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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43096 Based on medical record review and interviews with facility staff, it was determined that the facility failed to inform the residents of their right to establish an advance directive and provide assistance if the resident wished to execute one or more directives. This was evident for 3 (#88, #108, and #354) of 6 residents reviewed for Advance Directives. The findings include: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. On 4/02/24 approximately 9 AM, surveyors reviewed advance directives for Resident #88, #108, and #354 in their medical records, including hard copies and electronic documents. The review revealed that no advance directive was found for Residents #88, #108, or #354. No documentation was found in those medical records to indicate that the facility staff provided the resident advance directive information and offered him/her an opportunity and/or assistance to formulate an advance directive if desired. During an interview with the Registered Nurse (RN #10) on 4/03/24 at 11:30 AM, RN #10 stated that providers and social workers were responsible for providing information and assisting residents and/or resident's responsible parties to complete advance directives documents. In an interview with the Nursing Home Administrator (NHA) on 4/03/24 at 2:06 PM, the NHA confirmed that the facility had a regional social worker (Staff #11) who covered this facility. NHA explained that Staff #11 comes to the facility 2-3 times weekly to manage residents' issues like guardianships, surrogates, and other concerns. On 4/03/24 at 2:26 PM, the surveyor interviewed Staff #11 via phone. Staff #11 stated that the admission department managed new residents' advance directives and further stated that she did not offer advance directives to residents. In an interview with the Admission Director (Staff #12) on 4/03/24 at 2:43 PM, Staff #12 stated that she didn't do anything clinical, including advance directives upon admission. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the NHA on 4/16/24 at 09:30 AM, the surveyor shared concerns about residents being offered an opportunity to formulate an advanced directive and his/her response. The NHA validated the concerns.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 43096 Based on review of facility records and interview with facility staff, it was determined that facility staff failed to ensure that all allegations of abuse were thoroughly investigated. This was evident for 1 (Resident #108) of 5 residents reviewed for Abuse during the survey. The findings include: On 4/08/24 at 7:41 AM, the surveyor investigated the facility-reported incident, MD00201978. The facility self-report documented that Resident #108 reported two staff members tossed him/her to bed on 1/27/24 during the evening shift (3 PM to 11 PM). The review of the facility's investigation revealed that they had two written statements from two Geriatric Nurse Aides' (GNAs #28 and #29), who worked on 1/26/24, and one Licensed Practical Nurse's (LPN #27) statement written on 1/29/24 (without indicating they cared the resident on 1/26/24 or not). The facility investigation packet also included an assignment sheet for the night shift on 1/26/24. However, GNA #28, #29, and LPN #27 were not listed on the sheet. During an interview with the Nursing Home Administrator (NHA) on 4/08/24 at 9:00 AM, the NHA recalled the incident. The NHA stated that she was not able to verify whether the incident occurred on 1/26/24 or 1/27/24. The surveyor shared the facility's self-report form, which indicated the event date was 1/27/24. However, there was no documentation to support the facility's effort to investigate the incident that was reported to have occurred on the date and to identify perpetrators. Also, there was no statement from Resident #108. On 4/16/24 at 9:30 AM, the surveyor shared the concern about the above with the NHA.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 43096 Based on medical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative in writing of the reserve bed payment policy upon a resident's transfer to an acute care facility. This was evident for 3 (Resident #72, #88, and #108) of 5 residents reviewed for hospitalization during the recertification/complaint survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent for therapeutic leave or hospitalization and should include information about the cost to reserve a bed. 1) On 4/04/24 at 9:41 AM, a review of Resident #72's medical records revealed that the resident transferred to an acute care facility on 2/16/24. The resident's medical record also contained a form titled Acute Transfer Letter dated 2/16/24, which included information about the resident's bed hold. However, the form did not list the daily amount of payment for bed hold. 2) A review of the medical record for Resident #108 on 4/04/24 at 7:29 AM revealed that the resident transferred to an acute care facility on 3/20/24. The acute transfer letter explained the bed hold policy. However, the form did not list daily payments for bed hold. 3) On 4/05/24 at 1:03 PM, a review of Resident #88's medical record revealed that the resident transferred to the hospital on 1/22/24. The bed hold notice form was documented in his/her record. However, the form did not have the amount. A review of the facility's bed hold policy on 4/05/24 at 10:32 AM revealed that the Admissions Director or Designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. And the business office manager or designee will follow all state specific guidelines upon resident return regarding notifying resident or responsible party of amount of bed hold days used and left. On 4/05/24 at 1:14 PM, the Director of Nursing (DON) was interviewed. The DON explained the procedures for the bed hold policy. However, there was no information about the daily amount for the bed hold for residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48168 Based on record review and interview it was determined that the facility failed to ensure care plans were comprehensive. This was evident for 1 resident (Resident #26) of 2 residents reviewed for pressure ulcers during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 4/11/24 at 11:19 AM a record review of Resident #26's medical record revealed an order dated 3/28/24 for daily dressing changes for the resident's sacral wound. A review of the resident's care plan revealed problem statements for the resident's left heel and left buttock wounds but did not list the resident's sacral wound. On 4/11/24 at 12:04 PM an interview with Registered Nurse (RN #4) was conducted who verbally confirmed that Resident #26 had a sacral wound in addition to the heel and buttock wounds. RN #4 reviewed Resident #26's care plan and indicated that the care plan did not include the resident's sacral ulcer and should have. On 4/11/24 at 3:12 PM the surveyor informed the Nursing Home Administrator (NHA) regarding the concern that Resident #26's care plan was incomplete since the resident's sacral ulcer was not listed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48168 Based on medical record review and staff interviews, it was determined that the facility failed to: 1) revise and update a comprehensive care plan within 7 days after completing the comprehensive assessments, and 2) have care plan meetings with residents and/or their representatives. This was evident for 5 (Resident #61, #75, #87, #88, and #110) of 41 residents reviewed during the recertification survey. The findings include: A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Facility staff must develop the comprehensive care plan within seven days of completing the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each evaluation. After each assessment means that after each assessment, it is known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS). Minimum Data Set: The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, forming the foundation of a comprehensive assessment. 1) During the entrance conference on 4/01/24 the Nursing Home Administrator (NHA) stated that the facility was a smoke-free facility, and that no residents smoke. On 4/03/24 at 11:08 AM in an interview with Resident #88, the resident stated that he stopped smoking a year ago. On 4/08/24 at 11:07 AM a review of Resident #88's care plan revealed a problem titled [Resident #88] utilizes nicotine products due [to] Lifestyle, with the initiation date of 12/30/23. The corresponding care plan interventions included in part, Educate resident to designated smoking areas. A review of the resident's medication list revealed no active order for any nicotine products. A previous order for a nicotine patch was discontinued on 7/31/23. On 4/08/24 at 12:42 PM an interview with the NHA was conducted to review Resident #88's care plan for the use of nicotine products and smoking. The NHA again stated that the facility was a smoke-free facility. When the care plan and orders were reviewed with her, the NHA indicated that the care plan had not been revised and was inaccurate. 