STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215109	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossville Rehabilitation and Healthcare Center	6600 Ridge Road Baltimore, MD 21237

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48259 Based on record review and interviews, it was determined that the facility staff 1) failed to notify a provider of a blood sugar level outside an order's acceptable range for a resident, and 2) failed to notify the physician immediately following an accident that had the potential for requiring physician intervention. This was evident for 1 (#65) of 5 residents reviewed for unnecessary medications, and 1 (#245) of 5 residents reviewed for accidents. The findings include: 1) On 1/16/24 at 12:56 PM, during a review of an attending provider's note, dated 7/25/23, for Resident #65, it showed that Resident #65 had diagnoses including type 2 diabetes. Continued record review revealed a physician's order summary report as of August 2023 for Resident #65. The order summary report recorded an order initiated on 8/5/23 for Humalog (insulin injection). The order stated the following: Humalog Injection Solution 100 UNIT/ML (Insulin Lispro), inject as per sliding scale: 0 - 69 = 0 if Blood sugar (BS) is less than 70 (Blood sugar is obtained by testing a drop of blood), notify the attending provider; 70 - 200 = 0; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401+ = 8 units if BS is greater than 400, give insulin and notify provider. Further record review was completed on 1/16/24 at 1.30 PM for Resident #65. The review revealed a medication administration record (MAR) for August 2023 that showed on 8/6/23, Resident #65's blood sugar reading at 6:30 AM was 450, and 8 units of insulin were administered. However, the review failed to show that Resident #65's attending provider was notified of the high blood sugar reading. On 1/22/24 at 1:36 PM, during an interview, Resident #65's attending provider, Staff #51, said s/he expected a nurse notification regarding any change in Resident #65's condition. On 1/22/24 at 2:05 PM, during an interview, Staff #50, Licensed Practical Nurse (LPN), stated s/he would notify an attending provider for a high blood sugar reading outside of the parameters ordered On 1/24/24 at 8:29 AM, an interview was conducted with the Director of Nursing. During the interview, s/he stated that hIs/her expectation of the nurses was to notify an attending provider and resident's representative of a high blood sugar reading. However, the interview failed to show that Resident #65's provider and representative were notified of the high blood sugar reading on 8/6/23. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48470 2) Resident #245 was admitted to the facility late in 2023 and had left sided weakness following a stroke. On 2/01/2024 at 12:20 PM, a review of the resident's medical record revealed a care plan regarding risk for falls that was initiated within 48 hours upon admission. On 2/1/2024 at 1:57 PM, a review of Resident #245's progress note, with a reference date of 1/23/24, indicated that the resident had complained of pain in the left hip, was assessed by the physician, and had an X-ray ordered related to the pain. The next progress note, with a reference date of 1/24/24, revealed a late entry note documented by the Registered nurse (RN staff #47) and indicated that the resident had an unwitnessed fall on 1/22/24 at approximately 10:30 PM. Further review of the progress notes with a reference date of 1/25/24, revealed that the resident's left hip X-ray showed a fracture. The results were reported to the Nurse Practitioner who ordered for the resident to be sent to the hospital for further evaluation. Resident #245 had not returned to the facility. Further review of Resident #245's electronic medical record (EMR) on 2/01/2024 at 2:53 PM indicated that Staff #47 had initiated all his/her assessments regarding the unwitnessed fall on 1/24/24. The assessments included: Change in Condition evaluation, Fall Risk evaluation, and Vitals and Pain only evaluation. On 2/02/24 at 9:45 AM, Registered Nurse, RN, Staff #19 was interviewed and reported the facility's process regarding unwitnessed falls. Staff #19 reported that initially, the nurse would start with documenting an incident report and followed by the evaluations. Staff #19 was asked specifically about the timing of these documentations and evaluations, and she reported that it should be done within the same shift of the incident. Staff #19 was asked to print out a copy of the incident report on Resident #245 for the fall that occurred on 1/22/24 along with the evaluations completed by Staff #47. Later at 10:41 AM, a review of the printed-out incident report was conducted with Staff #19 and revealed the last section as Agencies / People Notified and indicated that the physician (Staff #51) was notified on 1/24/24 at 5:59 PM. Staff #19 further reported that s/he did not know why Staff #47 initiated the incident report, evaluations, and provider notification 2 days after the incident. On 2/02/24 at 11:37 AM, the concern was discussed with the Director of Nursing (DON) that Staff #47 failed to notify the physician immediately after an incident that had the potential of requiring physician intervention. The physician had already seen Resident #245 and had ordered an X-ray related to complaints of pain before the physician was notified of an unwitnessed fall that happened 2 days prior. CROSS REFERENCE F684

