jeopardy and the facility was verbally notified of this determination on 10/27/23 at 7:00 PM. The facility provided a plan to remove the immediacy while the surveyors were onsite. The removal plan was accepted by OHCQ at 11:37 PM after 4 initial plans were submitted at 8:48 PM, 10:59 PM, 11:20 PM, and 11:29 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The plan included: Reviewing and updating safe smoking assessment and skin assessment for Residents #78, #41, #90, #63, #28, #463 and #464. The Nursing Home Administrator (NHA) to educate the Activities department on the process of providing supervision during smoke times. The facility's smoking policy was updated to include smoking assessments to be done on admission and upon noncompliance with the smoking policy as needed. The date of completion was 10/31/23. Additionally, the facility's plan for removal included the following: the Regional Director of Clinical Operations to complete a house wide audit of current residents to evaluate for following: If current smokers were assessed upon admission. Review Residents with non-compliant smoking behaviors, identified in care plans, and ensure reassessed for safe smoking are completed. Evaluate supervision of smoking during smoking times and supervision on units to ensure Residents are adhering to the facilities smoking policy. Listed the following actions would be taken if non-adherence to the smoking policy were found: The NHA will be notified, behavioral contract will be initiated, a room search done with permission, and if a Resident continues to be non-complaint the police will be notified. The date of completion was 10/31/23. The Regional Director of Operations will update the current smokers list with a completion date of 10/27/23. The education plan included the Regional Director of Operations to educate the Unit Managers on the importance of adhering to the facility's smoking policy and ensure smoking is assessed on admission and any noncompliance actions will be followed as outlined. The Unit Managers will then educate all licensed staff. The Administrator will educate the facility staff on the facility' s smoking policy. The plan for monitoring included the Director of Nursing to complete a record review audit to validate smoking assessments were completed appropriately and conduct observational rounds. The audits are to be performed randomly once a week for four weeks and then monthly for three months. The Audits will be submitted to the Quality Assurance Performance Improvement (QAPI) committee for review. The NHA will complete observational rounds once a week during smoke times as well as on the units to validate that supervision is being provided. The audits will be done once a week for four weeks and then monthly for three months. The Audits will be submitted to the Quality Assurance Performance Improvement (QAPI) committee for review. After determination of Immediate Jeopardy concerns, an extended survey was conducted. The Immediate Jeopardy was removed on 11/2/23 after validation that the plan had been implemented. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents. 7.) On 10/23/23 at 9:57 AM, the surveyor reviewed a progress note written by a Nurse, Staff #90 on 11/19/22. The note describes that the nurse was smelling cigarette smoke from the hallway and while checking residents' rooms, She opened Resident #368's door. The note further describes the room was filled with smoke and 2 cups filled with water had parts of cigarette in them. The note stated education was given on the risk of smoking and that smoking in the room was not allowed. Resident #368 refused to give up her lighter and cigarettes that were found in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/23/23 at 9:31 AM, the surveyor reviewed the safe smoker assessment completed on 12/4/22 for Resident #368. The assessment states that Resident #368 has a visual deficit that impairs ability to smoke safely. An observation was documented on the assessment and further stated, Resident was not able to extinguish smoking material completely in an appropriate receptacle. Also noted on the assessment was documentation that stated Resident #368 lies in bed and smokes cigarettes. The assessment further stated Resident #368's roommate is on oxygen. After the statement unsafe smoker was checked with an explanation that stated, Resident smokes in room while in bed and lights are off, Resident has poor vision, and roommate is on oxygen. Supervision was checked with a comment after; Resident keeps cigarettes in room, ashes in bed and on floor, additionally Residents uses paper cups to put out cigarettes. On 10/23/23 at 9:40 AM, the surveyor reviewed the smoking policy which was updated on 1/17/23. In the policy section 13 states, smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The last statement in the policy states, flammable materials are not allowed in resident rooms. These materials include, but are not limited to, candles, matches, lighters, E-cigarettes, pipes, diffusors, ect. If a resident violates this rule, they may be issued a 30-day involuntary discharge. Further review revealed a note written on 1/16/23 from Registered Nurse (RN) Staff #91. The note describes Resident #368 reported he/she had lit a candle by the television then fell asleep. The television had caught on fire and the Resident was able to put out the fire but the television was destroyed. The nurse further stated she had warned Resident #368 of the risks of smoking in the room over the last few days. There was no evidence in the medical record that indicated staff took possession of Resident #368's prohibited smoking materials. On 10/23/23 at 11:46 AM, the surveyor conducted a phone interview with the previous Nursing Home Administrator Staff #52. During this interview Staff #52 confirmed that smoking materials were not allowed at the bedside. Staff #52 remembered the fire from Resident #368 and stated she believed a staff member had given Resident #368 the candle as a Christmas present. She stated a house wide audit was done and no other candles were found. She also stated education was done for staff and Residents that candles were not permitted. She remembers Resident #368 was given a 30-day involuntary discharge. 37277 8. On 09/28/2023 at 11:24 AM, Resident #63 said that he/she cannot get across their room in his/her wheelchair without hitting a power strip block that hangs off the wall. A subsequent observation revealed that hanging off the wall was a tan, multiplug power strip block. It was hanging 13 above the floor and the bottom stuck out 9 from the wall. It was being utilized as an extension cord by Resident #63's roommate. On 09/29/2023 at 1:10 PM, Staff #3, the Unit Manager, was shown the power strip and acknowledged it's a hazard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/04/2023 at 9:50 AM, Staff #7, the Maintenance Director, observed the hanging power strip and explained that the facility does not provide power strips or extension cords, usually it's visitors that bring them and that they are not approved. Per Staff #7, the problem is there are not enough outlets in the room. He acknowledged the hanging power strip was a safety concern.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review, observation, and staff interview it was determined that the facility staff failed to appropriately administer pain medications as ordered. This was evident for 3 (#15, #63, and #517) residents out of 11 residents reviewed for pain management. The findings include: 1. A review of Resident #15's clinical record on 10/5/23 revealed the resident was prescribed Oxycodone 7.5 mg every 4 hours as needed for pain. A review of July 2023's Medication Administration Record (MAR) revealed the resident rated their pain as a 0 on a 0 to 10 scale on July 24, 2023, at 5:25 AM. The resident received a dose of pain medication to treat the presumed absence of pain. A review of August 2023's MAR revealed the resident rated their pain as a 0 at 2:56 AM and 7:19 AM but still received the Oxycodone. A review of September 2023's MAR revealed the resident rated their pain as a 0 at 1:55 AM on 9/20/23 and at 6:25 PM on 9/21/23. The Director of Nursing (DON) was interviewed on 10/5/23 at 12:25 PM. This surveyor asked what a nurse should do if as needed pain medications did not include a pain scale to tell nurse when to administer. She replied that the nurse should have called the physician for a pain scale to tell her when she should administer. If the resident says they are in pain but rate pain as 0 out of 10 then she would expect them not to administer. She looked at each example to determine which nurse(s) are responsible. The survey team interviewed the DON on 10/10/23 at 12:18 PM. She said the initial order for medications should be put in when the resident arrives. When a resident is in pain but there is no pain scale when would you expect them to administer the medicine? She replied, they should be using a pain scale that the resident can understand. If there is not a level ordered, then the order needs to be clarified. The medication should not be given if pain is rated as a 0 on a pain scale where zero means no pain. 37277 2. On 10/05/2023 at 9:00 AM, a medical record review revealed that Resident #63 had an order that had been active since 05/11/2023, for oxycodone HCL, an opioid pain medication. The instructions read give 2 tablets by mouth every 4 hours for pain 7-10. A review of Resident #63's medication administration records revealed that in August 2023 oxycodone was administered 15 times for a pain score below a 7. In September 2023 oxycodone was administered 42 times for a pain score below 7. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/05/2023 at 11:00 AM, Staff #24, a nurse, stated If there's parameters a [nurse] can't give outside of pain scale parameters. On 10/05/2023 at 11:22 Staff #39, a Regional Nurse, and Staff #3, a Unit Manager, were made aware of the findings. Staff #3 explained that Resident #63 could have been given the medication outside of parameters because the resident intimidates my staff. Facility pain management policy reads that opioids will be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences. Dosing outside of prescribed parameters does not meet professional standards of practice. 49148 Pain management is an aspect of medicine and health care involving relief of pain; the process of providing medical care that alleviates or reduces pain. Analgesic is a medication that relieves pain. 3. On 9/27/2023 at 9:50 AM, review of Resident #517 electronic medical record confirmed that the resident was admitted on [DATE] with diagnoses that included but not limited to ESRD (end stage renal [kidney] disease), dependence on renal dialysis, osteomyelitis (bone infection), laminectomy, fusion of spine, hypertension, hypoglycemia, and chronic postprocedural pain. On 9/29/2023 at 10:34 AM during an interview with Resident #517, resident stated I'm waiting for my meds (pain medication) since I've been back from the hospital. I haven't had my meds yet this morning or last night. They told me because I was discharged I couldn't get my meds. Resident told surveyors his/her pain score was a 7. On 10/3/2023 at 9:00 AM, surveyors conducted a review of Resident # 517's medical record, which revealed a pain evaluation conducted 9/29/23 at 11:30 AM which revealed that pain was noted frequently and limits day to day activities, he/she vocalized pain at 9 and stated pain was relieved with medication. Surveyors toured the unit on 10/4/2023 at 6:40 AM. While on tour, the surveyors conducted an interview with Licensed Practical Nurse (LPN), who revealed to surveyors that Resident # 517 was returned to the facility from the hospital on 10/3/2023 at 7:30 PM. On 10/10/2023 at 9:45AM, during an interview with Resident #517, the resident stated I have not received my pain medication since I came back here (facility) from the hospital on October 3rd. They (nurses) said I have to ask for it. 10/10/2023 at 10:00AM, review of electronic medical records showed that the resident reported experiencing pain (at the back of the neck near the surgical incision site) occasionally and the pain can limit day to day activities. Further review into the resident's medical record revealed pain medications were not available to Resident #517 from 10/4/2023 at 12:40 AM to 10/6/2023 at 2:15 PM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order for a controlled drug that is used to relieve pain, which read: Give one 10 mg (milligram) tablet, by mouth every 6 hours as needed for pain was noted as having a start date of 10/6/2023. Additional review of Resident #517's medical record revealed an order for a pain evaluation to be conducted every shift to assess for pain. This order was initiated on 10/3/2023. Surveyors noted the following documentation listed under, Pain Assessment on the electronic medical record, that showed Resident #517 reported being in pain. Resident# 517's pain assessment scores were documented as follows, a pain score of: 7 on 10/4/2023 at 3:36 AM 9 on 10/5/2023 at 11:51 AM 6 on 10/6/2023 at 5:50 AM 8 on 10/7/2023 at 1:58 PM 6 on 10/8/2023 at 6:13 AM 7 on 10/9/2023 at 3:08 AM 7 on 10/9/2023 at 5:40 AM 9 on 10/19/2023 at 12:36 AM A pain assessment scale measures a patient's pain intensity from 0 representing ' no pain at all ' through 10 representing ' the worst pain ever possible ' . According to the resident's medication administration record for the month of October 2023, pain medication was ordered on 10/6/2023 for the resident yet, not documented as administered to the resident until 10/9/2023. During continued review of Resident #517's electronic medical record, surveyors noted a care plan created on 10/4/2023 to address Resident # 517's chronic pain (located at the back of the neck). The care plan included interventions to administer analgesic(s) as ordered and to monitor, record, and report to the nurse resident ' s complaints of pain or requests for pain treatment. On 10/10/2023 at 12:19, during an interview with interim DON, it was reported that the expectation is that pain medication will be ordered immediately after the resident is admitted to the facility. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2023 at 12:35 PM, surveyors conducted an interview with Physician, Staff #50. Staff #50 stated that she assessed Resident #517 on 10/5/2023. Following the assessment, Staff #50 ordered an analgesic for pain on 10/6/2023. Surveyors made Staff #50 aware of the concerns that the resident's medical record did not show pain medication available to the resident from his/her readmission on 10/4/2023 through 10/6/2023, and even once it was ordered on 10/6/2023, the pain medication was not administered as ordered for documented pain until a dose was administered on 10/9/2023. According to Resident #517 pain assessment documentation, he/she was experiencing pain from 10/4/2023 through 10/9/2023without pain relief. On 10/18/2023 at 10:30 AM surveyors reviewed the concern with the Administrator and the interim DON regarding the failure to ensure that Resident #517 received timely pain medication when experiencing pain. The facility staff did not provide any additional documentation regarding the missed opportunities to provide the resident with any pain relief Surveyors made concerns known to the facility administrator, interim DON, and the Regional Director of Clinical Operations throughout the survey and again during exit conference.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on medical record review, review of pharmacy records, review of a facility's program description, and interviews with staff it was determined that the facility: (1) failed to timely implement physician instructions and orders related to SUD treatment, and (2) failed to effectively plan care for residents with Substance Abuse Disorder (SUD) and (3) failed to initiate a Substance Use Disorder care plan for Residents identified with Substance Use Disorders. This was evident for 5 (Residents #147, #90, #101, #141 & #154) of 18 residents reviewed for Substance Use Disorder during survey. These failures contributed to resident overdoses and placed residents at increased risk for serious harm and possible death. The findings include: 1. Suboxone: is part of a family of medications used in Medication Assisted Treatment (MAT). Medication Assisted Treatment (MAT): is an addiction recovery treatment plan that includes medications designed to treat opioid use disorders. Substance Use Disorder: is a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Narcan: A medication given to help reverse an opioid overdose. On [DATE] at 11:38 AM, the surveyor reviewed Resident #147's medical record. The record revealed a progress note written on [DATE] by the Wellness Program Director, Staff #29. The note stated Staff #29 visited with Resident #147 and introduced the Wellness Pathway Program to the resident. After the introduction, Resident #147 discussed his/her history of substance abuse with Staff #29. Resident #147 reported having cravings and requested to be prescribed Suboxone stating, this has worked in the past. Staff #29 wrote in her note she would make the physician aware of the request. On [DATE] at 10:53 AM, the surveyor interviewed Staff #29. During this interview Staff #29 stated she was an advocate for residents with Substance Use Disorders (SUD). She further explained that she is made aware by the administrator or nursing staff when a Resident with a history of SUD is being admitted to the facility. Staff #29 stated she introduced herself to the Residents and introduced them to the program. She gets a history as well as assists Residents with identifying triggers that may cause them to relapse. Staff #29 also stated she relays medication needs with providers and communicates a need for a psychological evaluation if needed. She stated she helps in developing the care plans for SUD Residents. Staff #29 stated that nursing is responsible for assessing, monitoring, and implementing interventions to prevent relapse. On [DATE] at 6:26 AM, the surveyor reviewed the Wellness Program overview. The program description documents evidence-based services to support a life of recovery while at a skilled nursing/rehabilitation center. It further indicated that the Wellness Director (WD); develops, plans, organizes, evaluates, and directs the overall operation and therapeutic aspects of the Wellness Program. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:38 AM, the surveyor review of the progress notes written in Resident #147's medical record on [DATE] by a physiatrist (a doctor who specializes in physical medicine and rehabilitation) Staff #78. Under medication changes, Staff #78 wrote, Resident #147 stated he/she was previously on Suboxone, but the dose will have to be verified and restarted. Staff #78 added that Resident #147 reported his/her pain was not controlled by pain medications. A progress note written on [DATE] at 2:12 PM, by Social Service Staff #83 documented Resident #147 was reporting terrible sleep due to anxiety attacks and trouble concentrating. In a [DATE] progress note, Staff #78 recommended to verify Suboxone dosing and restart medications. This note concluded; thank you for allowing me to participate in the care of your patient. I will continue to follow. No evidence was found in Resident #147's medical record that the verification was obtained after the prior [DATE] note written with these same instructions. Further review of the medical record revealed that Resident #147 suffered a medical emergency on [DATE] at 2 PM. Resident #147 was found unresponsive and two doses of Narcan (an emergency treatment for a narcotic overdose) was administered. Resident #147 responded to the Narcan and requested to be transferred to the hospital. No evidence was found that the dose for Suboxone was clarified or that he/she had ever started on Suboxone after it was first recommended two weeks prior to the [DATE] clinical emergency. Further review of the medical record on [DATE] at 1:50 PM, revealed that Resident #147 returned to the facility on [DATE]. With the discharge paperwork, the hospital provided an order for Buprenorphine HCL 8mg Sublingual tablet. (Buprenorphine is the active ingredient in Suboxone). The surveyor reviewed the orders written for Resident #147 on [DATE] at 1:58 PM. The review revealed that on [DATE] an order was written for Buprenorphine Hydrochloride HCL sublingual 8 mg three times a day for smoking cessation. On [DATE] at 11:45AM, the surveyor reviewed a progress note written by Physician Assistant (PA) Staff #56 on [DATE] at 3:32 PM. In this note Staff #56 indicated that Resident #147 continued on Suboxone 3 times a day and had no signs or symptoms of withdrawal. On [DATE] at 11:51 AM, the Surveyor review of the Medication Administration Record (MAR) for Resident #147. The review revealed the documentation was incomplete and did not provide evidence the Buprenorphine was administered as directed. The documentation indicated that on 12 occasions from [DATE] through [DATE] the administration was coded, see progress note and on 3 occasions during that same time period the administration documentation was blank for administration on Buprenorphine. On [DATE] at 10:35 AM, the surveyor reviewed medication administration progress notes. On [DATE] at 5:57 AM, the MAR comment was, pharmacy to deliver, and on [DATE] at 6:31 AM, the MAR comment was, pharmacy to dispense med (medication). Further review of the clinical record revealed a note written on [DATE] at 2:46 PM, that stated Resident #147 was responsive only to a sternal rub and Narcan was administered. On [DATE] a note written at 3:25 PM, stated Resident #147 appeared to be sluggish. The note further indicated that the physician was aware and orders were received including a urine toxicology screen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Park Healthcare	3330 Wilkens Avenue Baltimore, MD 21229

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:10 AM, the surveyor conducted a phone interview with the Manager from the pharmacy the facility utilizes, Staff #80. During this interview Staff #80 stated the pharmacy received the order for Resident #147's Buprenorphine on [DATE] at 9:45 AM, however, it was sent back asking the provider for more clarification. At this point, Staff #80 asked a Staff Pharmacist, Staff #81 to join the phone conversation. Staff #81 stated a clarification was re-sent and dated [DATE] on the form, however the fax had a time stamp from the facility that indicated the order was sent on [DATE] at 7:48 AM from the facility and the pharmacy received the clarification order on [DATE] at 7:51 AM. Staff #81 reviewed the dispensing records for Buprenorphine to the facility for Resident #147. The review revealed that only a portion of the dose was sent to the facility on [DATE] and signed as received at 5:30 PM. The complete dose was not sent until [DATE] at 1:54 AM. On [DATE] 6:37 AM, the surveyor reviewed Resident #147's care plan. On [DATE] a care plan was created stating Resident #147 was receiving Medicated Assisted Treatment (MAT) for Substance Use Disorder (SUD) and was at risk for an overdose. This care plan was created 5 months after Resident #147's first overdose and the one intervention stated, to educate Resident #147 on risks related to substance abuse. No individualized interventions were planned for staff to monitor for triggers or withdrawal symptoms to prevent potential relapse. 2) On [DATE] 8:39 AM, the surveyor reviewed Resident #90's medical record the review revealed Resident #90 had a history of Substance Use Disorder. The review further revealed that Wellness Program Director Staff #29 wrote a progress note on [DATE] shortly after introducing the Wellness Pathways Program to Resident #90. In the note, Resident # 90 indicated he/she was currently taking Suboxone and was able to maintain abstinence with Medicated Assistance Treatment (MAT). However, no order was written for Suboxone for Resident #90 at this time. Staff #29 documented she would follow up as needed. On [DATE] at 5:22 AM, the surveyor reviewed Resident #90's care plan. A care plan was initiated on [DATE] by Staff #29. On [DATE] Staff #29 updated the care plan and initiated the following interventions: Monitor and report any unusual behavior to the physician; Wellness coordinator to follow-up with treatment; Follow up with social worker; Psychiatry consult for substance abuse; and Continue with medications for opioid use disorder. The plan did not include any interventions for monitoring for individualized triggers or signs of withdrawal, to reduce risk for relapse. Further review revealed a [DATE] progress note. That documented Resident #90 was found unresponsive in another Resident's room in a suspected overdose. Narcan was given twice, and Resident #90 became responsive after. On [DATE] at 1:15 PM, Wellness Program Director Staff #29 wrote a progress note after visiting with Resident #90. In this progress note, Staff #29 documented that Resident #90 reported struggling with cravings and reported when on Suboxone in the past he/she had less cravings and urges to use. Staff #29 stated she would follow up with the medical team about MAT. On [DATE] a progress note documented that Resident #90 was found unresponsive and after 3 doses of Narcan Resident #90 became responsive. Resident #90 was placed on 1:1 monitoring, and psychiatry was ordered to evaluate for possible transfer to the hospital for an evaluation. On [DATE] at 9:12 AM, the surveyor reviewed the orders written for Resident # 90. The review revealed Suboxone was first ordered on [DATE] by Physician Staff #50. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:20 AM, the surveyor reviewed a progress note written by Physician Assistant PA Staff #56 on [DATE] in Resident #90's medical record. In the assessment and plan section, Staff #56 documented the plan after the overdose for Resident #90 was to continue to assist with activities as needed and would evaluate for Suboxone. The note concluded; the plan of care was discussed with Medical Director Staff #19. On [DATE] at 11:35 AM, the surveyor reviewed Resident #90's September Medication Administration Record (MAR). The review revealed that Suboxone was documented as given on [DATE] in the am and given twice a day [DATE]-[DATE]. Further review of the care plan initiated on [DATE] revealed that the care plan stated Resident #90 was receiving Medication Assisted Treatment for Substance Use disorder. The care plan was updated on [DATE] by Unit Manager Staff #3, who stated Resident #90 was receiving MAT for Substance Use Disorder and was found unresponsive. However, after reviewing Resident #90's medical record he/she did not receive MAT until [DATE]th 2023, after the second overdose. The Maryland Office of Health Care Quality (OHCQ) determined that these concerns met the Federal definition of Immediate Jeopardy and the facility was verbally notified of this determination on [DATE] at 10:00 AM. The facility provided a plan to remove the immediacy while the surveyors were onsite. The removal plan was accepted by OHCQ at 6:50 PM after 4 initial plans were submitted at 1:19 PM, 4:22 PM, 6:15 PM, and 6:37 PM. The plan included: Education for Staff #29 on effective management for Residents with SUD, to include communication with physician and nurses on Resident changes such as withdrawal symptoms or craving for substance use. Education was provided for Staff #78 to include, communication on the use of MAT for Residents who are noted as craving for substance use as well as communication with the nursing team if there is a recommendation for residents with substance use. The Wellness Director completed a house wide audit of current Residents with Substance Use Disorder to evaluate if any other Residents are reporting carvings for substance use or any symptoms of withdrawal to ensure MAT is ordered according to their person centered plan of care. The facility's plan for removal also included the following: Education on the use of a screening tool, used on admission, to identify any residents with a history of substance use disorder and evaluate if they are interested in receiving treatment. Nursing will then update the care plan accordingly. The Director of Nursing will educate the Unit Managers on the effective management of residents with Substance Use Disorders. This will include using the screening tool on admission; Ensure Residents with SUD are ordered appropriate medications on admission; Communicate any changes noted with SUD Residents with the Wellness Director and physicians to ensure MAT is implemented if indicated; Ensure if a MAT medications is unavailable the physician is notified and symptoms of withdrawal and triggered are monitored, if needed obtain a order for MAT; Ensure comprehensive care plan are completed to include resident's history of SUD, withdrawal symptoms, triggers, relapse, and treatments. The Unit Manger will then educate the licensed nurses. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON will complete random questionnaires audits for physician, nursing team and wellness services to validate the team is communicating changes. The Medical Director will complete random audits of the Residents receiving MAT to validate effective MAT treatment. The DON will complete random medical record audits for those SUD residents identified on MAT where the MAT was not available. The audit will evaluate if assessments are being made to monitor for signs of withdrawal and an order effective treatment is in place to prevent drug overdose. The audits will be done weekly for four weeks then monthly for three months and the findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review. After determination of Immediate Jeopardy concerns, the Immediate Jeopardy was removed on [DATE] after validation that the plan had been implemented. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents. 3) Medical record review for Resident #101 on [DATE] 7:23 PM, revealed that Buprenorphine HCl-Naloxone HCl (Suboxone) Sublingual (applied under the tongue) ,d+[DATE] Milligrams, 2 times daily, for SUD, was ordered on [DATE] at 9:00 PM. The order was written at 9 PM with the first administration documented as given on [DATE]. Medical record review on [DATE] at 7:41 AM, revealed that Staff #29 created a new care plan for Resident #101 for Medication Assisted Treatment (MAT) for Substance Use Disorder (SUD) related to opioid use disorder on [DATE]. Medical record review on [DATE] 7:31 AM, revealed a potential overdose event on [DATE]. In an initial progress note dated [DATE], Staff #29 documented seeing Resident #101 for a change in condition related to substance abuse. Staff #29 indicated that Resident #101 had been found on the floor after suspected use on [DATE]. Staff #29 further documented that Resident #101 reported struggling with cravings. Staff #29 concluded the progress note indicating a plan to follow up with the medical team. Medical record review revealed inconsistent documentation entered by Staff #56 on [DATE]. Although the [DATE] event was documented in the medical record, Staff #56 inconsistently documented on [DATE] that Resident #101 was on Buprenorphine, had experienced no changes in mental status, and that no evidence of withdrawal was evident. Staff #56 documented that the plan of care was discussed with Medical Director Staff #19. Additional medical record review on [DATE], revealed that the [DATE] MAT care plan was revised on [DATE]. The revisions included documenting the new [DATE] change in condition associated with substance use and interventions were added including to monitor and report any unusual behaviors to the doctor, for the wellness coordinator to follow-up with treatment, for the social worker to follow up, for psychiatry consult related to substance abuse, and to continue Medicated Assisted Treatment. However, no interventions were initiated in the plan to monitor for individualized triggers and/or withdraw symptoms. Medical record review revealed a second potential overdose event for Resident #101 on [DATE]. A nursing note by LPN Staff #24 on this date indicated that Narcan HCL nasal liquid 0.1 milligram was given at 8:45 AM for suspected overdose. In a later note at 2:50 PM on the same date, Staff #29 documented that she met with Resident #101 due to substance use. Again Resident #101 reported to Staff #29 experiencing carvings and again Staff #29 documented the plan to update the medical team. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After the second event, the MAT care plan was still not revised to ensure that staff would begin to monitor Resident #101 for individualized triggers and/or withdrawal symptoms. 18819 4. Review of Resident #149's closed medical record on [DATE] revealed Resident #149 most recent admission to the facility was on [DATE] with diagnoses that included anxiety, depression, bipolar disorder, alcoholic cirrhosis of the liver, heart failure, chronic kidney disease, insomnia, and psychoactive substance dependance. Resident #149 was receiving the following medications: Aripiprazole, bupropion HCL, Lexapro, Methadone HCL, Risperdal, Trazodone, Lasix, Xanax, Gabapentin, and oxycodone. Review of intake MD00186021 on [DATE] revealed an investigation that Resident #149 was observed to be drowsy, lethargic, and unresponsive with a bottle of diazepam found next to Resident #149 on [DATE] at 10:15 AM. The facility staff identified Resident #149 as having an overdose and administered 2 doses of Narcan. Resident #149 was observed to become more alert and was transferred to the emergency room . After a few hours, Resident #149 returned to the facility and was educated on the risks and dangers of ingesting medications not prescribed by the facility physician. Resident was issued and signed a behavior contract on [DATE]. Resident #149 explained to the facility staff that he/she brought the medications from home when he/she went on a leave of absence. The facility investigation indicated that the facility staff were educated on the importance of rounding to identify residents with illicit drug use, Resident #149 was educated on the risk and dangers of ingesting medications not prescribed by a facility physician, and a Behavioral Contract was presented to the resident. Review of facility reported incident MD00188974 on [DATE] 23 revealed an investigation that on [DATE] Resident #149 was observed with an unknown pill and ingested the pill in front of a staff member. Resident #149 was also observed with agitation, slurred speech, and was having difficulty forming thoughts into sentences. Another bottle of pills was discovered with Resident #149 who stated that a family member gave them to him/her. Resident #149 was sent to the emergency room . The facility determined that Resident #149 had another overdose on illicit medications. Further reviews of the closed medical record failed to reveal the facility staff had implemented a care plan for Resident #149's diagnosis of psychoactive substance dependance. 5. Review of Resident #154's closed medical record on [DATE] revealed Resident #154's most recent admission to the facility in [DATE]. The State Survey Agency (SA) received complainant allegations (Intake MD00194736) indicating that Resident #154 suffered an overdose and died on [DATE]. A review of facility reported incident MD00189238 on [DATE] revealed information that Resident #154 was found unresponsive on [DATE] at 1:40 AM. Staff administered Narcan twice, initiated CPR, and called 911. EMS personnel arrived and continued to perform CPR. Resident #154 was shortly pronounced dead. The facility investigation listed a summary of events that indicated no evidence to support active drug use. After the incident, staff were educated on the importance of reporting any suspicion of illicit substance use. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Closed medical record review on [DATE], revealed that Resident #154 suffered a drug overdose event on [DATE]. Record documentation indicated that on this date at 8:30 PM, Resident #154 was observed by a staff member unresponsive and lying on the floor. The staff administered 2 doses of Narcan nasally. Resident #154 was sent to the emergency room . Per the hospital documentation, Resident #154 was diagnosed with an opioid overdose in the emergency room . Additional review of the closed record revealed that on [DATE] Resident #154 suffered another drug overdose event. On this date at 3:27 PM, staff observed Resident #154 to be lethargic with little to no response to verbal or tactile stimuli, speech that was described as sluggish, and s/he could not sit straight in his/her wheelchair. With consent, a toxicology test was conducted which later returned (returned on , d+[DATE]). The reported event of [DATE] was therefore the third overdose event for Resident #154. Nonetheless, no care plan was ever opened providing staff direction on what and how to manage Resident #154's needs related to his/her substance abuse disorder.