15701 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #87's medical record was reviewed on 4/3/24 in relation to complain intake MD00203943. Review of the medical record revealed that the most recent MDS (Minimum data set) quarterly assessment was dated 2/26/24. Review of the medical record did not reveal documentation to indicate that a care plan meeting was held within 7 days of the quarterly MDS assessment. Review of the paper chart and the miscellaneous tab in the electronic record did not reveal any care plan signature sheets since the quarterly MDS assessment. An interview was conducted with the director of the unit (Staff#2) that Resident #87 resided on 4/3/24 at 12:45 PM. She was informed that upon surveyor review of Resident #87's medical record care plan conference/meeting documentation was not found. She reviewed the resident's medical record and confirmed that a quarterly care plan meeting was not documented since the last quarterly assessment of 2/26/24. 3) On 4/3/24 at 10:55 AM, Resident #61's medical record was reviewed. Resident #61 was admitted to the facility on [DATE] and the 1st quarterly MDS assessment was dated 2/28/24. Review of the progress notes in the electronic health record (EHR) did not reveal that a quarterly care plan meeting was conducted after the MDS assessment of 2/28/24. An interview with the Unit director (staff #2) was conducted on 4/3/24 at 12:45 PM. She revealed that the facility did not have a social worker and she took over as a social services liaison in November of 2023 to coordinate care plan meetings. She indicated the best way to read her notes was to use a custom search for her name in the EHR progress notes. A follow-up meeting was conducted with the Unit Director #2 on 4/4/24 at 9:24 AM. She was informed that documentation of a care plan meeting/conference was not found in Resident #61's medical record related to the quarterly MDS assessment of 2/28/24. At 10 AM the Unit Director #2 provided a document signed by her and a nurse dated 3/14/24. The Unit Manager was asked to provide the letter that was provided to the responsible party/guardian of Resident #61. The letter was addressed to the cognitively impaired resident who based on medical record review on 4/3/24 had documented certifications of incapacity and an undated handwritten note at the bottom of the form Called mother [name of Resident #61's mother and telephone #]. It was reviewed with the Unit Director #2 that the facility had provided a document to a cognitively impaired individual, and there was no documentation in the record to indicate the lack of participation of resident and the resident's responsible party and the alleged date of the care conference was greater than 7 days after the quarterly assessment. 43096 4) On 4/08/24 at 12:27 PM, a review of Resident #75's medical record revealed that the resident's quarterly MDS assessments were completed on 11/16/23, 2/16/24, and 4/08/24. The resident's progress note contained care conference notes dated 12/01/23, which was 15 days later than the comprehensive assessment completed. Additionally, care conference notes dated 3/06/24 showed Resident #75 had a care plan meeting. However, this was 19 days later than the MDS assessment was completed. In an interview with the Nursing Home Administrator (NHA) on 4/03/24 at 2:06 PM, the NHA confirmed that the facility had a regional social worker (Staff #11) who covered this facility. The NHA explained that Staff #11 comes to the facility 2-3 times weekly to manage residents' issues like guardianships, surrogates, and other concerns. The NHA also stated that Staff #2 (activities director and Alzheimer care unit manager) coordinated care plan meetings for residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/08/24 at 1:30 PM, the surveyor requested Resident #75's care plan meeting documentation from Staff #2. The staff provided a copy of the care conference notes in progress dated 12/01/23 and 3/06/24, the same notes the surveyor had already verified. No additional documentation was submitted to the surveyor. 5) On 4/10/24 at 10:20 AM, the surveyor interviewed Resident #110's loved one while investigating a complaint. The resident's loved one reported that he/she received no update regarding the care plan except the initial one upon Resident #110's admission. Resident #110's medical record review on 4/10/24 at 11:00 AM revealed that the resident's quarterly MDS assessments were completed on 9/09/23 and 12/10/23. Resident #110's progress note contained a care plan note on 9/14/23. However, there was no supportive documentation that the resident's representative party attended and/or was notified about the care plan meeting. Additionally, the progress note date 12/27/23 documented the care plan meeting. However, it was 17 days later that the comprehensive assessment (MDS) was completed. During an interview with the Director of Nursing (DON) on 4/12/24 at 11:40 AM, the surveyor shared the above concerns about Resident #110's care plan meeting documentation.

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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** 47200 Based on medical record review, staff interviews and a complaint, it was determined that the facility failed to: 1) have a process in place to address and review medical orders pending provider signature; 2) provide timely care for residents who experienced a change in condition; and 3) timely arrange for a resident to go for their 2-weeks follow up (F/u) post op visit. This was evident for 4 of 41 residents (Resident #46, #109 and #110, #107) reviewed during recertification survey The findings include: 1) On 4/4/24 at 10:02AM the surveyor conducted a review of the medications for Resident #46. Upon review of the resident's April 2024 Medication Administration Record (MAR) it was revealed that on 4/1/24 the following medication had been documented as administered: methylprednisolone sodium succinate injection. Review of the medical order dated 4/1/24 indicated the medication was a one-time dose. Further review of the April 2024 MAR revealed a second order dated 3/31/24 for the one-time dose of the medication, which had not yet been administered, and the following was notated on the order: pending order signature. On 4/5/24 at 10:15 AM the surveyor conducted an interview with Staff #35, Licensed Practical Nurse, who reported that if an order is pending signature, it is waiting for the doctor to approve it to be given. Staff #35 further reported that if they saw two of the same orders and one was still pending signature, they would tell their supervisor. On 4/5/24 at 11:10 AM the surveyor conducted an interview with Staff #4, Registered Nurse, Infection Control Preventionist and Educator, reported to the surveyor that they rely on nurse to nurse verbal report to make them aware of situations like this, but there is no process in place to ensure the resident would not receive the duplicate dose if the provider ends up signing off on it later on. They further reported that if the medication having been administered was not communicated during the nurse to nurse verbal report and the provider signed the second duplicate order, the resident could end up getting the medication a second time. On 4/5/24 at 11:20 AM the surveyor conducted an interview with Staff #23, Registered Nurse, Acting Unit Manager, Regional Mobile Director of Nursing. When the surveyor inquired as to the duplicate orders they stated: that's the telehealth people. When asked if they review provider's pending orders that have not been signed yet, they reported no. At this time, the surveyor shared their concern with Staff #23, who acknowledged and confirmed understanding of the concern. 15701 2) Resident #109's medical record was reviewed in relation to complaint MD00202250. Initial review of resident #109's medical record on 4/8/24 at 1:11 PM revealed the resident was admitted to the facility on [DATE] and was transferred to a hospital on 2/3/24. (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 a nursing progress note dated 1/31/24 at 1:43 PM indicated that Resident #109 had a decline in functioning, difficulty chewing, and had difficulty sitting up unassisted. The nurse documented that Resident #109 stated I don't feel like my normal self. The nurse had contacted a physician (not the residents attending) and had received new orders for laboratory blood work, urinalysis with culture and sensitivity, and the resident's diet was downgraded to puree. Review of a nurse's progress note of 2/1/24 at 5:49 AM revealed the collection of the urinalysis and the urine culture and sensitivity with indication that 1200 ml (milliliters) of output from urinary straight catheterization. Review of the blood laboratory results revealed that the laboratory received the blood specimen on 2/1/24 at 10:45 am and reported the results at 2:36 PM. There was a late entry Acute Visit note by a certified registered nurse practitioner (CRNP Staff #25) time stamped for 1 AM on 2/1/24 and signed on 2/4/24. The note documented Patient seen today for lab review. The note reflected abnormal values for BUN (Blood urea nitrogen) and GFR (glomerular filtration rate) as both of these test measures how well the kidneys' function. The CRNP documented that he discussed with MD and per his recommendation, no IV hydration. Will order nephrology consult for patient. Nursing note of 2/1/24 at 9:15 PM indicated that Resident #109 had a PIV line placed in the right forearm. (Peripheral Intravenous