STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215108	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doctors Community Rehabilitation and Patient Care	6710 Mallery Drive Lanham, MD 20706

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42783 Based on observation and interviews it was determined that the facility failed to ensure that staff respond to call bells in a timely manner. This was found to be evident for 1 (resident #80) out of 3 residents observed for call bell response time. The findings include: During an interview conducted on 4/18/24 at 8:50 AM, Resident #80 stated that his/her call bell had not worked, and that maintenance had worked on it. This surveyor pressed the red button on the call bell, went to the hallway, and observed the resident's call bell light illuminated. The surveyors continued to observe Resident #80's call bell illuminated on 4/18/24 at 9:00 AM. The surveyors observed Geriatric Nursing Assistant (GNA) #13 & #14 walk down the hallway and go into Resident #51's room who did not have a call bell light illuminated. During an interview conducted on 4/18/24 at 9:12 AM, the surveyors witnessed an audible beep sound that came from the nursing station. The Unit Secretary #12 explained that the sound was the call bell alarm for Resident #80. The Unit Secretary further stated that she had spoken to GNA #13 earlier and advised that Resident #80 required assistance however GNA #13 did not respond to the call bell but instead chose to go to another resident's room. The Surveyors observed Registered Nurse (RN) #2 enter Resident #80's room and the call bell light turned off at 9:14 AM. There was a total of 14 minutes before staff responded to the call bell. During an interview conducted on 4/18/24 at 11:23 AM, the Director of Nursing (DON) stated that the expectation was for the staff to respond to the call bell in a timely manner. She further explained that if the GNA did not respond to the call bell the Unit Secretary should have.

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

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44440 Based on interview, and record review it was determined that the facility failed to have a resident's and/or Resident Representative's acknowledgement of change in coverage including any charges for services not covered under Medicare/Medicaid. This was found evident in 2 (Resident #92 &#14) of 3 residents for beneficiary notice review. The finding include: Center for Medicare and Medicaid Services (CMS) form 10055 is known as the Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage form (SNF-ABN). Center for Medicare and Medicaid Services (CMS) form 10123 is known as the Notice of Medicare Non-Coverage form (NOMNC). It is a written notice that informs a beneficiary when their Medicare-covered service will end. Medicare requires Skilled Nursing Facilities (SNFs) to issue the SNF-ABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: 1. Not medically reasonable and necessary; or 2. Considered custodial. The SNF-ABN form provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF may fill in the date if the beneficiary needs help. This date should reflect the date that the SNF gave the notice to the beneficiary in-person, or when appropriate, the date contact was made with the beneficiary's authorized representative by phone. If an authorized representative signs for the beneficiary, write (rep) or (representative) next to the signature. If the authorized representative's signature is not clearly legible, the authorized representative's name must be printed. If the beneficiary refuses to choose an option and/or refuses to sign the SNFABN when required, the SNF should annotate the original copy of the SNFABN indicating the refusal to sign and may list a witness to the refusal. The SNF should consider not furnishing the care. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1a) On 4/29/24 at 9:10 AM, the surveyor reviewed the SNF-ABN form for Resident # 92. Documented on the form was a note that stated, NOMNC (Notice of Medicare Non-Coverage) was given to Resident. Resident refused to sign. Called Resident's representative (RP) per Resident's request. RP stated she does not have an email for deliveries. The surveyor reviewed the page attached. The instructions on the form stated, use to document telephonic delivery of the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN). On the form was the name of Resident #92's RP with the day she/he was contacted and the date of the last day of coverage for Medicare. Below this information was a section where it stated, I mailed a copy of the SNFABN (Form CMS-10055) and noticed of non-discrimination on {slot for date} to {Slot for name}. The only date or signature was the Business office assistant Staff #52 indicating the SNF-ABN form was not sent to the RP. On 4/29/24 at 12:59 PM, the surveyor interviewed Business Office Manager Staff #53. During the interview the surveyor asked Staff #53 why Resident #92's SNF-ABN was not sent to the RP per request or why an option was not indicated or refusal to sign the SNF-ABN. Staff #53 stated Resident #92 was his/her own Representative. The surveyor followed-up and asked Staff #53 if Staff #52 called and updated Resident #92's RP on the NOMNC why she did not address the SNF-ABN form with a choice or option or refusal of signature for the SNF-ABN. The surveyor further asked why she did not obtain a mailing address to send the SNF-ABN form to the RP per instructions. Staff #53 was not sure. 1b) On 4/29/24 at 9:22 AM, the surveyor reviewed the SNF-ABN form for Resident #14 and noted no signature, declaration, or acknowledgement. Attached with the SNF-ABN form was Resident # 14's NOMNC form. On the NOMNC form a description was written by Staff # 52. The statement stated Staff #52 is verbally informing Resident #14's RP of the non-coverage date and a way to appeal. Attached to the NOMNC form was a copy of an email sent to the PR with the message; Please see attached NOMNC with the last covered day. There was no indication that the SNF-ABN was given in the email to the RP. On 4/29/24 at 12:59 PM, the surveyor interviewed Business Office Manager Staff #53. The surveyor asked #53 without any documentation on Resident #14's SNF-ABN form how the facility could say Resident #14's RP was informed of the change in coverage and responsible obligation. Staff #53 stated an email was sent. The surveyor showed Staff #53 that there was no documentation that the SNF-ABN form was sent, only the NOMNC. Staff #53 stated there was no way to print the email sent because it was just a screen shot of the email. She further stated she was unable to say for sure that Resident #14's RP was informed and acknowledged Resident #14's SNF-ABN form.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 49815 Based on surveyor observation, medical record review and staff interview, it was determined that the facility failed to maintain confidentiality of resident medical records as evidenced by accessibility of a laboratory log. This was found to be evident for 7 (Residents #3, 16, 42, 51, 55, 71 and 77) out 7 Residents reviewed for confidentiality of medical records. The findings include: On the initial tour of the nursing unit 400 conducted on 4/15/24 at 8:38 AM the surveyors observed a black binder that sat on the countertop at the nursing station. The review of the black binder revealed a laboratory log that included Residents #3, #16, #42, #51, #55, #71, and #77 names and laboratory information. The laboratory log included the following documents for April 1, 2024 through April 15, 2024: resident lab test log divided by dates, list of residents who were scheduled for a specific lab by dates, Clinical Laboratory Outpatient Requisition forms that were attached for each resident that had a lab scheduled, and the lab and diagnostic record from Point Click Care (PCC) (a computer software for nursing home medical record documentation) that listed the resident names and laboratory tests that were due for each day. During an interview conducted on 04/15/2024 at 8:40 AM the Registered Nurse (RN) staff #2 confirmed that the black binder was the resident's laboratory log. The RN further stated that the binder should have been stored behind the nursing station away from public access. The surveyors observed RN staff #2 remove the binder from the countertop and place it behind the nursing station.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 44440 Based on record review, and interviews, it was determined the facility failed to notify the Ombudsman of residents that transferred or discharged . This was found evident of 3 (Resident #17, #90 & 73) of 5 residents reviewed for hospitalization during the survey. The finding include: 1a) On 4/15/24 at 11:56 AM, the surveyor interviewed Resident #17. During this interview Resident #17 stated he/she had recently been hospitalized . On 4/19/24 at 7:47 AM, the surveyor reviewed Resident #17's medical record. The review revealed that Resident # 17 was transferred to the hospital on 3/15/24. On 4/19/24 at 11:33 AM, the surveyor requested documentation that the Ombudsman was notified of Resident #17's March hospitalization . The Director of Nursing (DON) stated she would look for the documentation. On 4/19/24 at 2:13 PM, the DON stated she was not able to find any documentation that the Ombudsman was notified, and she believed the communication was not done after speaking with the Social Worker and business office. 1b) On 4/15/24 at 3:26 PM, the surveyor conducted a phone interview with Resident #90's son and daughter. During the interview the family reported Resident #90 had been recently transferred to the hospital. On 4/26/24 07:11 AM, the surveyor reviewed Resident #90's hospital discharge summary dated 3/25/24. Resident #90 was treated for sepsis and readmitted back to the facility. On 4/26/24 at 10:36 AM, the surveyor requested documentation demonstrating that the Ombudsman was notified of Resident #90's transfers in March. On 4/26/24 at 12:08 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated she was unable to provide any documentation the ombudsman was notified of Resident #90's hospital transfer from March. 49815 1c) During an interview on 4/16/24 at 10:39 AM Resident #73 stated to the surveyors that he/she was hospitalized for 5 days. On 4/24/24 at 7:30 AM the surveyor reviewed Resident #73 ' s medical record. The review of the medical record revealed that Resident #73 was transferred to the hospital in October of 2023. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #73's medical record revealed an eINTERACT Transfer Form that was completed by Registered Nurse (RN) #2 for the hospital transfer dated 10/18/23. The eINTERACT Transfer Form stated that Resident #73 ' s Representative/Emergency Contact was notified of the transfer and aware of the clinical situation, but there is no documentation that the facility Ombudsman was notified of Resident #73 ' s transfer to the hospital on 10/18/23. The surveyors interviewed the Director of Nursing (DON) at 12:10 PM on 4/26/24 and the DON stated that the expectation was that the Social Services staff or the Business Office staff was to notify the Ombudsman of the Resident transfers and discharges. In addition, the Director of Nursing also stated that there was not a system in place for this process, and that going forward the responsibility for the notification of Resident transfers and discharges to the Ombudsman would be completed by the Guest Services Director.