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40927 Based on interviews and record review it was determined that the facility failed to provide residents with an environment that was free from abuse. Due to this deficient practice Resident #505 suffered physical and psychosocial harm. This was evident for 1 (MD00204162) of 2 facility reported incidents of abuse. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. A medical record review for Resident #505 on 4/25/24 at 9:39 AM revealed an admission Minimum Data Set (MDS) with an assessment reference date of 3/7/24 in section C revealed the resident scored a 12 out 15 on the brief interview of mental status indicating moderate cognitive impairment. However, on a note from psychiatric services dated 4/1/24, the provider documented that the resident had intact cognitive function. An interview with the Unit Manager #12 confirmed that the resident was cognitively intact and was able to verbalize his/her needs and concerns. On 4/25/24 at 9:05 AM a review of the facility's investigation file revealed a final self-report form that was submitted to the State Agency. According to the document Resident #505 reported that on 3/28/24, the night shift GNA (geriatric nursing assistant who was later identified as GNA #9) came into the resident's room, did not say anything to the resident, and yanked the covers off the resident. GNA #9 pointed for the resident to roll, and the GNA grabbed the resident's arm and pushed him/her over to the side and when it came time to roll the opposite way the GNA grabbed the other arm and pushed the resident. The report documented that the facility verified that abuse had occurred. A statement written by GNA #10 on 3/29/24 documented that she was giving Resident #505 a shower on 3/29/24 at 2:15 PM and noticed bruising on the resident's left forearm and left bicep. She further documented that when she asked the resident how s/he got the bruises, the resident reported that the GNA on night shift (later identified as GNA #9) was very rough with him/her while changing them and grabbed their arms while turning them. Also, she noted that the resident reported that GNA #9 would not acknowledge or speak to them during care. GNA #10 reported that Resident #505's roommate corroborated the GNA's roughness while changing them and she noted the name of the roommate. Further review of the file revealed a statement from the roommate. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The statement handwritten on 3/29/24 by GNA #9, the staff member accused of abusing Resident #505, revealed she had reported that when she came on shift it was reported to her that the resident had bruising. However, this could not be corroborated as all other staff who cared for this resident had reported the bruises were new. She also reported that she had changed Resident #505 and Resident #543, but had not assisted them to roll from side-to-side as they were able to do so on their own. A review of the resident interviews in the investigation file revealed that multiple residents had reported concerns about the night shift GNA #9. The following interview statements were obtained by Unit Manager #5 on 3/29/24: Resident #520's interview statement revealed the resident turned on their call light several times and GNA #9 would turn off the call light and leave before tending to their needs. The resident reported another GNA had to come in and care for their needs. The facility failed to further investigate to determine the GNA who assisted Resident #520 and obtain a statement from them. Resident #543's interview statement revealed that s/he had been roommates with Resident #505 at the time of the incident. Resident #543 reported that GNA #9 had been ignorant-rude and did not speak. The resident had asked for soap, water, and a washcloth to wash off before leaving for an appointment and GNA #9 only provided the washcloth. Resident #542's interview statement revealed that when s/he put on the call light for assistance GNA #9 came in the room and complained about the resident messing up his/her bed. When Resident #542 asked for a change of clothes (that they brought from home) GNA #10 said no and handed the resident a hospital gown. The resident reported that while being changed, GNA #9 was rough. Resident #541's interview statement revealed that on 3/28/24 at 11:15 PM, the resident had turned on the call light to be changed. A staff member turned the light off and reported that someone would be in to tend to the resident's needs. However, an hour later no one had come in. The resident turned on the call light on again and GNA #9 came in and turned off the call light, looked at the resident, but said nothing and walked back out. The resident reported s/he continued turning on the call light every hour and GNA #9 continued to come in and turn the light off without providing care. The resident reported that at 4 am another GNA came in the room