Line. It's a small, short plastic catheter commonly used to deliver fluids or medications.) Nursing note of 2/1/24 at 10:04 PM revealed that the resident had poor intake (eating decline) and a continued decline in baseline. A PIV line placed in the right forearm. The note indicated that the pharmacy was called for a stat delivery of intravenous fluid to be administered to the resident upon delivery. There was not a note to indicate when the resident was started on intravenous fluids. Review of the medication administration record for February 2024 revealed that the administration of sodium chloride intravenous fluids was provided on the day shift of 2/1/24. Review of a nursing note written by the facility's infection control preventionist at 2:35 PM on 2/2/24 revealed the interdisciplinary team met reviewed lab results and the medical director provided orders to discontinue IV fluids for elevated BUN and new order for nephrology consult. The only other note written on 2/2/24 revealed that the patient's IV and IV fluids were discontinued. Review of the medication administration record for February 2024 revealed that an appointment was made for the resident to be seen by nephrology on 2/29/24. Interviews were conducted with the CRNP (staff #25) on 4/10/24 and on 4/11/24 at 11:55 AM. He explained the significance of the resident with identified chronic kidney disease and the abnormal blood work and that IV fluids would be invaluable to the resident. He indicated the resident did not receive intravenous fluids. It was explained that per the physician's order sheet it was he that ordered intravenous fluids. He was asked about the staff removing 1200 ml of urine per note. He was unaware of the note indicating the removal of 1200 ml in the AM hours of 2/1/24, and he seemed unaware of the resident receiving IV fluids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A meeting/interview was held with the director of nursing, the Divisional VP of clinical services, Division VP of Clinical Assessment and Reimbursement, the CRNP, and at least for a time the nursing home administrator. Questions and concerns were shared related to the resident being provided with IV fluids without documentation of the decision as the CRNP was unaware that the resident was placed on IV fluids. The director of nursing began to express her thoughts as to how the orders were obtained but stopped short of her explanation. There was not any indication that the CRNP or the interdisciplinary team had discussed that Resident #109 was retaining fluids and that the resident was administered additional fluids. The Divisional VP of clinical services acknowledged that the CRNP's late note would not have been in the resident's chart for review on 2/2/24 and 2/3/24. Questions went unanswered as to why or what the facility would be waiting for prior to the resident being transferred to the hospital per family request on 2/3/24. 43096 3) On 4/10/24 at 9:15 AM, as part of a review of complaint MD00202974, the surveyor reviewed Resident #110's medical records which revealed that Resident #110 had a change in condition on 2/22/24 which consisted of lethargy, slow response, and elevated pulse rate. However, the medical record revealed that the resident did not receive any interventions until he/she was transferred to a hospital on 2/23/24. Further review of Resident #110's medical record on 4/10/24 at 9:40 AM revealed a progress note dated 2/22/24 at 3:11 PM, written by the mobile Director of Nursing (Staff #33) that described Resident #110's change in condition: upon entering room. [Resident #110] lying in bed with eyes closed, slow to respond to stimuli, v/s obtained. In house NP (Nurse Practitioner) notified and will assess and call family to discuss. The same document also noted that the resident has abnormal vital signs such as blood pressure 143/84, pulse 108, respiration rate 22, temperature 97.5, and pulse oximetry O2 91%. Further review of the medical records revealed that a progress note dated 2/23/24 written by a Registered Nurse (RN #36) documented that Resident has altered mental status. Vital signs: temperature 100.2, pulse 130 per minute, respiration 40 per minute, oxygen 61% on room air, after 15% with non-rebreather applied, 02 saturation recorded 85%. NP notified. New order to transfer patient to the ED for evaluation. Resident transferred to [hospital name] for evaluation. Resident #110's medical record lacked any documentation that described any interventions for the resident's change in condition on 2/22/24 until the transfer to the hospital on 2/23/24. The surveyor reviewed Resident #110's historical vital signs records on 4/10/24 at 10:30 AM. The records revealed that the resident's average pulse was 60s-70s since his/her admission in July 2023. Based on comparing Resident #110's average pulse rate, the resident's pulse rate on 2/22/24 (108 per minute) was elevated. During an interview with the facility attending Nurse Practitioner (NP #25) on 4/11/24 at 1:29 PM, NP #25 insisted that he did not see Resident #110 on 2/22/24. The surveyor shared Resident #110's progress note dated 2/22/24 at 3:11 PM, documenting, in-house NP [Name of NP #25] notified and will assess. NP #25 said, I don't know when they contacted me. If it were here, I would evaluate the resident. I saw him/her on 2/23/24 and ordered to send him/her out for further evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/24 at 1:38 PM, the Director of Nursing (DON), NP #25, and Staff #33 requested a meeting with the surveyor. They stated that Resident #110's condition change occurred on 2/23/24, not 2/22/24. Staff #33 insisted that she made a mistake in not changing the event date when she put the late entry note under the progress note. She said, condition changed reported on 2/23/24 NOT 2/22/24. The surveyor questioned how she could explain the vital signs (blood pressure 143/84, pulse 108, respiration rate 22, temperature 97.5, and pulse oximetry O2 91% on 2/22/24 at 3:12 PM) documented in Staff #33's note on 2/22/24. Staff #33 did not answer the surveyor's question. On 4/16/24 at 9:30 AM, the surveyor shared the concern with the Nursing Home Administrator (NHA) about delayed care when Resident #110 had a condition change reported on 2/22/24. The NHA validated the concern. 44441 4) On 4/10/24 at 9:45 AM review of a complaint MD00197991 alleged that Resident #107 who had surgery and was admitted on [DATE] to the facility was supposed to have a 2-weeks post op visit but was unable to have the f/u appointment for 6 weeks because the facility was unable to make the appointment for the resident. Review of the nurse's progress note dated 8/22/23 on 4/10/24 at 11:25 AM documented a first follow up appointment/Visit on 8/22/23 to the orthopedic surgeon's office accompanied by family members. A second visit was documented on 9/12/23. On 4/10/24 at 12:39 PM the Director of Nursing (DON) was asked in an interview who schedules doctor's appointment for residents. She stated that Staff #24, a scheduler, does scheduling for all residents. She was made aware of the concerns and said she will check with the scheduler. She came back to report that she spoke with Staff #24 and was told that when they tried to make the appointment for Resident #107, staff #24 was told that the earliest available date was 8/22/23. The DON was asked if they made the surgeon or residents family aware, and she said no. She was asked if this was documented anywhere in the medical records, and she said no. Staff #24 the scheduler in an interview on 4/11/24 at 10:45 AM was asked about the process for scheduling post op doctors' appointments. She stated that it was dependent on whether the resident was going to see a specialist, the slot availability, type of surgery and the urgency of the appointment. She was asked why the 2-weeks F/u post op appointment was not scheduled as instructed by the surgeon. She stated that when she called the office to schedule the f/u with the specialist, she was told that the next available opening was in August 2023. She was asked if she notified the surgeon or the residents' families or documented her responses. She stated that she did not notify the surgeon or residents family and did not document regarding the appointments unless it was canceled. On 4/11/24 at 11:27 AM: The surgeon's office was called, and an office scheduler was asked in an interview the process for when a surgeon requests to see a resident 2 weeks post op, if they get the appointments. The scheduler said they will. She was asked if the appointment was dependent on the type of surgery, and she said no. She was asked what date the resident was seen post op. She said the resident was first seen post-op on 8/22/23 and subsequently on 9/12/23. She was asked if their office gave preferences to first time post op patients, and she said yes. On 4/11/24 at 3:15 PM- The Administrator was made aware that this was a concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48168 Based on record reviews and interviews it was determined that the facility failed to ensure that resident care was provided in a safe manner. This was evident for 1 facility reported incident (MD00204591) of 7 facility reported incidents reviewed during the recertification survey. The findings include: A Hoyer lift is a mechanical device designed to lift and transfer patients from one place to another. The basic components include a mast (vertical bar that fits into the base), a boom (a bar that extends over the patient), a spreader bar (which hangs from the boom), a sling (attached to the spreader bar, designed to hold the patient), and several clips or latches (which secure the sling). Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths. On 4/15/24 at 9:45 AM a review of the facility reported incident MD00204591 was conducted. The report was submitted to the Office of Health Care Quality on 4/11/24, and alleged that Resident #32 received rough care while being bathed. On 4/15/24 at 11:05 am an interview with Resident #32 was conducted. The resident explained that Geriatric Nursing Assistant (GNA#8) used a Hoyer lift to transfer him/her from the bed to a shower chair but did not have a second person to assist with the transfer. The resident further stated that GNA #8 situated him/her on the shower chair at a 45-degree angle with my butt hanging half off the chair and that he/she had to really hold myself on the chair to keep from sliding out. On 4/15/24 at 3:54 PM an interview with the Nursing Home Administrator (NHA) was conducted. She provided the surveyor with a revised final report of the facility reported incident which included the resident's allegation that GNA #8 used the Hoyer lift by herself. The NHA also stated that GNA #8 will be required to do additional training on Hoyer lift use for transfers and that the GNA was given a written final warning - which the NHA explained meant that the GNA had one more chance for improvement. On 4/16/24 at 10:35 AM a second review of witness statements from the facility's investigation file revealed a statement that Resident #32 reported the incident to GNA #9. On 4/16/24 at 11:01 AM an interview with GNA #9 was conducted. She stated that she had also cared for Resident #32 and that she first became aware of the incident on 4/11/24 when Resident #32 told her that GNA #8 was a little too rough and did not know how to properly use the Hoyer lift. When GNA #9 was asked if a Hoyer lift transfer always required 2 staff persons, she said yes. On 4/16/24 at 12:43 PM a telephone interview was conducted with GNA #8. When asked about the incident she explained that she used the Hoyer lift by herself because nobody was around to help her because they were always short staffed and that she did the best she could.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43096 Based on medical record review and staff interviews, it was determined that the facility failed to have a system to monitor and respond to changes in residents' weights and notify the physician when weight loss was identified. This was evident for one (Resident #354) of two residents reviewed for nutrition during the survey. The findings include: A review of Resident #354's medical record on 4/01/24 at 2:00 PM revealed that the resident's body weight was documented as 334 lb. (pounds) on 3/22/24 and 324 lb. on 3/26/24, which was a ten-pound difference within four days. However, there was no documentation in Resident #354's medical records regarding his/her weight loss. In an interview with a Registered Nurse (RN #10) on 4/03/24 at 11:32 AM, RN #10 explained that nurses should verify residents' body weight and follow up on their differences by ensuring measuring methods, condition changes, and/or lab results. Also, RN #10 stated that nursing staff should report to the providers and document residents' weight changes. During an interview with the Director of Nursing (DON) on 4/04/24 at 09:46 AM, the DON stated that residents' body weight needed to be documented on the first day of admission and the second day to get the baseline body weight. With the baseline body weight, they need to measure weekly, four times, and then monthly. The DON also insisted that a more than five-pound difference would be concerning, and any concerns would be reported and documented in residents' medical records. The surveyor shared concerns regarding Resident #354's ten-pound loss, which was not reported/discussed with any other clinical staff. The DON validated the concerns.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 43096 Based on observations, record reviews, and resident and staff interviews, it was determined that the facility failed to evaluate residents' pain. This was evident for one Resident (# 354) of two residents reviewed for pain during the survey. The findings include: During an interview with Resident #354 on 4/01/24 at 11:37 AM, the Resident stated that he/she had pain in both legs. Resident #354 reported that he/she had been taking Morphine twice a day regularly and Oxycodone as needed. The Resident also said, Morphine is not working for me. No one evaluated my pain. On 4/03/24 at 11:06 AM, a review of Resident #354's medical record revealed that the resident had orders of Tylenol 650 mg every 4 hours as needed when pain score 1-3, Oxycodone 10mg every 4 hours as needed for moderate pain (4-7), and morphine sulfate ER 15mg two times a day. Further review of Resident #354's Medication Administration Record (MAR) revealed that the resident administrated Oxycodone 10mg when his/her pain score was more than 7 as below: -On 3/23/24 at midnight, the pain was 10 -On 3/24/24 at 10:42 PM, the pain was 9 -On 3/28/24 at 10:18 AM, the pain was 9 -On 3/28/24 at 10:17 PM, the pain was 10 -On 4/02/24 at 1:34 AM, the pain was 8 -On 4/02/24 at 5:46 PM, the pain was 9 -On 4/03/24 at 11:27 AM, the pain was 8 During an interview with the Registered Nurse (RN #10) on 4/03/24 at 11:30 AM, RN #10 stated that the facility nurses assess residents' pain before administering medication. RN #10 insisted that if the pain score exceeds the order parameter, they should contact the provider and discuss the Resident's pain management. In an interview with the facility attending Nurse Practitioner (Staff #25) on 4/04/24 at 1:56 PM, Staff #25 stated that if residents' pain is above the parameter, he expects to receive a call from nurses and discuss the medications. On 4/16/24 at 9:30 AM, the surveyor shared the above concerns with the Nursing Home Administrator (NHA). The NHA validated the concerns.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on medical record review and staff interview it was determined that the physician/Certified Registered Nurse Practitioner (CRNP) progress notes were not written, signed and timely present in the resident medical records. This was evident for 2 (Residents #46, and #106) of 41 residents reviewed during the survey. The findings include. 1) On 4/4/24 at 10:02AM the surveyor conducted a review of the medication orders for Resident #46. During this review, it was noted the resident was currently receiving 15mg of the following psychiatric medication: escitalopram. On 4/4/24 at 10:02AM the surveyor reviewed the most recent psychiatric note present in the resident's medical record which was dated 3/15/24. The surveyor noted that the visit date was 3/15/24, however, the note had not been uploaded to the resident's medical record until 3/21/24, approximately, seven days after the visit was dated as having occurred. Review of this note indicated a recommendation made by Staff #38, Psychiatric Certified Registered Nurse Practitioner, on 3/15/24 for the resident to receive 10mg of the medication: escitalopram. On 4/4/24 at 1:50PM the surveyor conducted an interview with Staff #38, inquiring as to the dosage amount. The surveyor noted the information Staff #38 provided during the interview did not correlate with the information the surveyor reviewed in the medical record. During the interview Staff #38 reported they were seeing the resident weekly. At this time, the surveyor noted the last visits made according to the medical record documentation, were on 3/13/24 and 3/15/24. When the surveyor inquired as to where the documentation was for the weekly visits, Staff #38 reported they would need to be uploaded to the medical record. Further review of the medical record on 4/4/24 at 2:48PM revealed the following visit dates and upload dates: On 12/22/23 Resident #46's psychotherapy visit note was not uploaded to the medical record until 12/26/23. On 1/13/24 Resident #46's x-ray report was not uploaded until 1/16/24. On 1/24/24 Resident #46's psychotherapy note was not uploaded until 2/1/24. On 1/22/24 Resident #46's orthopedic consult was not uploaded until 2/6/24. On 2/1/24 Resident #46's psychotherapy note was not uploaded until 2/13/24. On 2/7/24 Resident #46's psychotherapy note was not uploaded until 2/14/24. On 2/14/24 Resident #46's psychotherapy note was not uploaded until 2/27/24. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/24 Resident #46's psychotherapy note was not uploaded until 2/28/24. On 2/27/24 Resident #46's facility requested consult was not uploaded until 2/29/24. On 1/6/24 Resident #46's follow up mental health visit was not uploaded until 3/9/24. On 2/28/24 Resident #46's psychotherapy note was not uploaded until 3/11/24. On 3/6/24 Resident #46's psychotherapy note was not uploaded until 3/11/24. On 3/10/24 Resident #46's follow up mental health visit was not uploaded until 3/21/24. On 3/15/24 Resident #46's facility requested consult was not uploaded until 3/21/24. On 3/13/24 Resident #46's psychotherapy note was not uploaded until 3/25/24. On 3/28/24 Resident #46's psychotherapy note was not uploaded until 4/5/24. On 3/21/24 resident #46's psychotherapy note was not uploaded until 4/5/24. On 4/3/24 resident #46's psychotherapy note was not uploaded until 4/7/24. On 4/11/24 resident #46's psychotherapy note was not uploaded until 4/15/24. On 4/5/24 at 2:27PM the surveyor conducted an interview with the Director of Nursing (DON) who reported that the facility expects providers to document and upload their medical notes within 72 hours of their visit with the resident. At this time, the surveyor shared their concern, and the DON stated the provider was not in compliance, and acknowledged and confirmed the surveyor's concern. 15701 2) Resident #109's closed medical record was reviewed on 4/8/24 in relation to complaint MD00202250. Resident #109 was admitted to the facility on [DATE] and was transferred to a hospital on 2/3/24. Review of a nurse practitioner's (CRNP staff #25) Acute Visit note revealed the date of service as 2/1/24 and an effective date as 2/1/24 at 1:00 AM. The CRNP's note was signed on 2/4/24 at 3:37 PM. By the time the CRNP's note was uploaded to the electronic medical record the resident no longer remained in the facility. A meeting was held on 4/15/24 at 2:21 PM with the director of nursing, Divisional VP of clinical services (staff#6), Division VP of Clinical Assessment and Reimbursement (staff #7), CRNP (Staff#25) and eventually the nursing home administrator. There was a discussion related to resident #109's transfer to the hospital on 2/3/24. The Divisional VP of clinical services acknowledged that the CRNP's late note would not have been in the resident's chart for review on 2/2/24 and 2/3/24.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43096 Based on a review of employee files and interviews, it was determined that the facility failed to put a system in place to ensure Geriatric Nursing Assistant (GNAs) were competent with their skill sets. This was found to be evident for 3 out of 5 (GNA #39, #40, and #41) GNA employee files reviewed for competencies and skill sets. The findings include: On 4/09/24 at 9:12 AM, the surveyor reviewed randomly selected Geriatric Nurse Aides' (GNAs) employee files, including agency staff, for their competency records. The review revealed that three agency GNAs (GNA #39, #40, and #41) of the five selected ones did not have records to support their competence with their skills. During an interview with the educator (Staff #4) on 4/09/24 at 2:10 PM, Staff #4 stated that the facility's staff provided orientation for agency staff upon their first day, and the orientation form signed by management staff, including herself, the director of Nursing, and supervisor. Also, Staff #4 verified three agency GNAs' first day of work as below: GNA #41 started to work at this facility on 3/19/24. GNA #40 started to work at this facility on 3/29/24. GNA #39 started to work at this facility on 3/28/24. However, a review of orientation forms for GNA #39, #40, and #41 on 4/09/24 at 2:30 PM revealed the form did not include signatures for those who provided education or verified their skills. Also, no date was documented on the form. On 4/10/24 at 9:43 AM, the surveyor shared the above concerns with Staff #4. The staff confirmed no supportive evidence that the facility verified the agency staff's competency skills. Staff #4 validated the concerns.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44441 Based on record review and staff interviews, it was determined that the facility failed to follow recommended parameters prescribed by the physician when administering blood pressure and pain medications. This was evident for 1 (#28) of 5 residents reviewed for unnecessary medications during the recertification survey. The findings Include: On 4/24 at 9:06 AM review of Resident #28's medical records revealed a Physicians order written on 12/7/23 as: Metoprolol Tartrate Tablet, Give 12.5 milligram by mouth in the morning for Hypertension. Hold for Systolic blood pressure (SBP)-pressure in the blood vessel when your heart beats <110 or Heart rate (HR)<60. Review on 4/4/24 at 11:41 AM of Resident #28's Medication Administration Records (MAR) from January through March 2023 showed that the resident got the metoprolol, but the blood pressure (BP) readings were not documented prior to medication administration per physician's order. Further review revealed a second order written on 11/10/23 as:Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug*Give 1 tablet by mouth every 6 hours as needed for Pain 5-10, and Acetaminophen oral tablet 325mg. Give 2 tablets by mouth every 4 hours as needed for pain 1-3 written on 8/12/23. Review on 4/4/24 at 12:00 PM of the MAR from January to March 2023 revealed that Resident #28 got oxycodone on 1/22, 2/3, 2/24, 2/27, 3/1, 3/8, 3/9, 3/11, 3/14, 3/23 and 3/24/24 when their pain level was less than 5 (Level 5-10). Resident #28 also got Acetaminophen on 1/6, 1/15, 1/18, 1/26 and 1/31/24 when their pain level was greater than 3 (Level 1-3). On 4/4/24 at12:29 PM Staff #10 a Registered Nurse (RN) was asked in an interview the process for giving a blood pressure(BP) medication with specified parameters. She stated that the process was to check the residents BP and document it prior to giving the prescribed medication and to hold the medication if the readings were outside of the recommended parameters. She was asked about the process for administering pain medication with prescribed parameters. She stated that she was expected to ask the resident for their pain levels prior to pain medication administration. That the pain levels would determine which medication to administer. She was asked if the nurse should give medication outside the recommended parameters. She said the nurse should not. On 4/4/24 at 12:49 PM Staff #23 a unit manager was made aware that the nurses gave BP medications without checking residents BP as ordered and that pain medications were given when parameters were above and below the recommended parameters. She was asked about the expectations for administration. Staff #23 said that the expectation was that residents with parameters should have them checked before medication administration and that pain medications should not be given outside of the prescribed ranges. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1:52 PM in an Interview with Staff #25 a Nurse Practitioner (NP), he was asked about the significance of medication parameters. He stated that if a resident was placed on a Beta Blockers which causes blood vessels to relax and widen thereby lowering blood pressure and heart rate, that these medications must have parameters to hold, to avoid complications from administration. He stated that the nurses must check BP and vital signs before they give these medications. He was asked about pain medications, and he stated that pain medications should have pain levels and should not be given outside the prescribed levels for effective pain management. The Director of Nursing (DON) was present during the discussion with the NP and was made aware that this was a concern.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48168 Based on observation, interview and record review it was determined that the facility failed to provide dental services to meet residents' needs. This was evident for 1 of 2 (Resident #17) reviewed for dental during the survey. The findings include: On 4/01/24 at 10:08 AM an observation and interview with Resident #17 was conducted. The resident was observed to have only bottom dentures and had no natural upper teeth. Resident #17 explained that his/her upper dentures had been lost a few months ago and had not been replaced, and although a care plan meeting was held last week when he/she was told a dentist would come to the facility to do the needed impressions, there had been no follow up to date. On 4/04/24 at 1:38 PM a review of Resident #17's medical record revealed a care plan problem for poor fitting dentures. No dental care notes were found in the resident's record. The surveyor requested all documentation related to the resident's dental care. On 4/05/24 at 1:55 PM another review of Resident #17's record was conducted, and no dental notes were found in the clinical progress notes or in the record where outside service notes were scanned and uploaded. Additionally, there was no response to the surveyor's request for dental services documentation made on 04/04/24. On 4/05/24 at 2:59 PM an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was conducted. The DON stated that Resident #17 went to the dentist in September or October 2023 and recommendations were made to the resident's family, but the facility was unaware of the recommendations. When asked how the facility ensured this resident's dental needs were being met, they were unable to provide an answer. On 4/09/24 at 11:13 AM in an interview with Unit Manager (Staff #1), and Licensed Practical Nurses (LPN#35), the Unit Manager stated the family was going to pay for the resident's missing dentures and were taking care of it. When asked if there was a grievance form or any documentation in the medical record about the missing dentures, they both said yes. When asked for the documentation, they could not provide any. On 4/10/24 at 2:32 PM in an interview with the NHA, the surveyor reviewed with her that the resident did not receive timely care for dental needs and the NHA verbalized understanding.