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on interviews with staff, and review of medical records, it was determined that the facility failed to appropriately treat a resident diagnosed with a mental disorder. This was evident of 2 of 4 residents (Resident #115 & #78) reviewed for mental health services during the annual survey. The findings include: The surveyor reviewed Resident #115's medical records on [DATE] at 2:03 PM. The review revealed that Resident #115 was admitted to the facility in early January of 2022 and had a past medical history of schizophrenia. Further review of the record revealed a progress note from Psychiatrist Staff #54 (a physician that specializes in mental health) on [DATE]. The progress notes stated that Staff #54 was asked to see Resident #115 due to agitation, depression and to evaluate medications. In the note Staff #54 recommended beginning Prolixin 2.5mg in the morning and 5mg before bed for schizophrenia. On [DATE] at 11:45 AM, the surveyor reviewed a progress note written on [DATE] by Resident #115's primary provider, Staff #51. The progress note stated he saw the resident and reviewed the psychiatry's recommendation. Staff #51 wrote for Resident #115 to receive an electrocardiogram (EKG) (a test to evaluate the heart rhythm) on Tuesday and if normal consider starting Prolixin (also known as Fluphenazine). Further review of the progress notes reveal a note written on [DATE] by the former Administrator, Staff #52. The note stated that Resident #115 was threatening a female resident in the lobby. The note also stated Resident #115 then threatened a male resident. Staff #52's note further stated Resident #115 pushed the Director of Nursing (DON) into the wall and told her that his/her gang will come to kill her. An Emergency Petition (EP) was sought from the Psychiatry provider and the resident was taken to the hospital. On [DATE] at 11:45 AM, the surveyor reviewed Medication Administration Record (MAR) for Resident #115 for August and [DATE]. The review revealed that Resident #115 had an EKG documented as completed on [DATE]th 2022. On [DATE] an order was written for Fluphenazine once per day for agitation. This was the first time the order was written for even after the primary physician had written on [DATE] that Resident #115 could start on Fluphenazine after the evaluation of the EKG. The surveyor reviewed the orders for Resident #115 and discovered that Prolixin was first ordered after Resident #115 returned from his/her hospital stay and not when recommended two weeks prior. The facility failed to administer psychological medications recommended by Staff #54. 2) On [DATE] at 12:31 PM, the surveyor reviewed Resident #78's medical record. The review revealed that Resident #78 was admitted to the facility in early January of 2023 with a medical history of, post-traumatic stress disorder, and adjustment disorder with mixed anxiety and depressed mood. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 00 AM, the surveyor reviewed Resident #78's orders. Resident #78 had an order for psychology/psychiatry (psych) to consult and treat as needed written on [DATE], [DATE], [DATE], & [DATE] and on [DATE], [DATE], [DATE] a psych consult was ordered related to specific behaviors. On [DATE] at 10:14 AM, the surveyor reviewed psych progress notes in the electronic medical record. Resident #78 was seen by psych on [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review of the progress note written on [DATE] by psych Nurse Practitioner (NP) Staff #55 stated, Refer for individual therapy pending insurance approval. On [DATE] at 9:50 AM, the surveyor reviewed progress notes written by Physician Assistant (PA) Staff #56. On [DATE] Staff #56 wrote a note and documented, Resident #78 reported his/her anxiety had not been controlled since Klonopin (a medication to help with anxiety) expired. Staff #56 wrote she would restart Klonopin and for a psych consult for anxiety. Following anxiety she stated a plan for depression and post-traumatic stress disorder as continue medications and psych consult. On [DATE] at 10:25 AM, the surveyor reviewed the care plans for Resident #78. The review revealed a care plan for Resident #78 stating, Resident has potential to be verbally aggressive related to ineffective coping skills created on [DATE]. One of the interventions was for psychiatric/psychogeriatric to be consulted as indicated. However, the most recent consult completed after this was [DATE]. On [DATE] at 12:01 PM the surveyor interviewed Regional Director of Clinical Operations Staff #39. During this interview Staff #39 was asked if Resident #78 received the psych services that were recommended and ordered, such as individual psychotherapy. Staff #39 stated the facility consults an outside service and they have the ability to provide all psychosocial services needed. She further stated every Resident in the building has an order to have a psych consultation. The psych services professionals come weekly and check a book on the floor to help evaluate who they need to see. Staff #39 stated, the facility is ultimately responsible to make sure these services are provided. On [DATE] 1:18 PM, the surveyor conducted a phone interview with the manager of the consulting psych services company, Staff #92. During the interview Staff #92 stated the process for offering psych services starts with a referral from the facility and once the Resident is seen they are placed on a working list. She further stated, there is a list of residents that need to be seen on the unit at the facility and providers check the list each time. She further stated, that if referrals are needed within our service the company handles referrals internally and will provide the services. Staff #92 was asked if Resident #78 received individualized psychotherapy per recommendations of Staff #56 with the instructions, per insurance approval. Staff #92 stated she would look into that and would follow up. On [DATE] at 3:16 PM, the surveyor conducted a follow-up phone interview with Staff #92. During the interview Staff #92 stated that Resident #78's individual psychotherapy would have been covered by insurance, however it was not communicated correctly in the system and Resident #78 did not receive those services.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review and staff interview it was determined that the facility failed to ensure social work assisted a resident with their needs. This was evident for 1 (#385) out of 140 residents in the survey sample. The findings are: A review of Resident #385's clinical record as part of the investigation into intake #MD00180949 was started on 10/12/23. The resident was admitted on [DATE] and discharged on [DATE]. Review revealed that there were two social work notes in the clinical record, one on 3/23/22 and the other on 8/2/22. The Nurse Practitioner wrote a progress note on 8/16/22 at 9:31 AM stating that the resident wanted to be discharged home. The resident denied any medical complaints and believed discharge was appropriate. There were no social work notes or evaluations found in the clinical record even after the resident requested to be discharged home. The Social Services Director (Staff #14) was interviewed by survey team members on 10/13/23 at 10:43 AM. She said she started working at the facility on 9/6/23. She said there wasn't an active social work department when she started. The administrator caught her up on the residents that needed immediate attention. They had someone come in from another facility to come in and help out. She said when there wasn't a social worker here then they had someone come in to help with the discharge planning, but she did not believe they were completing social histories. They were not doing care plan meetings. The Administrator was informed of the social work concerns on 10/20/23 at 2:17 PM. He said he would look into it. Evidence of social worker assessments and discharge planning for this resident were not provided prior to exit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 37584 Based on record reviews, and staff interviews it was determined that the facility staff failed to put a system in place to ensure that prescribed medications are correctly transcribed and administered. This was evident for 1 (Resident # 46) of 1 residents reviewed for medication administration concerns during the survey. The findings include: Polyneuropathy is a condition in which a person's peripheral nerves are damaged. It affects the nerves in your skin, muscles, and organs. When these nerves are damaged, they can't send regular signals back to your brain. A review of the medical record to investigate intake # MD00196805 was conducted on 10/25/2023 at 10:15 AM. revealed Resident # 46 was admitted to the facility with diagnosis that included Polyneuropathy, nerve pain, and kidney failure requiring dialysis. A review of the resident's Medication Administration Record (MAR) on 11/2/23 at 08:00 AM revealed an admission order dated 06/22/23 for Gabapentin Oral Capsule 100 MG (Gabapentin) Give 1 capsule by mouth one time a day every Mon, Wed, and Fri for nerve pain; To be given after dialysis. However, further review of the monthly MARs showed that Resident #46 had received Gabapentin 3 out of 7 days per week since their June 2023 admission. Further review of the Gabapentin monthly administration record found 74 missed doses from June 24, 2023, through November 3, 2023. During an interview with Resident #46's physician (staff # 50) on 11/02/23 at 10:15 AM it was revealed that it was expected that all admission orders are reviewed at least twice, once by nursing and the other by a physician. Staff #50 added that the nursing staff reviews can be completed with the physician over the phone. According to Resident # 46's Nursing Unit Coordinator (staff#3) during an interview conducted on 11/03/2023 at 1:45 PM, he performed daily reviews and reported any discrepancies he found to the residents' physician and the Director of Nursing. He also indicated that it was his responsibility to oversee physicians' order management and monitoring by daily progress notes and physicians' order reviews that included a review of all new admissions' documentation to ensure that orders are written and transcribed accurately and administered to residents accordingly. This was conducted through the reviews of all MARs and Treatment Administration Records and provided notifications to pharmacy for needed corrections associated with them. He also provided staff education as needed. During the interview he confirmed he knew Resident #46. When asked he stated he has been doing the reviews but never found any issues with Resident #46's medication orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview staff #3 reviewed Resident #46's admission order for Gabapentin and the transcribed administration instructions on the June 2023 - November 2023 MARs shared by the surveyor. Staff #3 acknowledged that the admission orders for the Gabapentin's, administration, and the monthly MARS transcriptions were inaccurate, should have been reviewed, and verified by the resident's physician before transcribed and checked by nursing for accuracy before administrating the medication to the resident. He also acknowledged the undetected inaccurate orders and MARs for Resident #46 caused continuous medication errors that resulted in the 74 missed doses from June 2023 through November 2023. During a follow-up interview with Staff # 50 on 1/07/23 at 2:00 PM, when asked she stated Staff #3 had made her aware of the inaccurate order and dosage frequency transcription errors for Resident #46's Gabapentin medication.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47758 Based on record review, interview and observation, the facility failed to prescribe a therapeutic diet for a resident. This was based on 1 (# 124) out of 1 resident reviewed for correct dietary orders. The findings include: On 10/18/2023 at 9:55 AM, the surveyor reviewed a complaint dated 9/27/21 on behalf of Resident #124. The complainant alleged the family had to have food delivered because the facility did not serve the resident a therapeutic diet. Although the resident was admitted on [DATE], according to the record review, the facility did not initiate a cardiac diet until 9/28/21 after Resident #124 requested a dietary consult. The surveyor's review of the Nursing Admission Assessment on 10/19/2023 at 8:11 AM, dietary requirements read: Cardiac Consistent Carb Diabetic for Resident #124. During an interview on 10/19/2023 at 8:25 AM with the Regional Director of Clinical Operations (RDCO), the surveyor asked what the process was for ordering a therapeutic diet. She stated the admitting nurse sends an order to dietary with the therapeutic diet request. When asked if she could find a therapeutic diet order from Resident # 124's admitted , she stated she would see if she could locate it. On 10/20/2023 at 9:30 AM during an interview with RDCO, the surveyor asked if there was any additional information regarding the admission diet orders for Resident #124. She stated that she was not able to find an admitting diet order and she did not believe there was any way to check what diet was served at that time, but she would consult the Regional Dietary Manager and let the surveyor know if anything was found. Nothing was produced prior to the end of the survey.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on observation, staff interview and medical record review, it was determined that the facility administration failed to provide effective oversight activities for the facility to ensure that resources were used effectively to meet the health and safety needs of each resident and identify and correct inappropriate care processes/standards, as evidenced by 1. Failure to ensure substantial compliance with regulations that were identified as deficient 2. Failure to implement plans of correction resulting in an immediate jeopardy for the safety of residents who required supervision while smoking by failing to adequately supervise those residents, 3. Failure to implement plans of correction related to residents ' behavioral health by failing to identify, monitor and prevent the additional occurrences of substance abuse, 4. Failure to provide oversight and monitoring of the maintenance and pest control plan of correction for the facility and the kitchen resulting in repeated citations of a non-homelike environment and unsanitary kitchen and food preparation area. The administration's failure to ensure processes were in place that could identify and correct deficient practice in care had the potential to adversely affect the health and safety of all the residents in the facility in addition resulted in an immediate jeopardy for the 3rd consecutive survey for the safety of residents regarding smoking and an actual harm regarding failure to identify and prevent additional occurrences of substance abuse in a resident with identified substance abuse disorder. The findings include: 1. A. Review of the facility Substance use Tracking tool on 4/18/24 at 1:00 PM and an updated tool on 4/19/24 at 11:29 AM revealed that facility failed to include Resident #63 who was hospitalized on [DATE] and again on 4/9/24 for an overdose and reported suicidal ideations. S/he also had a positive urine toxicology for marijuana and cocaine reported to the facility on [DATE]. Only the 4/6/24 incident was identified on the facility tracking tool. Additionally, on 4/17/24, a K-9 search of the facility identified multiple resident rooms with drug paraphernalia. Those individuals were placed on the list provided to the team on 4/19/24. Those individuals were not on the list provided to the team on 4/18/24. The survey team was told by the facility Director of Nursing on 4/19/24 at 12:10 PM that the reason the residents were not on the tracking tool provided to the survey team on 4/18/24 was that the items confiscated were not logged and cataloged yet by the wellness director, staff #10 who was off on 4/18/24. The survey team asked where all the items they found were located. She stated they were locked in staff #10 's office, again who was off on 4/18/24. B. Review of the residents placed on the Substance use tracking tool also failed to reveal consistency in the orders related to ongoing monitoring for the prevention of further occurrences for substance use. According to the facility DON, Regional Director of Operations (RDO) and RN staff #14 who were interviewed on 4/22/24 at 12:01 PM if a resident was on the substance use tracking tool, they should have an order for monitoring of substance use for 7 days on the medication administration record (MAR). Review of the tracking tool on 4/22/24 failed to reveal orders in place for Resident #572. This review also noted orders in place for Residents #583 and #584 however, failed to identify them on the Substance use Tracking tool provided to the survey team on either 4/18/24 or 4/19/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON, RDO and staff #10 who were in the conference room were also asked at that time if a policy and procedure was developed regarding this process. The RDO stated that they had not. They were further asked how staff were to know what to do. There was no response. C. On 4/22/24 a 6-page report, listing all residents, titled Tracking and Trending of Active and Suspected residents with substance use disorders audit was provided to the survey team by the Assistant Director of Nursing, staff #5. Upon review of the audit tool errors were immediately identified and brought to the attention of the ADON, Regional Director of Operations, and DON who had remained in the conference room. There were 9 (8, 22, 74, 76, 93, 566, 574, 583, and 584) residents randomly identified who were known and noted to have had overdoses or suspected drug use from previous review by this surveyor. All 9 were identified on the tool as having ' neither ' active or suspected substance use disorder. Specifically, Residents #566, 583 and #584 were just identified on 4/17/24, as having drug paraphernalia in their respective rooms and Residents #22, #74 and #76 were given involuntary discharge notices within the past 4 months regarding their behaviors and activity in the facility noting that the safety and health of individuals are endangered by their continued stay in the facility. Resident #583 was also noted to have a leave of absence (LOA) order since 3/23/24, although according to the facility plan of correction, there was to be no LOA when there was actual or suspected drug use. According to the QA tracking and trending audit, Resident #583 was also noted as 'no' for LOA. The concern related to the LOA order was reviewed with the facility on 4/22/24 at 12:01 PM. Cross reference F867 2. A review of the results from the facility's last revisit survey ending 3/8/24, revealed that an Immediate Jeopardy was identified related to unsafe smoking practices including the failure to adequately supervise residents who required supervision while smoking on 2/22/24. The facility indicated that their corrective measures would be completed by 4/8/24. During this revisit survey on 4/18/24, an Immediate