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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. 47758 Based on interviews and medical record review, it was determined that the facility failed to have an effective system in place to ensure that residents and resident representatives are notified in writing of the bed hold policy upon transfer to the hospital. This was found to be evident for 5 (Residents #6, #43, #17, #90 & 73) out of 5 residents reviewed for hospitalization during the annual survey. The findings include: A bed hold is when a nursing home holds a bed for you when you go into the hospital. 1a) During record reviews of Resident #6 and Resident #43 on 4/23/24 at 10:05 AM, the surveyor noted there were no notice of bed holds in the electronic or paper medical records from their recent hospitalization s. On 04/23/24 at 11:25 AM, the surveyor requested the bed hold notifications from the Director of Nursing (DON) for Resident #6 and #43. The DON stated, Let me be honest. We almost always don't do that. It is a process we are working on. When asked who was responsible for the process, she stated it is a shared responsibility and the facility is working to improve the process. 44440 1b) On 4/15/24 at 11:56 AM, the surveyor interviewed Resident #17. During this interview Resident #17 stated he/she had recently been hospitalized . On 4/19/24 at 7:47 AM, the surveyor reviewed Resident #17's medical record. The review revealed that Resident # 17 was transferred to the hospital on 3/15/24. On 4/19/24 at 11:33 AM, the surveyor requested documentation that written notice was given to Resident #17 of the bed hold policy when he/she was transferred to the hospital. The Director of Nursing (DON) stated she would look for the documentation. On 4/19/24 at 2:13 PM, the DON stated the nursing staff should be providing the bed hold policy at the time of transfer and that the business office is supposed to follow up with the resident or family member the next day. She further stated, they should be sending the policy in the mail or via email. However, she was not able to find any documentation a bed hold policy was provided to Resident #17. 1b) On 4/15/24 at 3:26 PM, the surveyor conducted a phone interview with Resident #90's son and daughter. During the interview the family reported Resident #90 had been recently transferred to the hospital. On 4/26/24 07:11 AM, the surveyor reviewed Resident #90's hospital discharge summary dated 3/25/24. Resident #90 was treated for sepsis and readmitted back to the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/26/24 at 10:36 AM, the surveyor requested documentation that a written notice was given to Resident #90 or his/her representative regarding the facility's bed hold policy at the time of transfer. On 4/26/24 at 12:08 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON explained that the expectation is for nursing it to give the bed hold policy at the time of transfer and that the business office it to follow-up on the next day. However, the DON stated she was unable to provide any documentation that the bed hold policy was given. 49815 1c) During an interview on 4/16/24 at 10:39 AM Resident #73 stated to the surveyors that he/she was hospitalized for 5 days. On 4/24/24 at 7:30 AM the surveyor reviewed Resident #73's medical record. The review of the medical record revealed that Resident #73 was transferred to the hospital in October of 2023. Further review of Resident #73's medical record revealed an eINTERACT Transfer Form that was completed by Registered Nurse (RN) #2 for the hospital transfer dated 10/18/23. The eINTERACT Transfer Form stated that Resident #73's Representative/Emergency Contact was notified of the transfer and aware of the clinical situation, but there is no written documentation that resident or Resident Representative was notified of the facility bed hold or reserve bed payment when Resident #73 was transferred to hospital. On 4/24/24 the survey team asked the Director of Nursing (DON) about the bed hold policy/ procedure when Residents are transferred to the hospital. The Director of Nursing informed the survey team that this is not being done when residents transfer to the hospital. On 4/26/24 at 12:08 PM the surveyor reviewed the facility's Bed-Holds policy and procedure that was provided by the Director of Nursing. The policy indicated that the facility was to provide written notice to all residents or Resident Representatives at the time of transfer and maintain a copy in the medical record. The Director of Nursing stated that there was no documentation of the bed hold being offered to Resident #73. The Director of Nursing at 12:10 pm on 4/26/24 was interviewed by the surveyors and the DON stated that the expectation was that nursing was to offer the resident or Resident Representative the bed holds notification upon resident transfer to the hospital. The Director of Nursing also stated that there was not a system in place for this process, and that going forward the responsibility for notification of the bed holds would be completed by nursing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on staff interview and medical record review, it was determined that the facility failed to accurately document a resident assessment on the MDS (Minimum Data Set) as evidenced by an inaccurate coding for a resident. This was found to be evident for 1 (Resident #42) out of 1 resident reviewed for accuracy of MDS assessments. The findings include: The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident ' s functional capabilities and helps nursing home staff identify health problems. A pressure ulcer is a bedsore or decubitus ulcer and is classified into a series of stages based on the depth of the wound. The stages include: stage 1 - intact skin with non-blanchable redness of a localized area usually over a bony prominence; stage 2 - partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed; stage 3 - full thickness tissue loss; stage 4 - full thickness tissue loss with exposed bone, tendon or muscle and unstageable - non removable dressing or device, slough and/or eschar, deep tissue injury. On 4/18/24 at 10:00 AM the surveyor conducted a review of Resident #42's medical record. The annual MDS dated [DATE] revealed that the resident had an unstageable pressure ulcer (slough and/or eschar) documented in section M - Skin Conditions, but in section I - Active Diagnoses the unstageable pressure ulcer was not listed as a diagnosis. Further review of the medical record on 4/19/24 at 7:15 AM revealed that the quarterly MDS dated [DATE] indicated that the resident had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) documented in section M - Skin Conditions. However in section I - Active Diagnoses there were 2 pressure ulcers listed- an unstageable pressure ulcer of the sacral region and a stage 4 pressure ulcer of an unspecified part of the back as diagnoses. The surveyor conducted an interview with both MDS Coordinators #21 and #22 on 4/22/24 at 10:10 AM and reviewed Resident #42's annual and quarterly MDSs. The surveyor explained that section M of the annual MDS dated [DATE] indicated that the resident had an unstageable pressure ulcer, but section I of the MDS did not have unstageable pressure ulcer listed as a diagnosis. In addition, the surveyor explained that section M of the quarterly MDS dated [DATE] indicated that the resident had a stage 4 pressure ulcer, but section I of the MDS had 2 pressure ulcers listed - an unstageable pressure ulcer of the sacral region and stage 4 pressure ulcer of an unspecified part of the back as diagnoses. The MDS Coordinator #22 stated that she would review this documentation. At 11:15 AM on 4/22/24 during an interview, the MDS Coordinator #22 confirmed that the documentation on the annual MDS dated [DATE] and quarterly MDS dated [DATE] were inaccurate MDS assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44440 Based on medical record review, and staff interviews, it was determined the facility staff failed to provide the resident and their representative with a summary of the baseline care plan. This was found evident for 1 (Residents #90) of 10 residents reviewed for care planning during the annual survey. The finding include: On 4/15/24 at 3:44 PM, the surveyor conducted a phone interview with Resident #90's son and daughter. During the interview the family expressed having minimal communication regarding changes to their parent's (Resident #90) plan of care. Resident #90's son stated he was the Power of Attorney for Resident #90, however his sisters were also involved. On 4/17/24 at 7:46 AM, the surveyor reviewed Resident #90's medical record. The review revealed Resident #90 had been admitted to the facility in early January of 2024 and had been recently readmitted to the facility after a hospitalization . Further review revealed two certifications related to medical condition decision making by two different providers. Both providers certified that Resident #90 lacked adequate decision-making capacity for health care decisions. One assessment was completed on 3/25/24 and the other on 4/12/24. On 4/26/24 at 10:36 AM, the surveyor reviewed Resident #90's 3/25/24 baseline care plan note. This note was written after Resident #90 was readmitted from a hospital stay. The note documented attendance of the care plan meeting and were as followers, the resident, social services, nurse unit manager, and guest services. In the comment section a question asks; Copy given to resident and/or resident representative. Nothing was documented. There was no indication that the resident or the resident ' s Responsible Party received a copy of the baseline care plan.

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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. 44440 Based on interviews, and record review it was determined that the facility failed to develop and implement a comprehensive care plan to meet the needs of a resident. This was found evident of 2 (Resident #17 & #103) of 10 residents reviewed for care planning during an annual and complaint survey. The finding include: On 4/15/24 at 11:56 AM, the surveyor interviewed Resident #17. During the interview Resident #17 stated he/she had recently been hospitalized due to an infection after having his/her suprapubic tube (a catheter that is surgically placed in the bladder, leaves the abdomen and allows urine to drain from the bladder) was changed. On 4/19/24 at 7:47 AM, the surveyor reviewed Resident #17's medical record. The review revealed that Resident #17 was readmitted to the facility March 20th after a urinary tract infection associated with his/her suprapubic catheter. On 4/19/24 at 11:33 AM, the surveyor reviewed Resident #17's Minimum Data Set (MDS) assessment completed on 3/23/24. The assessment documented the resident had an indwelling catheter (suprapubic catheter) and urinary continence was not rated, with a notation resident has a catheter. The surveyor next reviewed Resident #17's care plans. No care plan was written or interventions for suprapubic catheter care. Further review revealed a care plan stating; Resident is incontinent of urine and is unable to cognitively or physically participate in a retraining program due to . No description followed. On 4/19/24 at 2:39 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated Resident #17 should have had a care plan for his/her suprapubic catheter and an incontinence care plan was not appropriate for a resident who had an indwelling catheter. 1b) On 4/17/24 at 1:51:27 PM, the surveyor reviewed Resident #103's medical record. The review revealed that Resident #103 was admitted to the facility in late March, with a past medical history of, but not limited to, benign prostatic hyperplasia (enlarged prostate) without lower urinary tract symptoms, need for assistance with personal care, and muscle weakness. On 4/18/24 at 9:51 PM, the surveyor reviewed Resident #103's care plan. The review revealed a care plan created on 3/25/24 that stated; Resident is frequently incontinent of urine with potential for improved control or management of urinary elimination. An additional care plan was created on 4/3/24 stating; resident requires an indwelling or foley catheter due to urinary retention. Further review revealed a progress note from Nurse Practitioner Staff #23. In the progress note dated 3/28/24, Staff #23 wrote, urine retention as one for Resident #103's chief complaints. Further in the note Staff #23 documents the plan for the urinary retention and requested a foley (a tube inserted through the urethra into the bladder to drain urine) be placed. Further instructions stated, if the volume is greater than 300 mg to keep the foley in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/24 at 2:39 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated Resident #103 did not have a foley catheter when he/she was first admitted , and once a foley was placed a new care plan was added. The DON confirmed that having both care plans was not appropriate and the incontinence care plan should have been removed.