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 47200 Based on record review, observation, and interview it was determined the facility failed to ensure overall supervisory responsibilities for the facility's kitchen was assigned to a qualified dietetic service supervisor. This was evident upon surveyor's initial tour of the kitchen during the facility's recertification survey. The findings include: Upon surveyor's initial tour of the facility's kitchen on 4/1/24 at 8:21 AM the surveyor conducted an interview with Staff #13, Culinary Director who reported they were in charge of the kitchen. Upon further inquiry by the surveyor, Staff #13 stated they were not a Certified Dietary Manager. Staff #13 further reported to the surveyor that Staff #18, Dietary District Manager, covers regionally, was currently on their way to the facility, and came into the building two to three times per week. On 4/1/24 at 8:46 AM, Staff #17, Culinary Director (of different location,) reported to the surveyor that Staff #13 was in charge of the kitchen, and Staff #19, Registered Dietician, was not running the kitchen. On 4/1/24 at 9:51 AM Staff #18 reported the following information regarding Staff #19: The dietician works 30 hours a week which is full time here. On 4/15/24 at 11:53 AM the surveyor conducted an interview of Staff #19 who reported they work 30 hours per week and did not know whether they were full time or part time. When the surveyor inquired as to if they were in charge of the kitchen or supervising the kitchen, they responded with the following information: I am not, I never was, the real reason I'm hired is for the clinical staff. Staff #19 further confirmed that Staff #18 oversees other buildings in addition to this facility and reported that documented kitchen consultations had not occurred since approximately December 2023. On 4/15/24 at 1:05 PM the surveyor reviewed the facility assessment which identified one full time dietician was needed. Additionally, the facility assessment failed to identify any food and nutrition services staff needed. On 4/16/24 at 9:42 AM the surveyor conducted an interview with the facility Administrator who stated the following information regarding Staff #19: Yes s/he isn't in charge of the kitchen.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47200 Based on interview and record review it was determined the facility failed to ensure the kitchen maintained adequate staffing levels. This deficient practice affects all residents. The findings include: On 4/1/24 at 12:16 PM observed Staff #15 working in the kitchen wearing a name tag indicating their job title was maintenance. At this time, the surveyor conducted an interview and inquired as to their role within the facility. Staff #15 reported they had performed different positions including in maintenance, social work, other roles with the exception of nursing, and now in the kitchen as of two weeks ago, they were a culinary aide. When the surveyor further inquired as to the staffing levels, they reported the following information: Monday was just me and the cook and that was it. On 4/10/24 at 12:35 PM the surveyor requested kitchen staffing schedules from the facility's Administrator. These were provided by Staff #18, Dietary District Manager, and reviewed by the surveyor. On 4/10/24 at 12:53 PM upon surveyor's review of food committee minutes, the following information was documented: 1.) 1/10/24: Various kitchen concerns were documented in addition to the following: Because we have a lack of staff, we cannot call the kitchen or ring the bell, lack of staff has caused us not to have soup or chili, they didn't have time to do desserts or make cakes. On 4/15/24 at 10:48 AM the surveyor conducted an interview with Staff #18, who confirmed with the surveyor that not including kitchen management, 1 Cook and 3 Culinary Aides are needed per shift to carry out the essential functions of the kitchen. When the surveyor inquired as to the facility's assessment for staffing, they reported they were not familiar with the facility assessment. Surveyor review of the 3/1/24 staffing schedule revealed that after 5PM, there were only 3 Culinary Aides. Surveyor review of the 3/3/24 staffing schedule revealed that after PM, there were only 2 Culinary Aides. Surveyor review of the 3/4/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/5/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/7/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/9/24 staffing schedule revealed that after 3pm, there was 1 Cook and 2 Culinary Aides. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor review of the 3/10/24 staffing schedule revealed that after 3pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/11/24 staffing schedule revealed that after 5pm, there was 1 Cook and 1 Culinary Aide. Surveyor review of the 3/14/24 staffing schedule revealed that after 5pm, there were only 2 cooks. Surveyor review of the 3/15/24 staffing schedule revealed that after 3pm, there was 1 Cook and 1 Culinary Aide. Surveyor review of the 3/16/24 staffing schedule revealed that after 3pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/18/24 staffing schedule revealed that on dayshift there was 1 Culinary Director, 1 Cook, and 1 Culinary Aide, and after 5pm, there was 1 Cook, and 2 Culinary Aides. Surveyor review of the 3/21/24 staffing schedule revealed that after 5pm, there were 2 Cooks and 1 Culinary Aide. Surveyor review of the 3/22/24 staffing schedule revealed that on dayshift there was 1 Culinary Director and 1 Cook, and after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/23/24 staffing schedule revealed that after 3pm, there was 2 Cooks and 1 Culinary Aide. Surveyor review of the 3/25/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 3/27/24 staffing schedule revealed that after 5pm, there were 3 Culinary Aides. Surveyor review of the 3/28/24 staffing schedule revealed that after 5pm, there were 2 Cooks and 1 Culinary Aide. Surveyor review of the 3/31/24 staffing schedule revealed that after 3pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 4/2/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. Surveyor review of the 4/3/24 staffing schedule revealed that after 3:30pm, there was 1 Cook and 1 Culinary Director, and 1 Culinary Aide. Surveyor review of the 4/4/24 staffing schedule revealed that after 5pm, there was 1 Cook and 2 Culinary Aides. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/15/24 at 1:05PM the surveyor reviewed the facility assessment which failed to identify any food and nutrition services staff needed. On 4/16/24 at 9:42AM the surveyor conducted an interview with the facility Administrator who confirmed the facility assessment failed to identify food and nutrition services staffing. At this time, the surveyor shared their concerns with the Administrator and Staff #32, Regional Director of Operations who acknowledged understanding of the surveyor's concerns. After surveyor intervention, the Administrator updated the facility assessment on 4/16/24 to include the following food and nutrition services staffing: 1 FSD (Food Service Director,) 8 direct personnel: 1 Cook, and 3 Aides for am and pm shifts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47200 Based on observations of the facility's kitchen, review of kitchen records and interviews of dietary staff, it was determined that the facility failed to: 1.) ensure the monitoring and oversight of food temperatures in accordance with professional standards for food service safety, 2.) ensure sanitary practices were followed in accordance with professional standards for food service safety, 3.) ensure food was stored in accordance with professional standards for food service safety, 4.) ensure the dishwasher reached adequate temperature according to the manufacturer's guideline and 5.) ensure the food supply order was adequate to support the needs of facility residents. These deficient practices have the potential to affect all residents. The findings include: 1.) Upon surveyor's initial tour of the kitchen on 4/1/24 at 8:38AM the food temperature logs were reviewed and observed to be incomplete on multiple dates. On 4/1/24 at 8:38AM the surveyor conducted an interview with Staff #13, Culinary Director, who acknowledged the incomplete logging of temperatures for meal service. At this time, the surveyor requested copies of the food temperature logs. On 4/1/24 at 8:38AM the surveyor observed there were no food temperatures present on the service line checklist food temperature log (kitchen checklist the facility utilizes to ensure appropriate kitchen procedures are followed which requires temperatures be taken of food prior to service) for the lunch meal on 3/22/24. On 4/1/24 at 8:38AM the surveyor observed there were no food temperatures present on the service line checklist food temperature log for the dinner meal on 3/26/24. On 4/1/24 at 8:38AM the surveyor observed there were no food temperatures present on the service line checklist food temperature log for the dinner meal on 3/28/24, and the service line checklist was not completed. On 4/8/24 at 11:57AM the surveyor observed there were no food temperatures present on the service line checklist food temperature log for the lunch meal on 4/8/24. On 4/8/24 at 11:57AM the surveyor observed the tray line and lunch food on the steam table being plated by kitchen staff. On 4/8/24 at 12:24PM the surveyor requested two test trays of food, one with an oven warmed charger, and one with a dinex system warmed charger. On 4/8/24 at 12:43PM the last food tray was served to a resident, and at 12:44PM the surveyor conducted temperature testing of the two trays with Staff #18, Dietary District Manager, which revealed the main entree of chicken pot pie which consisted of a biscuit with a chicken gravy on top, which had a temperature of 128. 