and provided the care. The facility failed to determine who the GNA was and obtain a statement. Review of the incident report completed by Unit Manager #12 revealed that Resident #505 had redness to the left forearm measuring 3 cm (centimeters) x 3 cm, bruising to the left elbow measuring 5 cm x 5 cm, bruising to the right outer forearm measuring approximately 3 cm x 3 cm, left upper arm bruising measuring 1 cm x 4 cm. The report indicated the resident was able to move all extremities without difficulty and was not in pain. However, this incident report was clearly marked at the bottom of the page that it was not a part of the medical record. A subsequent review of the medical record revealed that Unit Manager #12 failed to document an assessment of the resident's change in condition following the abuse allegation and injuries. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A handwritten note that was not signed or dated noted, In house NP (nurse practitioner) full head to toe assessment. However, a subsequent medical record review failed to reveal documentation that a nurse practitioner or physician examined the resident following the abuse allegation and injuries. The note also had a statement that pt (patient) declined psych (psychiatric) services, however the resident was seen by a psychiatric provider on 4/1/24. The documented visit noted that the provider had spoken with staff and reviewed the medical record, but the provider did not indicate in the note that they were aware of the resident's recent allegation of abuse and injuries. The provider could not have obtained the information from the medical record because facility staff had failed to document the allegation and injuries in the medical record. There was a copied form from local law enforcement's domestic violence unit that read an officer had been sent to the facility and included a case # and phone #. The facility reported they had not received a copy of the police report. On 4/30/24 at 9:50 AM an attempt was made to call the responding officer for an interview but was unsuccessful. An interview with GNA #13 on 4/25/24 at 3:42 PM revealed that he had been assigned to Resident #505 the evening shift prior to the alleged abuse incident. He stated that during that shift on 3/28/24, he had not noticed any bruising on the resident's arms while providing care. Furthermore, he reported that he had not told the oncoming GNA, GNA #10, that the resident had any bruises. On 4/25/24 at 3:55 PM an interview with Unit Manager #12 confirmed that she had been the staff member who conducted the investigation for the abuse allegation. She reported that she had observed bruising on the resident's arms. She stated that during her investigation staff reported the resident had no bruising the day before (3/28/24) on day and evening shift and then had the bruising the next day on 3/29/24, following the night shift that GNA #9 had cared for the resident. She stated the interviews with other resident's confirmed that GNA #9 would not speak to the resident's during care and had been rough with residents. She stated she determined the abuse had occurred. On 4/30/24 at 9:20 AM an attempt to interview Resident #505 was made via telephone call, however, the resident did not return the call. On 4/30/24 at 9:25 AM a telephone call was made to Resident #505 representative (RP). The RP reported that s/he had been made aware of the abuse allegations and the injuries that occurred. When asked if Resident #505 seemed different after the incident the RP reported that when Resident #505 was discharged home s/he reported nightmares about being in the facility. An interview with GNA #10 on 4/26/24 at 6:27 AM confirmed that they were the GNA who found the bruises on Resident #505 during a shower on 3/29/24. They reported that when they asked Resident #505 how s/he got the bruises the resident stated they did not want to get anyone in trouble. The resident further reported that GNA #9 on night shift, had been rough with him/her during care and grabbed their arms to roll them over. GNA #10 reported that when they looked at the left arm above the elbow the bruising was in the shape of a handprint. During an interview with Registered Nurse (RN) #11 on 4/30/24 at 8:49 AM they reported that Resident #505 had expressed fear of getting GNA #9 in trouble and that GNA #9 might retaliate against them. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with the Certified Registered Nurse Practitioner (CRNP) #5 on 4/30/24, at 10:26 AM revealed that they had assessed the resident on 3/29/24, however, the CRNP had not written a note in the medical record due to billing concerns. They reported that the left arm bruising was in the shape of a handprint. On 4/30/24 at 1:30 PM the surveyor reviewed the concerns with the Nursing Home Administrator NHA, with the Director of Nursing and Regional Nurse #4 present. The NHA reported that the facility reported GNA #9 to their licensing board for the abuse, however, this was done only after surveyor intervention on 4/26/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37276 Based on review of facility documents and staff interview, it was determined the facility 1) failed to report an allegation