Jeopardy was identified again for unsafe smoking practices for the 3rd time related to the facility ' s failure to have a process in place to identify and consistently implement safety measures for residents while smoking and to provide supervision for residents who required supervision while smoking according to their assessments. The facility failed to consistently implement corrective actions for this deficient practice as identified during the 11/20/23 and the 3/8/24 survey resulting in a repeat immediate jeopardy citation related to unsafe smoking. Cross reference F689 3. A review of the results from the facility's last recertification survey ending 11/20/23 revealed that an Immediate Jeopardy was identified related to plans of care and treatment for residents with substance use disorder that contributed to resident overdoses. The facility developed a plan to correct the immediate concerns and the immediate jeopardy was abated on 11/16/23. The facility developed a plan to correct the continued lower-level deficient practice and prevent recurrence. They indicated that the corrective measures would be completed by 1/5/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a revisit survey, on 3/4/24 an Immediate Jeopardy was identified again for plans of care and treatment for residents with substance use disorder related to the facility and failure to plan care for residents with a diagnosis of Substance Use Disorder (SUD) and to monitor illicit drug use to prevent additional occurrences, relapse, and overdoses. The facility's plan to remove the immediacy was accepted on 3/4/24. The facility's plan was verified, and the immediacy was removed on 3/7/24. During this 2nd revisit survey, on 4/19/24 the survey team identified an actual harm where the facility failed to identify, monitor, and prevent additional occurrences of substance use in a resident with identified substance use disorder. The facility failed to consistently implement corrective actions for this deficient practice as identified during the 11/20/23 and again during the 3/8/24 survey. Cross reference F 740 4. The facility was also cited during the annual survey from 11/20/23, for concerns related to a safe, clean, comfortable, and homelike environment. The facility developed a plan to correct the deficient practice and prevent recurrence. They indicated that the corrective measures would be completed by 1/5/24. These concerns and more were identified and cited during the revisit survey completed on 3/8/24. A new plan of correction was implemented with a correction date of 4/8/24. During this revisit survey, the team continued to identify concerns with the environment, including the walls, beds, and equipment in resident rooms. Additionally, the facility failed to adequately implement pest control as per the plan of correction submitted to the Office of Health Care Quality as evident by the finding of mice and mice feces throughout the facility, including in the kitchen. The facility also failed to implement the recommendations set forth by the pest control company that they had contracted through leaving open holes throughout the facility beyond the recommended time frame in the facility resident area and the kitchen, identified during tour on 4/18/24 and throughout the survey. In addition, upon entrance to the facility on [DATE], at 7:50 AM, the survey team noted in the lobby the furniture had signs posted saying ' do not sit. ' This was brought to the attention of the facility consultant, staff #1 at 8:10 AM on 4/18/24. She stated that there was a concern related to bed bugs. The survey team asked if this was reported to the Office of Health Care Quality (OHCQ). She stated at that time that she was not sure. It was determined later during the survey that it was not. The RDO reported to the survey team on 4/23/24, that he on that day reported it to the OHCQ even though the concern about reporting to OHCQ was reviewed repeatedly with the administrative team throughout the survey. Additionally, staff #1 had stated on 4/18/24, that when they found out about the bedbugs there was also an identified concern related to lice. The facility was not sure if the lice and bedbugs came from an admission or a visitor. Again, the team could not get direct information regarding these concerns or what the facility was doing to prevent further spread of these potential infestations. Cross reference F584, F812 and F925

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observation, interviews, review of a complaint, review of administrative documents and record review, it was determined that the facility failed to keep accurate resident records in accordance with professional standards, to accurately display residents' names outside of their rooms, and to ensure that when the nursing staff destroy Schedule II medication, the administrative records were accurate. This was evident of 5 out of 140 (Resident #22, #8, #79, #64, #517, and #162) residents reviewed for accuracy of documentation on annual and complaint survey. The findings include: 1. On 9/28/23 at 11:45 AM, the surveyor conducted an interview with Resident #22. During this interview Resident #22 stated he/she did not have any teeth but also indicated he/she did not have any trouble eating with the lack of teeth. The surveyor observed Resident #22 confirmed that he/she did not have any teeth. On 10/4/23 at 11:44 AM, the surveyor interviewed Speech Therapist Staff #36. During this interview Staff #36 confirmed that she evaluated Resident #22 in early January and Resident #22 did not have any teeth or dentures. On 10/5/23 at 8:09 AM, the surveyor reviewed the medical record for Resident #22. The review revealed that on 1/10/23, 5/1/23 and 6/12/23 the admission/readmission evaluation documented that Resident #22 had his/her own teeth and indicated Resident #22 had no missing teeth. Further review revealed that Resident #22 had a Minimum Data Set (MDS) assessment completed on 1/17/23 that documented Resident #22 as having no natural teeth or tooth fragments, also known as edentulous. The 3 admission evaluations were not consistent with Resident #22 other assessments. 45733 2. Observation, on 09/27/23 at 1:08 PM, the surveyor was unable to locate Resident #8 by looking at the name labels on outside of the residents' rooms on 2nd floor unit. Record review, on 09/27/23 at 2:05 PM Resident was recently transferred from 411-A to 222-A. On 10/03/23 at 9:10 AM the surveyor observed the name label outside of room [ROOM NUMBER], discovering only one, Resident #95's, name on display. Entered the room and discovered two Residents in the room (Resident 95 # and #8). Observed 2 more rooms: 223 and 224 also missing name labels (223's Resident #79 and 224's Resident #64) on the outside of their rooms. An interview was conducted with the Geriatric Nursing Assistant (GNA) Staff #63, she was aware that the name labels for residents # 8, #79 and #64 were still missing. Staff #63 stated that if a resident's name label was missing then it must be reported to Staff #32 or the admission office to correct it immediately. The Geriatric Nursing Assistant (GNA) works directly with elderly patients to ensure their comfort and well-being. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview, on 10/03/23 at 09:23 AM, altered the Unit Manager (Staff #32) above findings and he was unaware that residents' name labels were missing. From a floor census that he provided, two residents were listed in room [ROOM NUMBER]: Resident 95 # and #8. 49148 3. On 9/28/2023 at 8:33 AM, during record review, surveyors discovered Resident #517, was transferred to the emergency room due to hypoglycemia (low blood sugar) on 9/27/2023 at 11:05 AM, shortly after being taken to the dialysis clinic within the facility. Further review of the medical record revealed that Resident #517 was admitted to the facility 9/25/2023 with diagnoses of, but not limited to, ESRD (end stage renal [kidney] disease), dependence on hemodialysis, hypoglycemia, osteomyelitis (bone infection), post procedural pain, heart failure, and high blood pressure. On 9/29/2023 at 11:45 AM, Surveyors reviewed Resident #517's active orders since Resident #517's initial admission to the facility and noted that there were no active physician orders addressing: 1) the resident's need for continued nutritional monitoring, blood sugar level monitoring, the addition of cornstarch or a complex carb for maintaining steady blood sugar levels and 2) the need for care for and the location of the resident's indwelling catheter, and dialysis access site as part of his/her medical record. On 9/29/2023 at 1:09 PM, during record review, Surveyors discovered an order created 9/29/2023 at 11:22 AM for Resident #517 to be sent out to the hospital immediately. The resident was transferred to the hospital due to another episode of low blood sugar. During an interview on 10/4/23 at 6:40 AM, Licensed Practical Nurse (LPN), Staff #6, revealed to the surveyors that the Admission Nurse is responsible for reviewing the discharge summary and then adding the orders into the electronic medical record. The Unit Manager is supposed to check and make sure they are complete and accurate prior to the physician verifying and then signing the orders in the electronic medical record. The surveyors asked if there is an admission policy or procedure to follow which guides the nurses and Staff #6 