1F on the oven warmed charger, and 125.4F on the dinex warmed charger. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/8/24 at 12:51PM the surveyor observed with Staff #18, that the service line checklist food temperature log for the lunch meal had not been completed. On 4/8/24 at 12:52PM the surveyor inquired to Staff #21, Cook, as to why there were no temperatures present on the log. Staff #21 reported to the surveyor and Staff #18 that the food temperatures had not been taken. On 4/8/24 at 12:57PM the surveyor shared kitchen concerns with Staff #18 who acknowledged understanding of the concerns. A copy of the 4/8/24 temperature log was then provided to the surveyor. On 4/9/24 in response to surveyor intervention, the surveyor was informed that education was conducted on 4/8/24 by Staff #19, Registered Dietician, to kitchen staff regarding food temperature maintenance and logs. On 4/10/24 at 12:53PM upon surveyor's review of food committee minutes, the following information was documented: 1.) 1/10/24: food is cold, 2.) 2/13/24: don't have the warming tray plates, food needs to be warm when served, 3.) 3/12/24 (multiple documentation): food is cold, 4.) 4/9/24: food is cold and no plate warmer were given out. 2.) On 4/8/2024 at 1:13PM the surveyor observed a cutting board hanging from a metal holder attached to the side of a metal kitchen rack with the cutting board surface resting against the wheel on the bottom of the kitchen rack, close to the floor. On 4/8/24 at 1:16PM the surveyor observed a handheld beverage device with three lines attached to it, one of which contained a red liquid in the line, another which contained an orange liquid in the line, and another which was an empty line. Each line was observed to have a nozzle at the end which was disconnected and observed to be resting on the kitchen floor. On 4/8/24 at 1:20PM the surveyor conducted an interview with Staff #20, Culinary Aide, who reported to the surveyor that usually the nozzles connect into boxes of juice. At this time, the surveyor shared their concern and Staff #20 acknowledged the concern and sanitized the equipment. On 4/8/24 at 2:07PM the surveyor observed Staff #20 removing wet trays from the dishwashing area and layering them on top of other trays which had napkins and silverware set on them. Wet nesting occurs when wet items such as dishes, trays, and/or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. On 4/8/24 at 2:19PM the surveyor shared concerns including the cutting board with Staff #13, Culinary Director, who observed and confirmed understanding of the concerns and removed the cutting board and placed it in the dishwashing area to be cleaned and reported they would be relocating the holder for the cutting boards. On 4/16/24 at approximately 2:00PM the surveyor shared the concern regarding wet nesting of trays with Staff #18, Dietary District Manager, who acknowledged understanding of the concern. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.) On 4/1/24 at 8:27AM the surveyor observed a container of mayonnaise based salad in the facility kitchen's walk-in refrigerator with two cracked, broken areas on the unsecured lid which allowed for direct observation of the salad contained within which was exposed to air. The label present on the container indicated only the following information: 3/30. On 4/1/24 at 8:29AM the surveyor conducted an interview with Staff #21, Cook, who acknowledged the concern and removed the container from the walk-in refrigerator. 4.) On 4/8/24 at 2:02PM the surveyor observed the facility's dishwasher temperature gauges and noted that the wash gauge indicated a temperature of 148F. At this time, Staff #20, Culinary Aide, observed and confirmed the temperature reading with the surveyor. The surveyor continued to observe the dishwashing process. The surveyor observed Staff #20 turn the dishwasher off in between the loads of dishes. Staff #20 stated the following to the surveyor: It's loud and it uses the soap up. On 4/8/24 at 2:17PM Staff #13, Culinary Director, observed the wash temperature gauge and confirmed the temperature was reaching 146F, with the next load of dishes, it reached 148F. At this time the surveyor conducted an interview with Staff #13 who reported the outside contractor for the dishwasher had been to the facility that morning to address an issue with the chemical/soap dispenser for the dishwasher, and that they would be placing a call for them to return to the facility to address the temperature issue. On 4/8/24 at 2:22PM the surveyor shared the concern with Staff #13 as to the dishwashing temperature not meeting the minimum requirement, and inquired as to whether cutting off the machine in between loads had effect on the dishwasher's ability to maintain adequate temperatures. On 4/9/24 at 2:23PM the surveyor observed the dishwasher's wash temperature gauge reading 166F, which met the required minimum temperature. On 4/9/24 at 2:42PM, Staff #13 reported they had called the contractor and in the meantime, had directed kitchen staff to not turn the dishwasher off between dish loads. On 4/9/24 at 2:46PM the surveyor requested copies of the dish washer temperature logs from Staff #18, Dietary District Manager. Upon review of the temperature logs for 1/2024, 2/2024, 3/2024, and 4/2024, the surveyor shared their concern with Staff # 18 who acknowledged the concern. The surveyor noted that on approximately 48 occasions throughout these logs, the temperature was documented as not meeting the required minimum wash temperature for the machine, and on approximately 27 occasions the temperature was documented as not meeting the required minimum rinse temperature for the machine. The surveyor further noted the dish washing machine was documented as out of service between the dates of 1/1/24 and 1/9/24, and out of service for breakfast and lunch on 1/10/24 and 1/11/24. On 4/10/24 surveyors conducted an observation of the plaque located on the dishwasher which read the following information: This machine is currently in hot water sanitizing mode, hot water sanitizing 160F minimum wash temperature. On 4/10/24 at 12:53PM upon surveyor's review of food committee minutes, the following information was documented dated 1/10/24: dish washer is broke, and silverware is dirty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5.) On 4/1/24 at 12:07PM the surveyor conducted an interview with Resident #2 who relayed the following concern: several days per week they have no milk. At this time, the surveyor observed the resident's tray and ticket indicating they should have milk, however, no milk was observed on their tray. At this time a facility staff member approached the resident, at which time the resident asked the staff if they could have some milk. The staff member replied: we don't have any. On 4/1/24 at 12:16PM the surveyor conducted an interview with Staff #16, Culinary Aide, and conducted an observation of the kitchen's milk supply. The surveyor observed one quarter gallon of milk left in a single, one gallon jug, and nine pre-filled four ounce cups of milk located in the walk-in refrigerator. When the surveyor inquired as to the facility's milk supply, Staff #16 responded that the previous kitchen manager was no longer working for the facility. Regarding the milk supply, Staff #16 stated: that's all we have. Staff #43, Culinary Aide reported staffing was an issue for the facility's kitchen, and the previous kitchen manager would not order anything. The surveyor observed Staff #17, Culinary Director (for a different facility), direct Staff #13, Culinary Director, that more milk needs to be placed in the order to provide for the amount of residents living at the facility. On 4/11/24 at 9:39AM the surveyor conducted an interview with Staff #18, Dietary District Manager, who confirmed that the kitchen order including the milk is delivered on Fridays and Tuesdays. The surveyor noted that the milk supply on Monday, 4/1/24 was only approximately three days after the date the last food order was received.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 47200 Based on record review and interview it was determined that the facility failed to include dietary staffing as part of the facility assessment. This was evident during review of the facility's assessment impacting dietary staffing planning/oversight for the facility. The findings include: On 4/1/24 at 12:16PM observed Staff #15 working in the kitchen wearing a name tag indicating their job title was maintenance. At this time, the surveyor conducted an interview and inquired as to their role within the facility. Staff #15 reported they had performed different positions including in maintenance, social work, other roles with the exception of nursing, and now in the kitchen as of two weeks ago, they were a culinary aide. When the surveyor further inquired as to the staffing levels, they reported the following information: Monday was just me and the cook and that was it. On 4/10/24 at 12:53PM upon surveyor's review of food committee minutes, the following information was documented: 1.) 