of abuse to the State Agency, the Office of Health Care Quality (OHCQ), immediately but not later than 2 hours of the allegation. This was evident for 2 (#235, #383) of 21 residents reviewed for abuse. The findings include: 1) On 1/10/24 at 10:11 AM, during an interview, Resident #235 reported that last night, during the night shift, s/he was belitted by a geriatric nursing assistant (GNA) who accused the resident of messing in his/her diaper on purpose. Resident #235 reported that the GNA slammed him/her around, almost pushing the resident off of the bed. On 1/10/24 at 11:17 AM, following Resident #235's interview, the surveyor reported the resident's allegation of abuse to the Nursing Home Administrator (NHA). In response, the NHA indicated that they would talk to the resident and investigate the allegations. The facility's self reported incident MD00201461 which documented the facility's investigation of Resident #235's abuse allegation was provided to the surveyor on 1/23/24 at 3:45 PM. Review of the self report revealed documentation that Resident #235 was interviewed by facility staff and reported the allegation to the NHA on 1/10/24 at 1:00 PM Review of email confirmation of the facility's self-report to the state agency was revealed the allegation of abuse was reported to the state agency on 1/10/24 at 7:28 PM, indicating that once the facility became aware of the allegation, the facility failed to forward a first report to the state agency immediately but not later than 2 hours The above concerns related to timely reporting an allegation of abuse to the state office within 2 hours were discussed with the DON on 1/24/24 at 10:18 AM and the DON acknowledged the concerns at that time. 21859 2) On 1/30/24 at 2:25 PM, a review of a facility reported incident MD00200805 revealed that an allegation of verbal abuse was made by Resident #383 on 12/19/23 at 9:00 PM. On 1/30/24 at 3:00 PM, during an interview with the (DON) Director of Nursing, she reported that resident #338 was moved to another unit after having an issue with Staff #10, Geriatric Nursing Assistant (GNA). Review of the facility's investigation documentation revealed that the allegations were not reported to the Office of Healthcare Quality until 12/20/23 at 1:07 PM. On 1/31/23 at 10:30 AM, the DON provided evidence of an email sent to the Office of Health Care Quality on 12/20/23 at 1:07 PM regarding the allegation of abuse and reported this was when the Administrator was made aware of the accusation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 16218 Based on review of facility investigation documentation, medical records and interviews, it was determined the facility failed to ensure that abuse allegations were thoroughly investigated. This was found to be evident for 2 (Resident #3, #34) of 21 residents reviewed for abuse. The findings include: 1) Review of Resident #3's medical record revealed that the resident was admitted to the facility in June 2023. Review of facility self report MD00194762 revealed that during a meeting with the resident and resident's family member in July 2023 there was a report that the night nurse had squeezed the residents hand. On 1/30/24, review of the facility investigation documentation failed to reveal interviews with potential witnesses other than the resident and nurse involved. There was no documentation of an interview with the geriatric nursing assistant assigned to the resident at the time of the alleged event and no documentation if the resident had a roommate or not. On 1/30/24 at 12:03 PM, surveyor reviewed this concern with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The NHA indicated she would look to see if there was any additional documentation. As of time of survey exit on 2/2/24 at 5:15 PM, no further documentation was provided regarding this concern. 2) Review of Resident #34's medical record on 1/22/24 revealed the resident had resided at the facility for several years. Review of facility self report MD00182116 revealed that, on 1/28/22, while being interviewed during another investigation of abuse, Resident #34 reported that, on Tuesday 1/25/22, one of the resident's aides was pulling and tugging on him/her while providing care. The final investigation report was submitted to the licensing agency on 2/2/22. On 1/30/24, review of the facility investigation failed to reveal documentation to indicate any staff were interviewed prior to the conclusion of the investigation. On 1/30/24 at 1:37 PM when asked if a resident provides a date but is unable to provide a name what is the expectation regarding an abuse investigation, the DON responded that everyone that was working that day would be interviewed. Surveyor then reviewed the concern with the DON that the resident provided a specific date but the investigation failed to reveal any staff were interviewed prior to the conclusion of the investigation on 2/2/22.