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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** 49815 Based on observation, interview and medical record review it was determined that the facility failed to: 1) revise residents care plans and 2) to hold care plan meetings with an interdisciplinary team for residents at the time of the Minimum Data Set (MDS) assessment. This was found evident for in 3 (Resident # 42, #75 and #80) and 1 (Resident #322) of 10 residents reviewed for care planning. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. A wound vac is a negative pressure wound therapy device that decreases air pressure on the wound and helps wounds heal more quickly. The Minimum Data Set is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems of residents. Foley catheter is a device inserted into the bladder that drains the urine from the bladder into a collection device. 1a) On 4/18/24 at 9:30 AM the surveyor conducted a medical record review of Resident #42's chart. The medical record review revealed that Resident #42 had a physician order for a wound vac to the sacrum ordered 3/15/24 and there was a physician order to hold wound vac due to active bleeding on 4/15/24. Further review of the medical record on 4/19/24 revealed that there was no revision or update to the care plan that the wound vac was on hold. The wound vac remained on the care plan as an intervention. 1b) On 4/23/24 at 8:30 AM the surveyor conducted a medical record review of Resident #80's chart. The medical record review revealed that Resident #80 had a physician order for Clopidogrel 75 milligrams (mg) daily dated 8/18/23. Clopidogrel is an antiplatelet medication which prevents clots from forming by working to stop your platelets from sticking together. Further review of the medical record revealed that section N - Medications of the quarterly Minimum Data Set (MDS) completed on 3/4/24 indicated that Resident #80 took an antiplatelet medication but not an anticoagulant medication. The resident's plan of care had a focus, goal and interventions for an anticoagulant medication, but there was not a care plan for an antiplatelet medication. The focus of the care plan was: Resident is at risk for injury or complications related to the use of anticoagulation therapy medication - clopidogrel. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In addition, the surveyor reviewed Resident #80's physician orders and the review revealed that Resident #80 had a physician order for clopidogrel and Aspirin, but did not have any order for an anticoagulant medication. 1c) On 4/16/24 at 9:24 AM the surveyor interviewed Resident #75 and did not observe a foley catheter drainage bag. On 4/22/24 at 1:25 PM the surveyor conducted a medical record review of Resident #75's chart. The medical record review revealed that Resident #75 had a current care plan that addressed indwelling foley catheter care dated 11/27/23 with no revisions or updates to the care plan. On 4/23/24 the surveyor interviewed the Director of Nursing (DON) and the DON confirmed that Resident #75 does not have a Foley catheter. On 4/17/24 at 9:24 AM the surveyor conducted a review of Resident #75's medical record. The medical record review revealed that Resident #75 had a resolved pressure ulcer of the right heel as documented on the Skin/Wound evaluation assessment dated [DATE]. Further review of the medical record revealed that there was no documentation of a right heel pressure ulcer addressed on the care plan since 11/16/23 for Resident #75. 44440 2) On 4/16/24 at 9:38 AM, the surveyor conducted an interview with Resident #322. During the interview Resident #322 stated he/she had never had a care plan meeting. On 4/18/24 at 12:51 PM, the surveyor reviewed Resident #322's medical record. A post admission patient family conference note was written on 3/27/24. The note entailed baseline care planning information and anticipated needs for discharge. On further review no note or documentation that a comprehensive care plan was completed following the baseline care plan. On 4/19/24 at 11:28 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated within 7 days after completing the comprehensive assessment it is expected to have a care plan meeting. She stated she would look for documentation of the care plan meeting for Resident #322. On 4/19/24 at 12:25 PM, the surveyor reviewed Resident #322's progress notes. A note was written that same day at 12:08 PM, by Social Service Designee, Staff #51. The note stated Staff #51 met with Resident #322 to schedule a care plan meeting for 4/22/24 at 11AM. On 4/23/24 at 11:59 AM, the surveyor interviewed the Social Services Director, Staff #48. During the interview Staff #48 stated she was unfamiliar if Resident #322. She further stated a care plan meeting is usually set up 7-10 days after admission. She stated she would have to follow up to find out why there was a delay in the care plan meeting for Resident #322. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 12:53 PM, the surveyor interviewed Staff #51. During the interview Staff #51 stated she met with Resident #322 a few days earlier for a care plan meeting. The surveyor asked if the care plan meeting was completed within 7 days after Resident 322's Minimum Data Set assessment. Staff #51 agreed the meeting was delayed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44440 Based on observations, interviews, and review of facility policy, it was determined that the facility failed to utilize professional standards during medication administration. This was found evident in 1 of 26 medications observed being administered on the survey. The findings include: Nursing and other health care professionals utilize the five rights of medication administered to ensure accurate safe medication administration. The right patient, the right drug, the right route, the right time, and the right dose. All five are used as a standard for safe and medication administration practices. On 4/30/24 at 8:14 AM, the surveyor observed Certified Medication Assistant CMA Staff #37 gather medications to administer to Resident #53. The medications were located in a medication cart just outside Resident #37's room. The surveyor observed Staff #37 pull out 6 punch cards from the medication cart. Each of the cards had a label identifying the resident by the name, the name of the drug, how to be given (route) the time the medication was due to be given, and the amount. Staff #37 also pulled out a bottle of a stock medication (senna-plus- a stool softener) from the top drawer. Staff #37 referenced the electronic Medication Administration Record (eMAR) to find the dosing instructions for senna-plus and placed this medication with the others. A second medication cup was pulled from the medication cart and contained a white pill in it. No label or direction was noted on the medication cup. The surveyor asked Staff #37 what the white pill in the medication cup was and how she could be certain of the dosing without any label on the medication cup. Staff #37 stated she was a CMA for a long time and was certain it was Tramadol (a medication prescribed to relieve moderate to moderately severe pain). She further stated that Registered Nurse, Staff #2, had given it to her in the morning with instructions to be given to Resident #53. Without a label, Staff #37 was unable to use the five rights of medication administration to assure accuracy of dosing at the time of administration. On 4/30/24 at 8:25 AM, the surveyor observed Staff #37 administer the medications in both medication cups to Resident #53. On 4/30/24 at 8:33 AM, the surveyor observed Staff #37 rolling the medication cart just outside another resident's room. Staff #37 pulled a medication cup out of the top draw which contained a red pill. The cup was not labeled. The surveyor asked Staff #37 what the medication was. Staff #37 stated it was Lyrica (a medication prescribed to relieve nerve pain or seizures). She stated she received three medications from Staff #2 with instructions to give to three different residents. The surveyor observed a third cup in the top of the medication cart with an unlabeled pill in it. The surveyor asked Staff #37, if the medications were not labeled, how would she be certain the medications would be given accurately and to the correct resident. Staff #37 stated the medication cups were labeled by the nurse yesterday and she was unsure why they were not today. She further stated she knew the order in which the cups were placed and how to distribute them. The surveyor asked Staff #37 to hold off on administering unlabeled medication until the process was clarified by Staff #2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 8:41 AM, the surveyor interviewed Staff #2. During the interview Staff # 2 confirmed she had given the medications to Staff #37 in the morning. She further stated she was unable to label the medications because her marker was not working but had done so in the past. On 4/30/24 at 9:01 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated CMAs cannot give narcotic medications (controlled pain medications), medications through gastric tubes or insulin. The surveyor described the observations made during the medication administration with Staff #37. The DON agreed the unlabeled medications administered by the CMA was a safety concern and the CMA should not have been given those medications to administer. On 4/30/24 at 1 PM, the surveyor reviewed the facility's policy for general dose preparation and medication administration. The policy stated, prior to administration the facility staff should; verify each time a medication is administered that it is the correct medication, at the correct doses, at the correct route, at the correct rate, at the correct time, for the correct resident. Additionally in the policy it stated, staff should not administer a medication if the medication or prescription label is missing or illegible. Review of facility's controlled drug management policy stated that controlled substances will not be accessible to other than licensed nursing staff, pharmacy medial staff (i.e., physicians, advanced practice providers) designated by the center. Cross Reference F755

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observations, review of resident's medical records, and interviews, it was determined that the facility staff failed to provide activities of daily living care in accordance with the Resident's care plan for dependent Residents. This was found to be evident for 5 (Resident #322, #97, #321, #41 and #80) out of 7 reviewed during the survey for activities of daily living. The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. A care plan is a federally mandated tool that is based on a resident's assessment and describes the services that the facility will provide to the resident to attain or maintain the resident's physical, mental, and psychosocial health. The care plan must be developed and revised after each assessment. The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. 1a) On 4/16/24 at 9:28 AM, the surveyor conducted an interview with Resident #322. During the interview Resident #322 stated that he/she had never been offered a shower. On 4/18/24 at 12:42 PM, the surveyor reviewed Resident #322's care plan. A care plan was created on 3/27/24 stating Resident #322 is at risk for decreased ability to perform (ADLs) related to generalized weakness. An additional care plan created on 4/5/24 stating, Resident #322 states it is important to engage in daily routines that are meaningful and are preferred. One of the interventions listed was, it is important for me to choose between a tub bath, shower, bed bath or sponge bath. On 4/24/24 at 10:30 AM, the surveyor interviewed Registered Nurse Staff #45 on the 100 Unit hallway. During the interview Staff #45 explained the process for identifying which residents would be offered a shower for the day. She pulled out a book and the surveyor was shown a shower schedule. Staff #45 stated the showers that were scheduled for that day are also communicated by having those residents room numbers added to the staffing sheet posted at the nurses station. She further stated that after a shower was completed a shower sheet would be filled out by both the Geriatric Nursing Assistant (GNA) and nurse. The sheets are then filed in the shower book. She further stated if a resident refuses, that is documented as well. On 4/24/24 at 10:33 AM, the surveyor reviewed the shower log book. Two shower sheets were in the book for the entire month of April and both were dated 4/20/24. The next shower sheet was dated 3/18/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 10:41 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #46 on the 200 Unit hallway. Staff #46 confirmed the same process for shower schedules and documentation. The surveyor asked the LPN where the shower logbook was located for the 200 hallway. Staff #46 flipped the pages in a binder and asked her Unit Supervisor, Staff #42, where the shower sheets were being stored. No sheets were noted in the book. At this time Staff #42 also looked in the book and stated he was unable to find them but he would look and follow up. On 4/24/24 at 10:49 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reported the observations of the missing shower documentation and the report from Resident #322 that a shower was never given. The surveyor asked for documentation that indicated if a shower was given/offered on the shower days scheduled for Resident #322. On 4/25/24 at 10:00 AM, the surveyor conducted a follow up interview with the DON. During this interview the DON stated she was not able to provide any documentation that a shower was offered or competed for Resident #322 and that only bed baths had been recorded. 