1/10/24: Various kitchen concerns were documented in addition to the following: Because we have a lack of staff, we cannot call the kitchen or ring the bell, lack of staff has caused us not to have soup or chili, they didn't have time to do desserts or make cakes. During an interview conducted by the surveyor on 4/15/24 at 10:48AM, Staff #18, Dietary District Manager, reported they were not familiar with the facility assessment. On 4/15/24 at 1:05PM the surveyor reviewed the facility assessment currently in place documented as last updated on 11/30/23 for the timeframe of 11/1/23 through 10/31/24 which failed to identify any food and nutrition services staff needed (page 20 of the facility assessment). Additionally, no food service staff was included in the facility's assessment tool which outlines persons involved in completing the assessment (page 3 of the facility assessment). On 4/16/24 at 9:42AM the surveyor conducted an interview with the facility Administrator who confirmed the facility assessment failed to identify food and nutrition services staffing. At this time, the surveyor shared their concerns with the Administrator and Staff #32, Regional Director of Operations, who acknowledged understanding of the surveyor's concerns. After surveyor intervention, the Administrator updated and provided copies of the facility assessment on 4/16/24 to include the following food and nutrition services staffing: 1 FSD (Food Service Director), 8 direct personnel: 1 Cook, and 3 Aides for am and pm shifts.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47200 Based on record review and interviews, it was determined the facility failed to: 1) adequately document certifications of incapacity and ensure accuracy of the Maryland Medical orders for life sustaining treatment (MOLST) form (Resident #15), and 2) ensure pertinent information regarding surrogacy/guardianship disputes were documented in the medical records (Resident #101). This was evident for 2 of 41 residents reviewed during the recertification survey. The findings Include 1. On 4/2/24 at 10:00AM the surveyor reviewed Resident #15's advanced directives document in which they had identified their selection of a primary health care agent. On 4/2/24 at 10:00AM the surveyor reviewed Resident #15's MOLST form dated 2/19/24 which indicated the patient had a guardian. No documentation could be found in the medical record regarding a guardian for the resident. On 4/2/24 at 10:00 AM the surveyor reviewed a Certification of Incapacity form dated 11/11/22 located on Resident #15's paper medical record, and noted Part 1 of the form requiring identifying information was left blank. The following items from Part 1 were left incomplete: 1.) Identification of the patient in which the information was being certified about, 2.) Identification of the certifying practitioner's credentials, and 3.) Documentation certifying the time frame in which the resident was examined within two hours of the certification. At this time, no second Certification of Incapacity could be found on the paper medical record. At this time, the surveyor inquired to Staff #23, Registered Nurse, Acting Unit Manager, Regional Mobile Director of Nursing, regarding documentation of the second Certification of Incapacity. On 4/2/24 at 10:07 AM Staff #23 provided the surveyor with the 2nd Certification of Incapacity form dated 1/28/24. Upon surveyors review of the documentation the following was noted: 1.) Part 1 identification of the certifying practitioners' credentials was left blank, 2.) Certifications under Part 2 of the form, (Section A) were left blank although the certification dated 11/11/22 certified both an end stage condition and terminal condition, and 3.) Section C was incomplete and failed to include a diagnosis or reason for incapacity. From this documentation, no information could be identified as to why the resident was being certified as lacking adequate decision-making capacity. On 4/2/24 at 10:10AM the surveyor shared their concern with Staff #23 who acknowledged understanding of the concern. After surveyor intervention, on 4/2/24 at 10:42AM Staff #23 was interviewed and informed the surveyor that the facility had corrected the MOLST form to reflect the resident's health care agent per their advanced directive and provided a copy of this dated 4/2/24 to the surveyor. On 4/3/24 at 12:41PM the surveyor shared their concerns with the facility Administrator who acknowledged understanding of the concerns. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31982 2) Resident #101's medical record was reviewed on 4/3/24 at 10:12 AM. The record revealed a certificate dated 12/23/23 signed by the resident's attending physician and another dated 12/28/23 signed by the medical director which indicated the resident lacked adequate decision-making capacity due to a brain injury. The residents face sheet indicated the resident's mother was his/her representative and healthcare surrogate. Social History Assessments dated 6/14/23 and 10/3/23 Advance Directives section C. 2. indicated Resident #101's father was his/her health care proxy/agent. C.5. indicated if resident lacks decision making capacity and does not have an advance directive in place who is the decision maker based on state statute? Father. The Assessment also indicated the resident had no power of attorney, conservatorship, or court appointed guardianship. Review of the resident's closed medical record on 4/10/24 at 2:17 PM revealed a paper dated December 21, 2023, that stated Attention: Staff Family is undergoing Guardianship proceedings. Until this becomes official, and we have the papers in (his/her) chart, (he/she) is not to leave the building with anyone, except for medical appointments. **If you have any questions about this, notify the Executive Director (Administrator). Bandage tape was folded over all 4 edges of the paper. No documentation was found in the record related to an interested family member seeking guardianship. In an interview on 4/10/24 at 2:45 PM the Administrator was asked about the notice. She indicated that there was an ongoing dispute between the resident's family and significant other. She was asked if there was any documentation in the resident's medical record regarding this issue. She indicated that the dispute involved protective orders between the parties, and it was not documented in the resident's record because it was all between family members.

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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 48168 Based on record review and interviews it was determined that the facility failed to employ a qualified social worker on a full-time basis. This was evident during the recertification survey and had the potential to affect all residents and resident representatives. The findings include: On 4/02/24 a review of the facility's list of key personnel revealed that there was no social worker listed. On 4/03/24 at 12:45 PM an interview with the Activities Director, Staff #2 stated that she had been providing social work services since November 2023, but she was not a social worker, and that no social worker was currently employed at the facility. On 4/03/24 at 2:05 PM an interview was conducted with the Nursing Home Administrator (NHA) who stated that there was no full-time social worker employed by the facility at this time, and that the previous social worker left at the end of January 2024. On 4/12/24 at 9:48 AM another interview with the NHA was conducted to review that the facility's capacity was greater than 120 beds and that the facility did not employ a qualified full-time Social Worker, and the NHA acknowledged this deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215094	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Healthcare Center	1234 Washington Road Westminster, MD 21157

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44441 Based on record reviews and staff interviews, it was determined that the facility failed to meet at least quarterly to conduct required Quality Assurance and Performance Improvement (QAPI) activities. This was evident during the recertification survey. The findings include: On 4/16/24 at 11:26 AM, the QAPI sign in sheets from November 2023 through March 2024 was provided by the Nursing Home Administrator (NHA). Review of the sign in sheets revealed that the facility did not hold a QAPI meeting in November and December 2023 or in January 2024. The facility provided copies of a sign in sheet for a clinical standard- weekly meetings held from 11/16/23 through 1/26/24, but it was not a QAPI meeting. The NHA in an interview on 4/16/24 at 12:45 PM explained that the Clinical standard weekly meeting serves as a subcommittee for QAPI. She acknowledged that the facility did not hold a QAPI meeting from November 2023 through January 2024 which was why they had an Ad Hoc QAPI meeting on 2/26/24 to address the issue.