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21859 Based on medical record review and staff interview, it was determined the facility failed to notify the resident/resident representative in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (#132) of 5 residents reviewed for accidents, and 1 (#241) of 4 residents reviewed for hospitalization . The findings include: 1) Review of Resident #132's medical record on 1/18/24 at 9:00 AM revealed that, on 4/25/22 and 5/4/22, the resident was transferred to the hospital for an altered mental status. Further review of the medical record failed to reveal that the resident and/or the resident representative were notified in writing of the transfer/discharge of the resident along with the reason for the transfer. During an interview with the Director of Nursing on 1/18/24 at 10:31 AM, she stated that she was unable to locate any documents that the resident and/or the resident representative was notified in writing of the transfer/discharge of the resident along with the reason for the transfer. She stated that the former Administration did not send out the transfer/discharge information. She stated a form is currently being developed to correct this issue. 37276 2) On 1/19/24 at 4:49 PM, a review of Resident #241's medical record revealed the resident was admitted to the facility in December 2023, then transferred to an acute care facility on 12/24/23 and returned to the facility on [DATE], then transferred to an acute care facility on 1/18/24. 2a) On 12/24/23 at 8:54 PM, in SBAR (the situation, background, assessment and recommendation) Communication Form, the nurse documented that Resident #241 had a critical low lab, the physician ordered the resident to be sent to the hospital for a blood transfusion, and the resident's representative was aware. Further review of the medical record failed to reveal documentation to indicate Resident #241 and the resident's representative(s) were notified of the transfer and the reasons for the move in writing and in a language and manner they understand. 2b) Continued review of Resident #241's medical record revealed, on 1/18/24 at 9:39 PM, in an Acute Care Transfer form, the nurse documented Resident #241 had an unplanned transfer to the hospital with no reason for the transfer documented in the transfer form. The transfer form included a section labeled Validation, check items a through e to validate completion, followed by a list of statements to be checked if completed. The statement Written notification sent with patient was not checked, indicating written notification was not sent with the resident. Continued review of the medical record failed to reveal documentation that Resident #241 and the resident's representative(s) were notified of the transfer and the reasons for the move in writing and in a language and manner they understood. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/24 at 10:20 AM, during an interview, when made aware of the above concerns, the DON indicated s/he was unsure who was responsible for notifying the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing when the resident was transferred to the hospital. The DON indicated that, prior to the current facility owners, the State Long-Term Care Ombudsman had not been notified when a resident was transferred or discharged , and to check with the social worker for the facility's current process. During an interview, on 1/24/24 at 11:11 AM, Staff #9, Social Service Director (SSD) stated that social services was not involved in notifying the resident and resident representative of the transfer or discharge and the reason for the move in writing. The SSD stated that, prior to last month, the Ombudsman was not being notified of resident transfers or discharges. The SSD stated that now, at the end of each month, social services will notify the Ombudsman of resident transfers and discharges, though this had not yet been done for December. On 1/24/24 at 12:12 PM, when asked whether a resident was notified of the transfer and the reason for the move in writing when the resident was transferred to the hospital, Staff #16, RN stated in the past, when the facility was owned by a different company, transfer notification and bed hold forms were implemented. Staff #16 indicated that transfer and bed hold forms were no longer available since switching from the previous company, and s/he was unsure whether they would start using them again. The Nursing Home Administrator and the DON were made aware of the above concerns at the time of exit 2/2/24 at 5:15 PM, with no further comments offered at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21859 Based on medical record review, it was determined the facility failed to notify the resident and/or the resident representative in writing of the bed-hold policy upon transfer of the resident to an acute care facility. This was evident for 1 (#132) of 5 residents reviewed for accidents, and 1 (#241) of 4 residents reviewed for hospitalization s. The findings include: 1) Review of the medical record for Resident #132 on 1/18/24 at 9:00 AM revealed that, on 4/25/22 and 5/4/22, the resident was transferred to an acute care facility for an altered mental status. Medical record documentation revealed that the resident representative was called, however there was no written documentation that the resident and / or the resident representative were notified in writing of the bed-hold policy. During an interview with the Director of Nursing on 1/18/24 at 10:31 AM, she stated that she was unable to locate any documents that the resident and/or the resident representative were notified in writing of the bed hold policy. She stated that a form has now been developed to correct the issue. 