1b) On 4/16/24 at 10:46 AM, the surveyor conducted and interview with Resident #97. During the interview Resident #97 stated he/she had never been in the shower since admitted . The resident further stated he/she was only offered a pan of water to bathe with. On 4/24/24 at 10:30 AM, the surveyor interviewed Registered Nurse Staff #45 who was in the 100 Unit hallway. During the interview Staff #45 explained the process for identifying which residents would be offered a shower for the day. She pulled out a book and the surveyor was shown a shower schedule. Staff #45 stated the showers that were scheduled for the day are also communicated by having those residents room numbers added to the staffing sheet posted at the nurses station. She further stated that after a shower was completed a shower sheet would be filled out by both the Geriatric Nursing Assistant (GNA) and nurse. The sheets are then filed in the shower book. She further stated if a rsident refuses, that is documented as well. On 4/24/24 at 10:33 AM, the surveyor reviewed the shower log book. Two shower sheets were in the book for the entire month of April and both were dated 4/20/24. The next shower sheet was dated 3/18/24. On 4/24/24 at 10:41 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #46 on the 200 Unit hallway. Staff #46 confirmed the same process for shower schedules and documentation. The surveyor asked the LPN where the shower logbook was located for the 200 hallway. Staff #46 flipped the pages in a binder and asked her Unit Supervisor, Staff #42, where the shower sheets were being stored. No sheets were noted in the book. At this time Staff #42 also looked in the book and stated he was unable to find them but he would look and follow up. On 4/24/24 at 10:49 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reported the observations of the missing shower documentation and the reports from the resident that a shower was never given. The surveyor asked for documentation of when a shower was given/offered on the shower days scheduled for Resident #97. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 1:38 PM, the surveyor reviewed Resident # 97's care plan. On 3/14/24 a care plan was created for Resident #97 which stated, Resident #97 requires assistance and is dependent for ADL care in bathing, rooming, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to limited mobility. On 4/25/24 at 10:00 AM, the surveyor conducted a follow up interview with the DON. During this interview the DON stated she was not able to provide any documentation that a shower was offered or competed for Resident #97 and that only bed baths had been recorded. 1c) On 4/15/24 at 2:24 PM, the surveyor observed Resident #321 resting in bed with a film noted on his/her teeth. On 4/24/24 at 10:30 AM, the surveyor interviewed Registered Nurse Staff #45 who was in the 100 Unit hallway. During the interview Staff #45 explained the process for identifying which residents would be offered a shower for the day. She pulled out a book and the surveyor was shown a shower schedule. Staff #45 stated the showers that were scheduled for the day are also communicated by having those Residents room numbers added to the staffing sheet posted at the nurses station. She further stated that after a shower was completed a shower sheet would be filled out by both the Geriatric Nursing Assistant (GNA) and nurse. The sheets are then filed in the shower book. She further stated if a resident refuses, that is documented as well. On 4/24/24 at 10:33 AM, the surveyor reviewed the shower log book. Two shower sheets were in the book for the entire month of April and both were dated 4/20/24. The next shower sheet was dated 3/18/24. On 4/24/24 at 10:41 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #46 on the 200 Uunit hallway. Staff #46 confirmed the same process for shower schedules and documentation. The surveyor asked the LPN where the shower logbook was located for the 200 hallway. Staff #46 flipped the pages in a binder and asked her Unit Supervisor, Staff #42 where the shower sheets were being stored. No sheets were noted in the book. At this time Staff #42 also looked in the book and stated he was unable to find them but he would look and follow up. On 4/24/24 at 10:49 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reported the observations of the missing shower documentation and the reports from the resident that a shower was never given. The surveyor asked for documentation of when a shower was given/offered on the shower days scheduled for Resident #321 On 4/24/24 at 11:55 AM, the surveyor reviewed Resident #321's care plan. A care plan was initiated on 3/29/24 and stated, Resident # 321 requires assistance and is dependent for ADL care in relation to recent illness, fall, hospitalization resulting in fatigue, activity intolerance, confusion and limited mobility. On 4/25/24 at 10:00 AM, the surveyor conducted a follow up interview with the DON. During this interview the DON stated she was not able to provide any documentation that a shower was offered or competed for Resident #321 that only bed baths had been recorded. 45733 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1d) During an initial screening, on 4/17/24 at 09:10 AM, Resident #41 was observed wearing a food-stained gown, the face was greasy, food was left on the lips and the eyes were crusty. The bed linen had a few stains on the cover sheet. Furthermore, the resident stated that he/she did not have someone to help with the morning grooming. Record review, on 4/18/24 at 01:02 PM, revealed that Resident #41 was admitted to the facility on [DATE] with diagnoses of a left side stroke and depression. He/she was able to answer questions appropriately and made his/her needs known. Further record review of the quarterly Minimum Data Set assessment section GG of the functional ability and goals, dated 3/1/24, revealed that this resident needed the level of maximum to dependent assistance care in all Activities of Daily Living (ADLs). Observation and interview, on 4/29/24 at 10:16 AM, found that Resident #41's face again was not cleaned. He/she had breakfast leftover on his/her left cheek and crusty eyes were present. The resident stated that no morning grooming assistance had been provided and he/she did not know what day the shower was scheduled. During interview, at Resident #41's bedside, on 4/29/24 at 10:40 AM, the Unit Manager Staff #9 agreed that this resident had not yet been provided with a morning grooming assistant, which was a failure by the nursing aide. Advised Staff #9 that this was a concern. Additionally, Staff #9 was asked for the resident's shower schedule and agreed to provide it for a review. However, Staff #9 never provided Resident #41's shower schedule. During the exit meeting, on 4/30/24 at 1:20 PM, the Director of Nursing and the Administrator were made aware of the concern that no proper grooming assistant was provided to Resident #41 to maintain this resident's good grooming and hygiene. 49815 1e) During an interview conducted on 4/16/24 at 10:52 AM the surveyors observed a black substance underneath Resident #80's fingernails. At 11:15 AM on 4/24/24 the surveyor visited Resident #80 and observed a few fingernails on both Resident's hands with a black substance underneath them. The resident stated to the surveyor that my nails were cut 3 weeks ago or so. The surveyor visited Resident #80 on 4/25/24 at 10:45 AM and again observed the black substance underneath the resident's fingernails. At 11:25 AM on 4/25/24 the surveyor interviewed the Director of Nursing (DON) about the expectation for fingernail care. The Director of Nursing stated that nail care should be performed during showers, bed baths and whenever needed for the rsident, and if the resident refuses, then there should be documentation about the refusal. The surveyor shared with the DON that Resident #80 was observed with a black substance underneath her fingernails for multiple days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed Resident #80's medical record on 4/25/24 and it was documented in the care plan that the resident is dependent for ADL care, and there was not a care plan that indicated that the resident refused ADL care or fingernail care. Further review of the medical record revealed that on the Geriatric Nursing Assistant (GNA) Task Flow sheet for Activities of Daily Living (ADL), the resident required extensive assistance and was dependent on staff for personal hygiene and bathing.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 47758 Based on observation, interview, and record review, it was determined the facility failed to follow professional standards of practice during the administration of intermittent intravenous (IV) antibiotic infusions. This was found to be evident in 2 (#43, and #376) out of 2 residents observed during the recertification survey. The findings include: Intravenous (IV) antibiotics are medications active against bacterial infections delivered into a vein by injection or through a catheter. On 04/22/24 at 07:56 AM, the surveyor observed that Resident #43's IV tubing was not labeled with the date and the end of the tubing was inserted to an upper tubing port. The Director of Nursing (DON) was at the nurses' station, so the surveyor showed her the IV tubing that was not labeled and had the end inserted to the upper port. When asked what the facility procedure was, she stated that the IV tubing end should be capped when not in use and the IV tubing should be labeled and dated. The DON stated she would talk to the nurse responsible right now and left the room. During an interview on 04/22/24 at 09:48 AM, the DON and Infection Preventionist (IP) confirmed with the surveyor that it was a concern that the tubing was not labeled and attached to the tubing cap. They stated staff were being retrained in the process of labeling and dating tubing and placing a new cap on the end when the transfusion is complete. During an interview with Resident #376 on 04/25/24 at 10:08 AM, the surveyor observed that the IV tubing was not currently infusing. It was noted to have no label with a date and the end was connected to an upper port on the tubing. During an interview on 04/25/24 at 10:15 AM, RN #30 stated she was caring for Resident #376. When asked about the process for labeling and capping the IV tubing, RN #30 stated, we are supposed to label tubing with the date when we hang it. When we disconnect an infusion, we cap the end of the tube. The surveyor requested RN #30 inspect the hanging tubing for a label, date, and cap to verify. RN #30 confirmed that the tubing was not labeled or capped. She further stated that she would throw it away, I always throw them away when they are not labeled and hang new tubing. On 04/25/24 at 10:32 AM, the surveyor observed that Resident #43's IV tubing was labeled with the date and capped according to policy. The surveyor informed the DON on 04/25/24 at 10:46 AM, that a second IV tubing had been found that was not labeled, dated, and was connected to the upper port instead of being capped. She stated that she would investigate the concern right away. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/26/2024 at 1:00 PM the surveyor reviewed the facility policy titled, Administration of an Intermittent Infusion. In the Guidance section, the policy stated that administration sets used for more than one dose in a 24-hour period will be changed every 24 hours, and to label medication/solution container and administration set with: Date, time, Nurse's initials and to place a new sterile end cap on the end of the administration set when infusion is completed.