states we want an admission resource binder to help us, especially new nurses and agency nurses. She informed the surveyors that there is nothing on the unit to give us guidance for the new admission process or a checklist to make sure everything is completed for the resident at admission. She went on to say that when Resident #517 was readmitted on [DATE], his/her orders were entered in his/her electronic medical record on 10/3/2023-10/4/2023 by Registered Nurse (RN), Staff # 107. On 10/4/2023 at 11:45 AM, the Administrator was made aware of the concern that Resident #517's hospital discharge recommendations were not thoroughly reviewed and accurately documented into the resident's medical record at initial admission to the facility and after subsequent admissions. Surveyors informed the Administrator that Resident #517 received specific care instructions listed in the discharge summaries from each hospitalization that the facility staff failed to acknowledge, initiate, and therefore implement within his/her plan of care from admission on 9/25/2023-10/4/2023. Administrator stated that education will be provided to all licensed nursing staff on accurate documentation into residents' records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/5/2023 at 9:30 AM, surveyors reviewed Resident 's #517 electronic medical record and discovered discharge instructions to include that the resident was to remain on a renal diet with complex carbohydrates: 5 meals a day (Encourage 5 meals a day {3 full meals with 2 snacks}) with carbohydrates (Cornstarch) to help with hypoglycemia. Surveyors reviewed residents medical record and did not find a active diet order for Resident #517 as of that time. On 10/10/2023 at 9:30 AM, surveyors conducted an interview with the Certified Dietary Manager, Staff # 94. He stated that there is a Diet Order and Communication form (on paper) which the nursing staff completes to inform him of any new dietary orders regarding the residents. The new orders are updated in the kitchen system, which is different from the facility. Staff # 94 had not received a Diet Order and Communication form for Resident #517. 10/10/2023 at 9:42AM, surveyors interviewed LPN, Staff #43. Staff #43 reviewed Resident #517's electronic medical record and was unable to locate Resident #517's diet order. Staff #43 went on to confirm the expected facility's practice was to document the resident's diet order on the resident's electronic record and to submit a completed Diet Order and Communication form (on paper). On 10/10/2023 at 10:25AM, an interview was conducted with the Registered Dietitian (RD), Staff #41. During the interview, Staff #41 stated that diet orders are put into the electronic medical record by nursing staff and reviewed by the physician and himself. He acknowledged that Resident #517 did not have a diet order since readmission 10/3/2023 and verified a diet order added 10/10/2023. On 11/17/2023 at 12:30 PM, the facility Administrator, the Registered Dietitian, and the Regional Director of Clinical Operations were made aware of the concern for accurate and thorough implementation of physician orders upon a resident's admission to the facility. No additional documentation was provided regarding this concern. 18819 4. A review of complaint MD00198126 on 10/26/23 revealed an allegation Resident #162 had not received medications timely. A review of the facility's Controlled Substance Administration & Accountability policy on 10/26/23 revealed under section 4 - Obtaining/Removing/Destroying Medications, d. Two licensed staff must witness any disposal or destruction of a controlled substance and document the same on the Drug Disposition Record. A review of Resident #162's closed medical record on 10/26/23 revealed that Resident #162 had been admitted to the facility on [DATE] with diagnoses that included: metabolic encephalopathy, liver abscess, diabetes, and sepsis. Resident #162 was discharged on [DATE]. A review of Resident #162's schedule II narcotic administration record on 10/26/23 revealed that the former Director of Nurses (DON) had independently destroyed 34 tablets of 5 mg Oxycodone on 10/16/23. The former DON was the only licensed staff member witnessing the Oxycodone destruction. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the 3rd floor Unit Manager on 10/27/2023 at 5:15 PM, the 3rd floor Unit Manager stated that upon discharge, the resident's medications are removed from the medicine cart and are to be destroyed right away. There should be 2 nurses to witness the destruction with the signatures of the 2 nurses. Review of Resident's 2 medication monitoring control records for Resident #162 only revealed the former DON's signature.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 14894 Based on clinical record review and family interview it was determined that the facility failed to ensure that a resident had access to a working adaptive device. This was evident for 1 (#121) out of the 140 residents that are part of the survey sample. The findings include: Resident #121's clinical record was reviewed starting on 10/30/23 as part of the investigation into intake #MD00189052. A nurse wrote in a nursing progress note on 1/23/23 that the resident had a follow up Angiogram [scan that shows blood flow through the circulatory system] appointment today (1/23/23) at [name of hospital]. Was unable to go to the appointment because we are unable to provide ambulance transportation at this time, [the resident] transfers using a Hoyer [a device used to lift a person off of a bed] which is also broken. The appointment was rescheduled. The resident's spouse was interviewed on 11/6/23 at 2:28 PM. Spouse said the resident needed the Hoyer lift to get out of bed. The facility Administration was informed of the results at the exit conference.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 37277 Based on Interviews, observation, and record review, it was determined that the facility staff failed to ensure that resident rooms were free from mice. This was evident for 2 residents (#23 and #16) of 140 residents reviewed during the recertification survey. The findings include: On 09/28/2023 at 2:16 PM, during an interview with Resident #23 he/she said that he/she has seen 2 mice at a time-every night and sometimes during the day. On 09/29/2023 at 9:30 AM, a mouse was observed running across the floor in Resident #16's room. Resident #16 pointed out that the mouse will climb up cords near the head of his/her bed. These findings were brought to the attention of the Nursing Home Administrator. A review of service reports dated 06/01/2023 to 09/14/2023 from Orkin, the company that the facility contracts with for pest control, revealed that mice had been identified as an issue months before the start of the recertification survey. The service reports had comments that the logbooks at the nurses' stations were checked but there were no requests made by staff. On 9/15/2023 a service report comment stated, please have nurses use logbooks in nurses' stations to report pest sightings. A review of the logbooks verified that the logbooks in the nurses' stations were not being used by facility staff to make requests and report pest sightings. On 10/26/2023 at 8:50 AM, an interview with Staff #2 and Staff #57 revealed that facility staff were aware there was mice problem. Staff #57 stated that she sees them go from room to room. Neither staff member had knowledge of the logbook which Orkin relied on to direct their pest management treatments on the units. Both staff members commented that if they were going to report pests they would put it in TELS, the electronic communication program. On 10/26/2023 at 9:42 AM, an interview with Staff #7, the Maintenance Director, revealed that he only recently gained access to Orkin service reports and was unaware that Orkin was relying on facility staff to fill out the logbooks. He acknowledged there was an issue with mice and said that he has seen maybe 2 [requests] in TELS and has tried to take care of it in house. Staff #7 said that he will have to make sure facility staff are educated on using the logbooks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215085	A. Building B. Wing	11/20/2023

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 18819 Based on reviews of a facility reported incident, a nursing assistant's employee files, and staff interview, it was determined that the facility failed to confirm an agency nursing assistant had abuse, neglect, exploitation, and misappropriation of resident property education before allowing the agency nursing assistant to work with residents in the facility. This was evident for 1 of 12 nursing assistants reviewed during an annual recertification survey. The findings include: Review of facility reported incident #MD00184909 on 11/01/23 revealed details were staff member #87 was asked by Resident #144 to go buy him some cigarettes on 10/22/22. In addition to buying the smoking materials with Resident #144's bank card, staff member #87 also withdrew an additional $40 dollars cash without Resident #144's permission. In an interview with the facility Director of Human Resources (HR) on 11/14/23 at 3:15 PM, the HR director was unable to produce documentation that staff member #87 received education regarding resident rights and abuse before being allowed to work with residents. Cross Reference F 602