37276 2) On 1/19/24 at 4:49 PM, a review of Resident #241's medical record revealed the resident was admitted to the facility in December 2023, then transferred to an acute care facility on 12/24/23 and returned to the facility on [DATE]. On 12/24/23 at 8:54 PM, in SBAR (the situation, background, assessment and recommendation) Communication Form, the nurse documented Resident #241 had a critical low lab, the physician ordered the resident to be sent to the hospital for a blood transfusion, and the resident's representative was aware. There was no documentation found in the medical record that indicated the resident's responsible party was given a copy of the bed hold policy. On 1/24/24 at 10:20 AM, the concern was discussed with the DON. At that time, the DON indicated that facility had not had a specific bed hold policy until recently and stated that the facility now had a bed hold policy that was started a few weeks ago.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of medical records and other pertinent documentation and interviews, it was determined that the facility failed to have an effective system in place to ensure that a resident's wishes regarding cardiopulmonary resuscitation (CPR) were clearly and accurately communicated to facility staff. This was found to be evident for 3 out of 7 residents reviewed for advance directives or death. (#184, #53, and #91) This failure resulted in an Immediate Jeopardy for Resident #184. The findings include: Review of Resident #184's medical record revealed the resident was admitted to the facility secondary to the initiation of hemodialysis. The resident's diagnosis included but was not limited to, chronic kidney disease, heart disease, high blood pressure and diabetes. The resident was less than [AGE] years old at the time of admission, was cognitively intact as evidenced by a BIMS (Brief Interview for Mental Status) score of , d+[DATE], and was his/her own responsible party. Review of the electronic health record revealed the resident had an order for Full Code (Attempt CPR) in effect from [DATE] until it was struck out by the unit nurse manager (Staff #23) on [DATE] at 4:54 PM. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form that includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. It is valid in all healthcare facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Included in the No CPR section are three options: A-1 Intubate; A-2 Do Not Intubate but comprehensive efforts may include limited ventilatory support by CPAP or BiPAP; or Option B No CPR, Palliative and Supportive Care, do not intubate or use CPAP or BiPAP. During review of the paper chart on [DATE] the surveyor found an active MOLST, dated [DATE], that included an order to Attempt CPR (full code). A copy of this MOLST was requested and received on [DATE]. After a meeting with the DON, the Nurse Practitioner (NP), Staff #37, and the corporate nurse, Staff #15, on [DATE] at 12:10 PM, in which the resident's code status was discussed, a MOLST with orders for No CPR Option A-2, dated [DATE] and signed by the NP, Staff #37, was provided by the Director of Nursing. The DON reported s/he had found it in the paper chart. On [DATE] at 3:12 PM the DON reported s/he was not aware of documentation by NP, Staff #37, to indicate a visit was conducted with the resident on [DATE] (date of the DNR MOLST). Earlier in the survey, the surveyor had identified a concern regarding the failure to ensure NP, Staff #37's notes were available in either the electronic health record, or the paper chart, and this concern had been addressed with the DON and corporate nurse on [DATE] at 3:45 PM. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the DON provided copies of several progress notes written by NP, Staff #37, including a note dated [DATE]. Review of this note revealed a visit was conducted on [DATE] in which the MOLST (Maryland Orders for Life Sustaining Treatment) was reviewed with the patient who wanted Option A-2 (No CPR, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate). This note also included a notation that the primary care physician (PCP), Staff #48, was Made aware of pt's change in code status and agreed with the POC (plan of care) for now. PCP will review with patient. Further review of the medical record revealed the Primary Care Physician (PCP), Staff #48, also visited the resident on [DATE]. Review of the note for this visit revealed in the Advanced Directives section: [DATE]- patient has the capacity to make decisions and requests full code and will accept blood transfusion and dialysis, tube feeding to be determined. This [DATE] notation in the Advanced Directives section of the PCP note continued to appear in all of the PCP's notes, including the most recent PCP note found in the medical record, which was dated [DATE]. No documentation was found in the [DATE] progress note to indicate the resident wished to change his/her code status to No CPR (DNR). Further review of the electronic health