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 47758 Based on record review and interviews, it was determined that the facility failed to clarify a medication discrepancy on the hospital discharge summary, monitor appropriate dosing of a medication by ordering the correct laboratory testing, and take action on abnormal laboratory results required for accurate medication dosing. This was found to be evident for 1 (#43) out of 6 residents reviewed for Vancomycin administration. This deficient practice resulted in harm to the resident. The findings include: Bacteremia is the presence of bacteria in the blood. Vancomycin is an antibiotic used to treat serious bacterial infections. Proper administration requires blood levels be monitored for accurate dosing. According to the National Institute of Health (NIH), the Vancomycin serum trough levels (the low point) are recommended for monitoring and concentrations are recommended in the range of 15 to 20 micrograms in one milliliter (mcg/mL). The reference level for Vancomycin peak levels (the high point) is 20 to 40 mcg/mL. There is no reference level for random (a level not timed with dosing) Vancomycin levels. A record review on 04/18/24 at 07:29 AM, revealed that Resident #43 had been transferred to the hospital with a diagnosis of Vancomycin Toxicity on 4/6/24. Review of the Medication Administration Record found orders for Vancomycin one gram intravenously one time a day for bacteremia for 22 days ordered and discontinued on 3/23/24. Additionally, on 3/23/24 a second order was found for Vancomycin one gram intravenously two times a day for bacteremia. Review of Resident #43's Hospital Discharge Medications section dated 3/22/24 listed both Vancomycin one gram every day and Vancomycin one gram twice a day, however in the plan of care it was stated that it should be given once a day. The Hospital Course/Discharge Diagnosis stated that the Infectious Disease (ID) recommendations were for Vancomycin one gram to be given every day. No notes were found in the medical records regarding an order clarification, therefore the surveyor requested documentation from the Director of Nursing (DON) of how the physicians determined that the dosage would be Vancomycin one gram twice a day. The DON spoke with Registered Nurse (RN) #40, regarding why Vancomycin twice a day was ordered. RN #40 stated to the DON that when she came in, she did not have the Vancomycin to administer. She called the Pharmacy and they stated they did not have the order. She then checked the discharge summary but stated she did not see two orders for Vancomycin. During an interview with Nurse Practitioner #23 on 04/22/24 at 01:10 PM, the surveyor asked how the Vancomycin order was determined to be once or twice a day. She stated, I don't know why the Vancomycin was changed from once a day to twice a day. Usually, the provider reviews the orders unless she isn't here, then it is reviewed by the after hours providers. We document that in the progress notes. I discovered after the fact that the resident was discharged back to the hospital for Vancomycin toxicity. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with RN #40 on 04/23/24 at 09:08 AM. The surveyor asked about clarifying the Vancomycin orders when Resident #43 was admitted . RN #40 stated when she could not find the Vancomycin to administer, she called the pharmacy who informed her that they did not have the Vancomycin order. RN #40 then reviewed the after visit summary and only saw the order for Vancomycin one gram twice a day, looked for a provider signature on the medication summary but did not find one, and she clarified with the on call providers. RN #40 further stated she was unable to remember who she spoke with or the conversation. Review of the closed record and laboratory values on 4/18/24 at 8:48 AM, revealed that Resident #43 had multiple Vancomycin levels drawn during his/her Admission. On 3/29/24, a random Vancomycin level was obtained with a result of 50 mcg/mL. The result was signed by Nurse Practitioner (NP) #36, no action was taken. On 4/2/24, a random Vancomycin level of 82 mcg/mL was obtained, signed off by NP #23 and no action was taken. On 4/5/24 a random Vancomycin level was obtained that was greater than 100 mcg/mL. This was reviewed by the Medical Director and two Vancomycin doses were held. On 4/6/24, the Vancomycin level was greater than 100 mcg/mL. This was reviewed by the Medical Director and Resident #43 was transported to the hospital. A review of the 4/19/22 Hospital Transfer Summary on 4/22/24 at 07:13 AM revealed that Resident #43 was admitted to the hospital with a Vancomyicin level greater than 200 mcg/mL on 4/6/24. During the hospital course Resident #43 was diagnosed with Acute Renal Failure with Tubular Necrosis - resolved as of 4/19/24. During an interview conducted on 04/19/24 at 1:00 PM, the Medical Director was asked how the providers assess residents who were administered Vancomycin for renal failure. The Medical Director responded that lab orders are normally ordered every week to check the Vancomycin levels. Based on the Vancomycin levels the pharmacy monitors redosing of Vancomycin and the facility monitors for side effects when we visit residents and monitor laboratory values. She further stated Resident #43 did not have any side effects and his/her vital signs were normal. We did not suspect any problems. When residents are admitted , we do baseline laboratory testing as soon as possible. Laboratory results are monitored every day. Orders are normally written when a resident is admitted and the on call physician reviews the orders. They must have realized there were two orders written and changed it from one to the other. The on call provider would have done that. She further stated that the DON is looking for documentation about how the dosing was determined. The surveyor reviewed all the laboratory results with the Medical Director. The surveyor pointed out that although the laboratory value was random, the timing of the collection was 10 hours after the last dose. When asked if that could be considered a trough level and interpreted as one, the medical director stated, That is a good point. On 04/22/2024 at 11:26 AM, during an interview with Nurse Practitioner (NP) #23, the surveyor asked what the expectation was when she reviewed and signed off on laboratory results. NP #23 stated that the unit secretary prints the laboratory results and flags them in the patient charts for the providers to review and sign off. When asked what she used as a reference for abnormal levels when the labs stated there was no normal value for a random Vancomycin level, NP #23 replied she would review it based on her knowledge, but generally laboratory results have reference values unless there is a comment that explains it. When we order Vancomycin levels, we always order a trough, but the nurses don't always put a Vancomycin trough level on the requisition request. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	During the continued interview the surveyor and NP #23 reviewed the NP's note that revealed she signed off on Resident #42's Vancomycin level of 82 on 04/02/24. The note did not indicate an order had been placed to address the high Vancomycin level. The NP stated I signed off on the Vancomycin Level of 82 dated 04/02/24, I don't remember seeing it. That was an error, I should have stopped the Vancomycin and had a trough level drawn the next day. During an interview with the Medical Director on 04/22/24 at 12:01 PM, the surveyor asked what her expectations are when the Nurse Practitioners review laboratory results and find abnormal values. She stated they are expected to address any concerns. Normally they make their own decisions, but I am available if they need to consult with me. When asked why the laboratory orders placed were Vancomycin levels instead of Trough levels, she stated that when we write the Vancomycin level order, we always mean Vancomycin trough level when we order it. Trough levels should always be drawn before the next dose is given. When asked how the pharmacy gets the laboratory results so they can monitor the results she stated that the facility faxed the laboratory results to the pharmacy daily. The way the Vancomycin levels came up as random is not the normal way we order Vancomycin levels. My providers were caught off guard when they reviewed the results because there were no reference levels with the laboratory results. Resident #43 was asymptomatic, so no red flags were raised by their clinical presentation. On 04/22/24 at 12:36 PM, the DON stated she was not able to confirm the Vancomycin level results were faxed to the pharmacy. When asked about ordering random Vancomycin levels vs the Vancomycin trough levels, she stated the physicians needed to order the Vancomycin trough level precisely. We are supposed to write exactly what is in the order on the laboratory sheet. The surveyor interviewed the DON on 04/23/24 at 11:41 AM and asked about the process for ordering laboratory testing. She replied when the laboratory tests are ordered they go on the order sheet. When the laboratory results come back in, the unit secretary places the results on the chart and flags it for the provider to review. If the laboratory result doesn't come in, the unit secretary is responsible to notify the nurse that it was not done. On 04/23/24 at 01:14 PM, the survey team advised the DON, Administrator and Regional Clinical Lead, that the deficient level of practice had been identified as causing actual harm to Resident #43.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44440 Based on observation and interviews it was determined that the facility failed to administer medication according to procedures that assure accurate dispensing of medications. This was found evident of 1 of 26 medications observed being administered on the survey. Then finding include: On 4/30/24 at 8:14 AM, the surveyor observed Certified Medication Assistant CMA Staff #37 gather medications to administer to Resident #53 from a medication cart just outside Resident #37's room. The surveyor observed Staff #37 pull out 6 punch cards from the medication cart. Each of the cards had a label identifying the resident and the prescription label with administration instructions. Staff #37 also pulled out a bottle of a stock medication from the top drawer and a medication cup with a white pill in it. Staff #37 placed 1 pill from each punch card into a second mediation cup and added one pill from the stock medication bottle. 7 pills were noted in the 2nd medication cup and the one white unlabeled pill in the first medication cup. The surveyor asked Staff #37 what the white pill in the medication cup was and asked how she could be certain without any label how and who to administer the medication to. Staff #37 said that she was a CMA for a long time and was certain it was Tramadol (a medication prescribed to relieve moderate to moderately severe pain). She further stated that Registered Nurse Staff #2 had given it to her in the morning with instructions to given to Resident #53. On 4/30/24 at 8:25 AM, the surveyor observed Staff #37 administer the medications in both medication cups to Resident # 53. On 4/30/24 at 8:33 AM, the surveyor observed Staff #37 rolling the medication cart just outside another resident's room. Staff #37 pulled a medication cup out of the top draw which contained a red pill. The cup was not labeled. The surveyor asked Staff #37 what the medication was. Staff #37 stated it was Lyrica (a medication prescribed to relieve nerve pain or seizures). She stated she receive three medications from Staff #2 to be given to three different residents. The surveyor observed a third cup in the top of the medication cart with an unlabeled pill in it. The surveyor asked Staff #37, if the medications were not labeled, how would she be certain the medications would be given accurately and to the correct resident. Staff #37 stated the medication cups were labeled by the nurse yesterday and she was unsure why they were not today. She further stated she knew the order in which the cups were placed and how to distribute them. The surveyor asked Staff #37 to hold off on administering unlabeled medication until the process was clarified by Staff #2. On 4/30/24 at 8:41 AM, the surveyor interviewed Staff #2. During the interview Staff # 2 stated she needed to attend to a resident and she knew another resident needed pain medications. When asked why the medications were should have a label, Staff #2 stated her marker was not working. The surveyor asked Staff #2, if she was responsible for taking and signing out the medications, would she also be responsible for administering them. Staff #2 responded by saying she was accountable for the controlled substances. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 9:01 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated CMAs can not give narcotic medications (controlled pain medication), medications through gastric tubes or insulin. The surveyor described the observations made during the medication administration with Staff #37. The DON confirmed that the nurse should have been the one to administer the medication and not the CMA. The DON agreed unlabeled medications and controlled medications administered by the CMA were safety concerns. On 4/30/24 at 9:12 AM, the surveyor confirmed with Staff #37 the third pill was Oxycontin (a narcotic pain medication used to treat severe pain). She also confirmed that the unlabeled medications were given back to the nurse to administer. On 4/30/24 at 9:30 AM, the surveyor reviewed the orders for Resident #53. The review revealed an order for Tramadol 50 mg by mouth two times a day for pain with instructions to hold for sedation. On 4/30/24 at 1 PM, the surveyor reviewed the facility's policy for general dose preparation and medication administration. The policy states, prior to administration the facility staff should; verify each time a medication is administered that it is the correct medication, at the correct doses, at the correct route, at the correct rate, at the correct time, for the correct resident. Additionally in the policy it stated, staff should not administer a medication if the medication or prescription label is missing or illegible. Review of facility's controlled drug management policy states that controlled substances will not be accessible to other than licensed nursing staff, pharmacy medial staff (i.e., physicians, advanced practice providers) designated by the center. On 4/30/24 at 1:36 PM, the surveyor reviewed an assessment note completed by Unit Manager Staff #9. The note stated, Resident #53 was assessed and at her baseline. It further stated that Resident #53 had no concerns with her morning medications. Cross Reference F658

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, interviews, and review of facility policy, it was determined that the facility failed to have a process in place that ensured a Resident 's medication irregularity reports were reviewed by the primary care physician and that the recommendations were addressed timely. This was found evident of 3 (#103, #90 & #42) of 5 Residents reviewed for medication regimen review. Then findings include: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the Interdisciplinary Team (IDT), including the resident, their family, and/or resident representative. 1a) On 4/18/24 at 7:42 AM, the surveyor reviewed the Medication Regimen Review (MRR) for Resident #103. During the review it was noted that Resident #103 had reviews done on 3/18/24 and 4/1/24. The review completed on 4/1/24 had a comment, recommendation noted, see report. On 4/22/24 at 8:57 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated the MRRs are completed by a pharmacist when a Resident is admitted and monthly. She further stated that if an irregularity was identified a report would be emailed to the unit manager and DON. The reports are printed and if there is a nursing intervention that needs to be addressed the nurse would take care of it otherwise the report is placed in the Residents record for the physician to review. The surveyor asked the DON for the report that was generated for Resident #103 on 4/1/24 by the pharmacist. On 4/22/24 at 1:29 PM, the surveyor conducted a follow-up interview with the DON. In this interview the DON provided the MRR report and stated that the report was not reviewed by the provider. The DON stated the reports did not contain the required physician's acknowledgement of irregularity or the action taken to address the irregularity. On 4/22/24 at 1:33 PM, the surveyor reviewed Resident #103 ' s MRR report from 4/1/24. The report stated that Hydroxyzine (a medication prescribed to treat histamines/allergic reactions) was prescribed on an as needed basis but did not have a stop day or a diagnosis or specific condition being treated and/or rationale for extended time limit. It further stated; Centers for Medicare and Medicaid require that as needed medication orders for non-psychotropic drugs be limited to 14 days unless the prescriber documents the diagnose specific condition being treated, the rationale for the extended time period, and the duration of the as needed order. On 4/22/24 at 1:45 PM, the surveyor reviewed the April 2024 Medication Administration Record (MAR) for Resident #103. The review revealed that the order for Resident #103 ' s Hydroxyzine was not changed and continued until the resident was discharged on [DATE] over 14 days from recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24 at 1:56 PM, the surveyor reviewed the policy Titled; Medication Regimen Review. The policy states: The pharmacist will address copies of residents ' MRRs to the Director of Nursing and the attending physician and the Medical Director. Facility staff should ensure that the attending physician, Medical Director, and the Director of Nursing are provided copies of the MRR. For those issues that require Physician/prescriber intervention, the facility should encourage Physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. It further states the attending physician should document in the resident's health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident ' s health record. No rationale was found in Resident #103 ' s medical record. 1b) On 4/29/24 at 11:44 AM, the surveyor reviewed the Medication Regimen Reports (MRR) for Resident #90. Irregularities were identified by the pharmacist and a report was created on 1/3/24, 2/1/24, and 4/1/24. Further review of the 1/3/24 report identified one time sensitive recommendations and for a response by the end of the next day. The review identified that the order for Methotrexate (a medication also known as an immunosuppressant which slows down a body's immune system and helps reduce swelling (inflammation)) was written as give 2.5 mg weekly different than what the hospital transfers summary stated. The transfer summary documented that Resident #90's dose was 25 mg weekly. It also asked for clarification for the indication of the medication. The current order for Methotrexate was written with an indication for CA. (CA is known in the medical field as an abbreviation for cancer) On the hospital transfer summary the indication was RA (Rheumatoid Arthritis). The report further stated 25 mg exceeds the recommended dosing for RA and asked the provider to consider decreasing the dose to 20 mg weekly. The report was initiated and dated 1/5/24 by a facility provider, with a note written, already corrected. On 4/29/24 at 12:40 PM, the surveyor reviewed Resident #90 ' s progress notes. The review reveals that a physician Staff #42 assessed Resident #90 on 1/4/24. In the progress note Staff #42 writes he ordered Methotrexate 2.5 mg 1 time daily for rheumatoid arthritis. This dose was written as daily not what weekly which was the actual order in Resident #90 medical record. No where in the progress note does the provider state the rationale for not following the recommendations or that the recommendations were seen. The surveyor further reviewed the progress notes written by multiple providers. On 1/6/24, 1/9/24, 1/15/24, 1/23/24, and 1/29/24 Resident #90 was evaluated by a medical provider. In all the progress notes the medication list was documented as Methotrexate is written as give (2.5 mg) 1 tablet by mouth, one time a day, every Fri (Friday) for CA. On 4/29/24 at 12:43 PM, the surveyor reviewed the order for Methotrexate. On 1/31/24 Nurse Practitioner (NP) Staff #36 writes an order for Methotrexate Sodium table 5 mg with the instructions, give 4 tablets by mouth one time a day every 7 days for RA. This was the exact recommendation that was recommended 27 days earlier on the 1/3/24 MRR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated the provider signed off on the recommendation on 1/5/24 because Staff #42 had seen the Resident the following day and wrote he reviewed the Methotrexate medication and indicated it was for RA. The surveyor asked where the documentation was for the rationale for not following the pharmacy recommendations. The DON confirmed that the rationale was not in the providers note. The surveyor asked why the pharmacy recommendation was followed until 27 days later even after multiple provider evaluated Resident #90. The DON stated that there was no documentation in the medical record to give the rationale for the delay in action. 49815 1c) On 4/22/24 at 9:00 am the surveyor conducted a medical record review of the monthly pharmacist medication regimen review assessments from October 2023 through March of 2024 for Resident #42. The medical record review revealed that on March 20, 2024, the consultant pharmacist made a recommendation to clarify the Tylenol Extra Strength tablets to include the dose in milligram (mg) for the Resident. During an interview conducted on 4/23/24 at 7:50 AM the Director of Nursing (DON) stated that the facility failed to notify the physician of the pharmacist recommendation and had now notified the physician after this surveyor ' s inquiry. The Director of Nursing presented the surveyor a copy of Resident #42 ' s pharmacist consultant recommendation report for March 20, 2024 that showed a Licensed Practical Nurse ' s (LPN) #28 signature with a telephone order to the facility ' s Medical Director with a date of 04/22/2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication by failing to ensure that psychotropic medication had an adequate indication for use. This was evident for 1 (#103) of 5 residents reviewed for unnecessary medications. The findings include: Psychotropic medications are medications that affect the brain and nervous system's chemical makeup. They are prescribed to treat a variety of conditions including mental illnesses. The Center for Medicare and Medicaid requires that any psychotropic medication prescribed to residents in long term care facilities must be prescribed, as necessary, to treat a documented, specific condition. On 4/16/24 at 12:51 PM, the surveyor reviewed Resident #103's medical record. The reviewed revealed that Resident #103 had a past medical history that included, but not limited to, cerebral infarction (stroke), abnormal gait, unspecified dementia , unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. On 4/18/24 at 7:42 AM, the surveyor reviewed the Medication Regimen Review (MRR) for Resident #103. During the review it was noted that Resident #103 had MRR reviews done on 3/18/24 and 4/1/24. The Review completed on 4/1/24 had a comment; recommendation noted, see report. On 4/22/24 at 1:29 PM, the surveyor conducted an interview with the Director of Nursing (DON). In this interview the DON provided the MRR report and stated that the report was not reviewed by the provider. The DON stated the reports did not contain the required physician's acknowledgement of irregularity or the action taken to address the irregularity. 4/22/24 at 1:33 PM, the surveyor reviewed Resident #103's MRR report from 4/1/24. The report recommended that Mirtazapine (a medication prescribed to treat depression) was prescribed for insomnia (difficulty falling asleep). Mirtazapine is classified as a psychotropic medication. The recommendation asked for the provider to reevaluate the use or provide clinical rationale for the use of the medication in the medical record. The report had a comment stating, insomnia was not an approved indication for the use of Mirtazapine. On 4/22/24 at 1:45 PM, the surveyor reviewed the April 2024 Medication Administration Record (MAR) for Resident #103. The review revealed that the order for Resident #103's Mirtazapine was not changed nor was the rationale for administration. The Mirtazapine was given until the resident was discharged on [DATE].

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations and staff interviews it was determined that the facility failed to maintain a safe and effective system for securing medication and treatments in designated carts on the nursing units. This was found to be evident for 2 out of 10 medication carts and 1 out of 4 treatment carts observed during random tours of the facility. The findings include: 1a) During a random observation on the 300-nursing unit conducted 4/17/24 at 08:45 AM, the surveyors observed an unattended and unlocked treatment cart. The Administrator approached the surveyor that had stood next to the unattended and unlocked treatment cart and locked the cart. The assigned Licensed Practical Nurse (LPN) #47 was observed at the other end of the hallway on the 300-nursing unit. The LPN came to the treatment cart at the surveyor's request. The LPN unlocked the cart and both the surveyor and LPN opened each drawer and found 1 pair of scissors, ointments, creams labeled with resident names, dressing and bandages. On 4/17/24 11:15 AM During an interview, the Administrator notified this surveyor that the nurse was given an education, and an in-service was being conducted. 1b) During a random observation on the 400-nursing unit conducted on 4/19/24 06:45 AM, this surveyor observed a medication cart assigned to rooms 400 - 413 unattended and unlocked. The surveyor was able to open each drawer and observe medications labeled with the resident names and room numbers, the narcotic book with narcotic sheets that were labeled with the resident name, resident room number and name of medication. Further observation of the medication cart revealed 1 unopened Tresiba Flex touch insulin pen that was dated 4/18/24 for Resident #3. The insulin pen was stored in a plastic bag with a pharmacy label that read refrigerate until open. During the observation this surveyor observed Licensed Practical Nurse (LPN) #11 come out of resident room [ROOM NUMBER] and return to the medication cart. The Surveyor asked the unit secretary who was assigned to the cart, the LPN yelled from the other hallway it's mine. During an interview conducted on 4/19/24 at 6:46 AM, LPN #11 confirmed he was assigned to the unattended unlocked medication cart. The surveyor notified the LPN of the unopened insulin pen that was dated and not refrigerated. The LPN acknowledged the medication cart should be always locked when unattended. 44440 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c) On 4/30/24 at 7:12 PM, the surveyor observed a medication cart that was unattended and unlocked located on 200 Unit. The medication cart was approximately 15 feet down the hallway from another mediation cart located just across from the nurses station. Two staff were observed counting medications on the cart across from the nurses station. No staff was by the unlocked medication cart. The surveyor observed both staff walk away after they were finished counting at the medication cart across from the nurses station. On 4/30/24 at 7:19 AM, the surveyor was able to open the top draw of the unlocked mediation cart located just down the 200 Unit hallway. The top drawer had multiple bottles of medications. The second drawer had punch cards with multiple doses of residents medications. The surveyor asked a nurse coming out of the nurses' station who was responsible for the unlocked medication cart. Registered Nurse Staff #38 stated she was. At that time, the Unit Manager Staff #42, came over to the medication cart. He called Staff #38 to the cart. Staff #38 stated that she was aware that the expectation for the medication cart is to be locked when unattended. She further stated she had recently received training on medication storage but must have forgotten to lock it before walking away. On 4/30/24 at 9:06 AM, the surveyor conducted an interview with the Director of Nursing (DON). The surveyor relayed the observation of the unlocked medication cart with the DON. She agreed the unlocked medication cart was a concern.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. 44440 Based on interviews, and record review, it was determined that the facility failed to have laboratory results in the resident's medical record. This was found evident of 1 of 6 (Resident #324) residents reviewed for vancomycin dosing. The findings include: On 4/23/24 at 9:42 AM, the surveyor reviewed the medical record for Resident #324. The review revealed that Resident #324 had an order placed on 3/29/24 by Medical Director Staff #3. The order was for a laboratory (lab) blood draw to obtain; a complete blood count, comprehensive metabolic panel, hemoglobin A1c, varicella titer, c-reactive protein, vancomycin trough on Monday, one time only for a baseline until 4/1/24. An additional lab order was written on 4/3/24 for a complete blood count, basic metabolic panel, erythrocyte sedimentation rate, c-reactive protein, vancomycin level every Wednesday. On 4/23/24 at 9:53 AM, the surveyor reviewed the policy titled, Diagnostic Tests. In step 2 it calls for the diagnostic service to be notified. Step 3 states, obtain report of diagnostic test. The last step states, maintain signed and dated diagnostic reports and other diagnostic studies in the patient's medical record. On 4/23/24 at 10:41 AM the surveyor requested the lab results from the 4/1/24 and 4/3/24's laboratory draws for Resident #324. On 4/23/24 at 11:39 AM, the surveyor conducted an interview with the Director of Nursing (DON). The DON stated she was able to print the result from the 4/3/24 lab draw and noted it was not in the Resident's medical record. She further stated she was unable to find lab results from the 4/1/24 lab draw and it appeared the labs were not completed. During the interview the DON explained the process for obtaining a lab blood draw for the lab services the facility utilizes. She stated that when a lab is ordered it is placed into the computer system which allows for a lab report to be printed each day with the labs scheduled to be drawn that day. The staff are expected to transcribe the order onto lab sheets. The lab services use these sheets to obtain ordered labs. For the results process the DON explained that the unit secretary prints the results Monday- Friday and the nurses are to do it on the weekend. The printed results should go into the Resident's paper medical record. She further stated the nurses are responsible to verify that the labs were completed. The surveyor requested the lab report that was printed for 4/1/24 that would have generated the lab sheet. On 4/23/24 at approximately 12:15 PM, the surveyor was provided the lab report record. Resident #324's name and labs that were ordered to be drawn were on the form as well as other resident names that had labs ordered to be drawn that day. The DON confirmed that other residents had labs drawn that day, however no labs resulted for Resident #324 and therefore not in the medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on interview and record review it was determined that the facility staff failed to promptly provide or obtain visit/appointments for routine dental care or treatment. This was found to be evident for 2 (Resident # 74 and #88) out of 2 residents reviewed for dental services during an annual survey. The findings include: 1) During an initial screening, on 04/16/24 at 12:24 PM, Resident #74 stated, I did not remember if I ever had a dentist visit here. Record review, on 4/17/24 at 01:47 PM, of Resident #74's record revealed that he/she was admitted on [DATE] to this facility with the diagnoses of cardiac arrhythmia, dementia, and anemia. Resident #74 was on Medicaid since 2/11/2023 and he/she was able to answer questions appropriately and made his/her needs known. During interview, on 4/24/24 at 09:38 AM, Unit Manager, Staff #9, stated that this resident did not have any dental visit since he/she was admitted to this facility on 6/09/22. She stated that she had just completed a dental referral and the scheduling of a visit date was pending. During interview, on 4/25/24 at 10:46 AM, the Director of Nursing (DoN) and the Administrator stated that the facility had partnered with Health Direct (a network provider for on-site services) for Medicaid residents in the following areas to provide on-site care: ear, eye, dental, and podiatry services. However, these services were not fully utilized by the residents. During the follow-up interview, on 4/25/24 at 3:20 PM, the Administrator stated that a long-term care resident like Resident #74 was eligible to receive care through Health Direct since 2/11/23 but staff had failed to sign him/her up. The Administrator was made aware that the facility staff failed to promptly provide or obtain appointments for routine dental care and treatment. 2) During an initial screening, on 4/16/24 at 2:38 PM, Resident #88's family reported, We were wondering about why the resident never had a dental visit here and it was overdue. They stated that they had asked the staff to schedule a dental visit for the resident. Record review, on 4/17/24 at 01:47 PM, of Resident #88's record revealed that the resident was admitted to the facility, on 9/09/23, with the diagnoses of heel decubiti, Parkinson's, dementia and chronic heart failure. Further review found that no dental on-site visits were recorded for this resident. It was noted that Resident #88 was on Medicaid since 11/11/23. During interview, on 4/18/24 at 1:56 PM, DoN stated that normally Medicaid residents were on a list to receive dental visits by Direct Health. The DoN was asked to provide the list. Record review, on 4/19/24 at 09:29 AM, of Resident #88's physician order summary revealed that Doctor Staff #3 ordered Podiatry, Dental, Audiology, and Ophthalmology, on 9/9/2023, for consulting and treatment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview, on 4/19/24 at 03:26 PM, the Unit Manager, Staff #9, stated that she had reviewed the record and that she noted that this resident was transferred from the skilled nursing side and was not activated for the Health Direct program. During follow-up interview, on 4/22/24 at 09:00 AM Staff #9 reported that she made the dental referral last Friday 4/19/24 but that she was not sure when the dental visit would be scheduled. She did not know how to improve the referral process. During interview, on 4/25/24 at 10:46 AM, the DoN and the Administrator stated that the facility had partnered with Health Direct to cover ear, eye, dental and podiatry services and that the residents had to be signed-up to the program. Due to Resident #88's being eligible since 11/11/23, the Administrator was advised that the facility staff failed to promptly provide or obtain appointments for routine dental care or treatment. During interview, on 4/26/24 at 10:25 AM, the resident's family stated he/she has not been approached by any facility staff for arranging the Health Direct benefits sign-up.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation, interview and record review it was determined that the facility failed to maintain proper sanitation for storage of food in the kitchen and on the nursing units. This was evident in the kitchen, on 2 out of 4 nursing units, and on 1 random observation of a beverage cart found during an annual survey. The findings include: 1a) During the initial tour of the kitchen on [DATE] at 8:15 AM the surveyors observed the following: dish machine log missing evening temperature on [DATE], walk-in freezer stocked too full of food items and disorganized with food items on floor, gnats flying around the freezer and around bread cart, freezer fan on ceiling with ice and sediment, ice on food in freezer, open loaf of bread dated ,d+[DATE], kitchen floor with crumbs and dried stains, aluminum pan on the floor underneath the food preparation table, pair of shoes on kitchen floor, trash piled up at the entrance to kitchen door, and wet-nesting on serving pans on the drying rack in the dishwashing area. Wet-nesting occurs when wet dishes or pots and pans are stacked, preventing them from drying and creating conditions that are ripe for microorganisms to grow. Food Drug Administration (FDA) guidelines mandate that all wares should be air dried. Using towels to dry dishes is never permitted. At 8:38 AM on [DATE] on the initial tour of the 400 nursing unit the surveyors observed the residents nourishment refrigerator log incomplete with only 3 dates for the month of April recorded and the refrigerator was dirty with spilled red substance and unlabeled food items that had missing dates and resident names. The surveyors interviewed the Director of Nursing (DON) at 9:00 AM on [DATE] regarding the nourishment refrigerator on the 400 nursing unit. The surveyors conveyed to the DON that the residents nourishment refrigerator had missing temperatures, spilled liquid and unlabeled food items. The DON stated that the expectation is for the temperature to be taken daily, the refrigerator to be kept clean, and the food items to be labeled. At 9:45 AM on [DATE] the surveyors and the Nursing Home Administrator conducted a brief tour of the kitchen. The following was observed: gnats flying around as the kitchen was entered, food items on the freezer floor, ice on the ceiling freezer and on the food items, freezer too full and food items on the floor, broken hand sink and crumbs and dried stains on the kitchen floor. In addition, the surveyor shared with the Nursing Home Administrator (NHA) of the observations that were identified on the initial tour of the kitchen at 8:15 SAM on [DATE]. On [DATE] at 8:12 AM the surveyors observed in the kitchen with the Assistant Food Services Director (AFSD) #6 at the walk-in freezer. Packages of meat on the floor and ice/frost on the ceiling of the freezer and on the food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nursing Home Administrator on [DATE] provided the surveyor an inventory of food items from the walk-in freezer that were discarded on [DATE] due to the accumulation of ice/frost on those food items. The food items included: 3 roast beef, 4 packs of chicken, 3 hams, 1 corn beef, 2 turkeys, 2 boxes of pizza dough, 2 boxes of cookies, and 1 pumpkin pie. In addition, the NHA provided the surveyor a copy of an in-service sign in sheet that listed the Topic: Freezer, the Presenter: AFSD #6, and the Date: [DATE]. On [DATE] at 12:30 AM the surveyors received from the Nursing Home Administrator an invoice dated [DATE] and a work order dated [DATE] from Aireco Supply, Inc.1 which is the company that the facility uses for repair of the kitchen walk-in freezer. At 8:47 AM on [DATE] the surveyors toured the kitchen with the Food Services Director (FSD) #5 and with the AFSD (#6) for the later part of the tour. The following was observed during the tour: ice/frost on the ceiling of the freezer and on the food items, freezer thermometer covered in ice, italian sausage links and chicken patties covered in ice and packaging not properly closed, one italian sausage link lying on shelf not in covered package, cinnamon rolls in cardboard box full of ice, ice cream in cardboard boxes sitting on kitchen floor from delivery, thermometer on floor of walk in refrigerator, temperature log for refrigerator and freezer not checked for this date of [DATE], kitchen staff checked temperatures of freezer and refrigerator from the outside thermometer instead of the internal thermometer of the freezer and refrigerator, unlabeled and expired food items in the dry storage area (biscuit mix [DATE], noodles no date and opened, [NAME] noodles [DATE], lasagna noodles [DATE], torn bag of tricolor pasta noodles with several noodles lying in cardboard box, egg noodles no date, opened, cheerios and rice Krispies no date on plastic container, package of [NAME] ' s salad dressing expired [DATE], cake mix expired date [DATE], craisins in a plastic bag in cardboard box opened not sealed no date; 2 containers of salad dressing in the reach in refrigerator without a date, wet-nesting on food preparation pans that were stacked together on the drying shelf, and dark substance on the wall behind the sink near the dishwasher. On [DATE] at 10:05 AM the kitchen observations on [DATE] were reviewed with the Director of Nursing. 1b) Between 10:30 AM and 10:45 AM on [DATE] the surveyor and the Director of Nursing conducted observations of the nourishment refrigerators on all 4 nursing units. The following was observed: 400-nursing unit at 9:00 AM nourishment refrigerator missing temperature recordings for ,d+[DATE] - , d+[DATE], soda bottle, 3 water bottles, 2 health shake cartons, and jar of applesauce not labeled or dated. 300-nursing unit at 9:07 AM 3 containers of Resident food with a date of [DATE]; 200 unit at 9:15 am nourishment refrigerator missing temperature recordings for ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] - , d+[DATE], ,d+[DATE] - ,d+[DATE], and ,d+[DATE], items not labeled and dated - yogurt, 2 ice cream cups, 3 bottles of water, bottle of milk, and large bottle of creamer. 100-nursing unit at 9:21 am items not labeled and dated - large bottle of creamer, pudding cup, ,d+[DATE] Hershey chocolate bar, 2 health shake cartons with label pulled off. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11: 00 AM the surveyor reviewed the Policy Titled: FNS 413 - Food Brought in for Patients/Residents from the Food and Nutrition Policies and Procedures effective date [DATE] and review date [DATE]. The facility policy indicated that food items in the nourishment refrigerators were to be labeled with Resident name and date and that the items are good for 3 days. This was confirmed with the Director of Nursing. During observation of the meal delivery on nursing unit 400 on [DATE] at 8:30 AM with the Food Services Director the surveyors observed wet-nesting on the plate lids that were used to cover the plates of the Residents ' food during services delivery from the meal cart to the Resident rooms. 45733 1c) Observation in the hallway, on [DATE] at 09:01 AM, the kitchen staff pushed a beverage kart from room to room to give each resident their choice of beverage. Observation, on [DATE] at 09:20 AM, found that the same beverage kart was left outside of room [ROOM NUMBER] in the hallway. The surveyor examined 4 out of 6 beverage containers with the used end date of [DATE] (orange juice, prune juice, nectar & honey consistency). At this time, the kitchen staff had already finished serving breakfast to all the residents about 10 minutes and went back to the kitchen. In addition to the expired 4 beverages, the kart was left unattended in the hallway so that anyone could have access to the beverage and the kart did not have a proper temperature control method to keep them below 41 degrees Fahrenheit. During interview, on [DATE] at 9:30 AM, the Unit Manager Staff #9 viewed the 4 expired beverage containers and agreed that the 4 beverages were expired and should not have been served to the residents and the kart should not be left in the hallway. During interview, on [DATE] at 09:29 AM, the Kitchen Serving Staff #26 stated that he was not working on [DATE], but per kitchen serve beverage procedure that residents should not have received expired-beverages and the beverage's kart should not left in the hallway unattended. During interview, on [DATE] at 10:15 AM, the Director of Nursing (DoN) reviewed the above findings and agreed that if the Kitchen staff had followed the correct procedure, then the expired beverages would not have been served to the residents. The DoN also agreed that the kart should not have been stored in the hallway, which was unsafe and the temperature could not be controlled.

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	215108	A. Building B. Wing	04/30/2024

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Doctors Community Rehabilitation and Patient Care	6710 Mallery Drive Lanham, MD 20706

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 3 of 54 (Resident #322, #4 and #103) residents reviewed during the survey. The findings include: MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. 1a) On 4/16/24 at 12:18 PM, the surveyor reviewed Resident # 322's paper medical chart. The review revealed a D.C. Medical Order for Scope of Treatment (MOLST). The order indicated the resident wished to have [NAME]-Pulmonary Resuscitation if he/she were to have no pulse or was not breathing. The resident's verbal signature was noted on 3/26/24. On 4/19/24 at 12:27 PM, the surveyor reviewed Resident #322's electronic medical record. The review revealed a progress note written by Nurse Practitioner Staff #36 on 4/2/24 stating, advanced care planning was discussed and the resident wants to be a full code with all life-sustaining measures as applicable. She further wrote a new MOLST form was completed and placed in the residents medical record. On 4/19/24 at 1:21 PM, the surveyor interviewed the Medical Director Staff #3. During the interview the Medical Director stated that the facility accepts MOLST from the District of Columbia however some providers replace it with a Maryland MOLST. She further stated that it is most important to update the MOLST if the resident wants to make changes. On 4/23/2024 at 11:59 AM, the surveyor conducted an interview with Social Service Director Staff #48. During the interview Staff #48 stated she files and keeps the voided MOLSTs in her office and the up-to-date MOLST is kept in the resident's medical record. The surveyor requested to a copy of the updated MOLST documented in Staff #36 ' s progress note. At the time of exit the Maryland MOLST was not provided or information given as if the Maryland MOLST was completed per providers note. 1b) On 4/16/24 at 12:51 PM, the surveyor reviewed Resident #103s, medical record. The review revealed that Resident #103 was admitted to the facility in mid March of 2024. Further review revealed two physician completed a certification related to medical condition decision making and treatment limitations for Resident #103. Medical Director Staff #3 certified that Resident #103 lacked adequate decision making capacity including life-sustaining treatments on 3/18/24 and Physician #49 made the same certification on 4/14/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 9:51 AM, the surveyor reviewed the social service assessment completed by Social Services Assistant #50. The assessment was completed on 3/23/24. The surveyor noted yes was checked in the legal status section to the question; Patient/resident responsible for self. This was checked 5 days after Staff #3 certified that Resident #103 lacked adequate decision making capacity. On 4/18/24 at 11 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that Resident #103's spouse was making the medical decisions for Resident #103. The surveyor asked why the social service assessment stated Resident #103 was his/her own decision maker. The DON stated it must have been an error. On 4/23/24 at 12:07 PM, the surveyor interviewed Social Service Director Staff #48. During the interview Staff #48 confirmed that her coworker mistakenly checked that Resident #103 was his/her own decision maker. 1c) On 4/17/24 at 7:51 AM, the surveyor reviewed Resident #4's paper medical record. The review revealed a MOLST dated 4/4/24 for Resident #4 indicating the life-sustaining orders were per based off Resident #4's surrogate decision maker. On 4/18/24 at 9:51 AM, the surveyor reviewed the social services assessment completed on 3/12/24 by Social service assistant Staff #50. In the legal section, yes was checked by the question; Patient/resident responsible for self. On 4/19/24 at 1:06 PM, the surveyor interviewed Medical Director Staff #3. During the interview Staff #3 stated Resident #4 was assessed prior to the MOLST discussion on 4/4/24 and it was determined that Resident #4 lacked adequate decision making capacity including life-sustaining treatments. Staff #3 was not sure why the social service assessment stated Resident #3 would be responsible for himself/herself. On 4/23/24 at 12:21 PM, the surveyor interviewed Social Service Director, Staff #48. During the interview Staff #48 stated that Resident #4 was unable to make his/her medical decisions from the time he/she was admitted . She confirmed that the social service assessment was marked in error and stated she would provide the certification for lack of capacity. On the day of the exit, Staff #48 provided two completed physician certifications related to the medical condition decision making and treatment limitations for Resident #4. The Medical Director, Staff #3, certified that Resident #4 lacked adequate decision making capacity including life-sustaining treatments on 3/12/24 and Physician #49 made the same certification on 3/15/24. Confirming the documentation that Resident # 4 was his/her own decision maker was an error.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47758 Based on record review, and interview it was determined that the facility failed to document the rational for non-administration of the pneumococcal vaccination. This was found evident for 1 (Resident #86) out of 5 residents reviewed for vaccinations during an annual survey. The findings include: Pneumococcal vaccines are vaccines against the bacterium Streptococcus pneumoniae. Pneumococcal vaccine can prevent some cases of pneumonia, meningitis, and sepsis against the bacterium Streptococcus pneumoniae. Prevnar 30 is a pneumococcal vaccine. Point Click Care (PCC) is a cloud-based healthcare software provider helping Long-Term Care. ImmuNet is Maryland's immunization information system (IIS). An IIS is a confidential and secure computer database designed to collect and maintain vaccination records of children and adults. When the surveyor requested copies of the vaccination pneumococcal consent/declination for Resident #86 on 4/24/24 at 08:34 AM, the Director of Nursing (DON) stated that they were not up to date with documentation of the vaccines getting placed in PCC especially on the 200 Hall, because they didn't currently have a unit secretary. When asked what the process was, the DON stated that the unit secretary inputs the vaccine information in PCC after the vaccines are given. The floor nurses are responsible for assessing vaccines on admission and administering when available from pharmacy. During an interview on 4/24/24 at 01:20 PM, the surveyor verified with the DON and the Infection Preventionist (IP), that Resident #86 was not administered a pneumococcal vaccine and no vaccine declination was signed. The IP stated the forms were still on his/her chart and not filled out. She further stated the process is that consents are obtained on admission and if they consent it is administered when available. The facility checked on ImmuNet and s/he was not signed up. When asked what they were going to do about it, the reply was, We are going to follow up with his/her representative and see if s/he would like the vaccination and we will administer it if s/he does. On 4/25/24 at 10:40 AM, the DON stated that the facility reached out to the representative and obtained the consent for the Prevnar 30 vaccine. The vaccine has been ordered from the pharmacy and will be administered to Resident #86 when it is available. We are working to educate staff on this process.

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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. 37296 Based on observation and staff interview it was determined the facility failed to keep the kitchen walk-in freezer in safe operating condition. This was evident during the initial tour of the kitchen and during subsequent visits. The findings include: 1. On 7/18/24 at 8:39 AM, an initial tour of the facility's kitchen was performed with the Dietary Manager. When the door was opened to the walk-in freezer it was like walking into a cloud and the visibility of items in the freezer was very difficult to see. 2. There were small mounds of ice covering the entire ceiling of the freezer. There was a built-up ice clump and ice cycles of the 2 circular fans of the main unit. Ice was observed to be on boxes of food, shelving and on the food packages. 3. The Strip curtains were missing from the freezer and refrigerator. At 11:45 AM a revisit of the freezer revealed the following: 1. The fans were not running. 2. The ice on the fans was melting and water was noted on the floor. 3. The ice built up on the ceiling has now melted. 4. The boxes were wet along with the food on the shelves. 5. The light attached to the ceiling had visible water inside of fixture. On 7/18/24 at 12 PM an interview with the Director of maintenance stated that the freezer was now in defrost mode. The Director of maintenance did not know how long or how often the defrost mode occurred. He stated that he ordered the strip curtains, and they are on back order, the seals were replaced and a new closing device was attached to the outside door. It also was discovered that the Director of maintenance was not certified to work on the commercial freezer.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation, interview and record review it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of rodents and insects. This was found to be evident during observations for pest control in the kitchen and nursing unit. The findings include: On the initial tour of the facility's kitchen on 4/15/24 at 8:15 AM with the Assistant Food Service Director (#6), the surveyors observed gnats flying around by the bread cart. At 9:45 AM on 4/15/24 the surveyors and the Nursing Home Administrator (NHA) observed gnats in the entrance of the kitchen. On 4/17/24 at 8:19 AM during a random tour of the Nursing Unit 300, the surveyors observed gnats and 2 mouse traps in room [ROOM NUMBER]. At 8:47 AM on 4/24/24 the surveyors conducted a follow-up tour of the kitchen with the Food Service Director (FSD) #5. On this tour of the kitchen the surveyors observed a large amount of mouse droppings on the floor in the dry storage room behind and in between 2 storage carts full of canned food items. In addition, the surveyors and the Food Service Director (FSD) #5 observed an opening/gap at the bottom of the exit doors in the service area of the facility. The surveyors reviewed the Pest Control reports on 4/29/24 at 10:10 AM that were from January 2024 through April 2024. The findings on these reports included: 1/31/24 - placed RTU (mouse bait station) in 312 due to mice activity, no mice captured throughout hallway areas yet, but there is activity in TV room, RTU under table, inspected no signs yet; 3/13/24 - treated kitchen for roaches, captured one mouse at back door of kitchen area due to opening under door; 3/22/24 - need a door sweep on the exit door, told maintenance man; 4/8/24 - put down new fly traps due to activity in mop area, caught a mouse in storage area and also one by back exit. In an interview with the Director of Nursing (DON) on 4/29/24 at 12:45 PM the DON stated that the new part for the bottom of the exit door in the back of the facility had been ordered since the surveyor's observation.