record revealed multiple social service notes that indicated the resident's code status was reviewed and that the resident wished to remain a full code. These progress notes include: - On [DATE] Social Service Worker, Staff #39, met with the resident. The note included the following: Current code status was reviewed and the resident would like to remain under a full code status according to the MOLST on file. -On [DATE], there was a care plan meeting. The corresponding note was written by the Social Service Worker, Staff #40, and included a statement that the resident was able to participate in person at the care plan meeting with the IDT (interdisciplinary team). The corresponding sign-in sheet for this meeting revealed one of the IDT members in attendance was the unit nurse manager, Staff #23. The note for this meeting included: Code status was reviewed and will remain Full Code. - On [DATE] social services worker, Staff #40, completed a quarterly assessment. The note for this assessment revealed the resident was his/her own RP [responsible party] and able to make needs known and that the code status was reviewed and will remain at Full Code as outlined on MOLST. - On [DATE] there was a care plan meeting. The corresponding note revealed the resident attended the meeting and included the following statement: Full Code status at this time. The corresponding sign-in sheet for this meeting revealed one of the IDT members in attendance was the unit nurse manager, Staff #23. - On [DATE], social service worker. Staff #40, completed a quarterly assessment. The note for this assessment revealed the resident was able to make his/her needs known; and Code status was reviewed and will remain at Full Code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of notes completed by the NP, Staff #37, for visits on [DATE], [DATE] and [DATE], all included the notation Code Status: Full/EMS. These notes were provided by the NP to the surveyor on [DATE] at 2:34 PM, at which time the surveyor reviewed the concern with NP #37 that none of the NP notes were found in either the EHR (electronic health record) or the paper chart. Interview with the NP on [DATE] revealed confirmation that the Full/EMS notation indicated the resident was a full code (Attempt CPR). Of note, a version of these same notes that were provided by the DON on [DATE] did not include the references to Code Status. Further review of the paper chart on [DATE] revealed the dialysis communication sheets, dated [DATE] and [DATE] with notations that the resident was a full code. On [DATE] at 1:20 PM, the surveyor observed that residents who attended dialysis had a communication notebook which was separate from the paper chart on the unit. Review of the communication notebook, for a Resident #91, who was currently receiving dialysis, revealed that a copy of the MOLST was kept in the communication notebook. Further review of several months worth of Resident #184's dialysis communication sheets failed to reveal a notation other than Full Code in the Code status section. A review of facility self-report MD00181520 revealed that, on [DATE], the Resident's breathing ceased related to potential complications at the IV access point, the resident's MOLST was DNR and no CPR was performed. Further review of the EHR order for full code, that was struck out by the unit nurse manager, Staff #23, revealed it was struck out on [DATE] at 4:54 PM with a notation of wrong chart. Additionally, on [DATE] at 4:50 PM, the unit nurse manager, Staff #23, put a new order in the electronic health record for a DNR, with an order date of [DATE]. This DNR order was electronically signed by the primary care physician (PCP), Staff #48, on [DATE]. On [DATE] at 10:59 AM, the unit nurse manager was interviewed regarding the events that occurred on [DATE]. S/he reported that, based on the MOLST that was in the resident's chart, the resident was a DNR/DNI with hospital transfer. S/he confirmed that the EHR said full code but the MOLST said DNR. When the surveyor reviewed the concern that the MOLST found in the paper chart documented the resident was a full code, the unit manager reported the MOLST s/he saw was a DNR with hospital transfer. S/he reported that s/he entered the DNR order in the EHR based on the MOLST and that s/he had not spoken to the PCP prior to entering the order. On [DATE] at 12:10 PM, an interview was conducted with PCP, Staff #48, with the NP, Staff #37, DON, and corporate nurse present. When asked why s/he signed the DNR order after the resident expired, the PCP reported: s/he did not know where the DNR order came from, did not recall a change in code status, had not read every word when signing the monthly orders, was not aware that s/he signed the DNR order and would not have signed it if s/he had known it was there. Based on the above findings the facility had failed to identify the issue that the resident repeatedly indicated they wished to be a full code despite having an active MOLST for DNR. On [DATE] at 12:40 PM a determination of immediate jeopardy was made in regard to the continued failure to have clear and accurate documentation of a resident's code status putting residents at risk of not receiving CPR when indicated. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:00 PM, the first version of a plan to remove immediacy was provided but was not accepted. At 5:30 PM a second plan was provided but was not accepted. At 7:23 PM, a third plan was provided but was not accepted. At 8:35 PM, a fourth plan was provided and accepted. The plan to remove the immediacy included the following: 1. 100% of current alert and oriented residents re-interviewed by Social Worker to confirm their code status. 2. Residents with Advance Directives will have them honored. 3. Residents with responsible parties will be contacted by Social Services to confirm resident code status. 4. If any changes are requested the medical providers will be contacted to make the change 5. System Change a. Current scanned-in copies of the MOLST will be moved to the Do Not Use Section by [DATE] b. Current MOLST previously removed will be returned to the residents ' charts by the medical records designee by [DATE] c. Current MOLST will be placed in the resident ' s chart located at each nurse ' s station by the charge nurse with each new admission, re-admission and change of status. d. The medical director will educate the physicians when there is a revised MOLST to flag the chart, notify nursing leadership of changes to the MOLST and void the old MOLST. e. Nursing leadership will review the MOLST to ensure the old one is voided and the revised one is in the resident chart. Nursing leadership will ensure old MOLST is voided. Changes in code status will be documented on the twenty-four-hour report. f. Physician orders reflecting the resident code status in the EHR will say: See MOLST g. 100% audit was completed to validate current code status say : See MOLST by the DON. 6. Nurses will be educated on the process by the DON or designee by [DATE]. 7. The medical director will educate the medical providers on ensuring they confirm and document the residents wishes on the MOLST. 8. The medical director will educate the medical providers that the NPs are responsible for notifying the attending physicians of MOLST changes. 9. The NHA or designee will re-educate the medical providers on the importance of notifying the Unit Manager, Supervisor, ADON, or DON regarding changes in the MOLST. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. The DON or designee educated current nurses on the facility ' s policy for initiating CPR and location of code status for each resident, which is in the resident ' s chart on each unit. 11. Agency nursing staff will be educated prior to start of their shift by DON, nursing supervisor or designee. 12. Social Service will audit new admissions, re-admissions to compare the resident ' s MOLST to the physician orders for accuracy to assure it reflects See MOLST. This is ongoing. On [DATE] at 2:33 PM, based on review of credible evidence, resident medical records, and interviews, it was determined that the facility completed the plan to remove the immediacy. After removal of the immediacy the non compliance remained at a D level. 2) Review of Resident #53's medical record revealed the resident was admitted to the facility in February of 2023. The resident is his/her own responsible party and is cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of ,d+[DATE]. Maryland Medical Orders for Life Sustaining Treatment (MOLST) is a form that includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR)and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Included in the No CPR section are three options: A-1Intubate; A-2 Do Not Intubate but comprehensive efforts may include limitedventilaroty support by CPAP or BiPAP; or Option B No CPR, Palliative and Supportive Care, don not intubate or use CPAP or BiPAP. On [DATE], a review of the current active MOLST, completed in [DATE] and found in the paper chart, revealed an order for NO CPR. A previously voided MOLST, dated [DATE], revealed the resident had been a full code. Review of the electronic health record (computer) revealed an order for full code, indicating CPR should be performed. On [DATE] at 2:21 PM the nurse (Staff #22) assigned to care for the resident during that shift was interviewed in regard to the resident's code status. At first, the nurse stated she thought the resident was a full code and indicated she would check. After looking at the computer, the nurse reported the resident was a full code and confirmed that she would perform CPR. Surveyor then requested that the nurse review the paperchart. At 2:23 PM, after reviewing the current MOLST, the nurse confirmed that there was conflicting orders and indicated she would follow the MOLST. On [DATE] at 2:30 PM, surveyor asked the Director of Nursing (DON) to access the resident's current orders. When asked what the resident current code status was, the DON responded: full code. Surveyor then reviewed with the DON that the July MOLST is for No CPR and the nurse's report that she would perform CPR. On [DATE] at 9:56 AM, further review of the electronic health record (EHR -computer) a new order was put in place on [DATE] for DNR. On [DATE] at 2:29 PM the DON reported the process was supposed to be when medical provider changes the MOLST they should notify the nurse to change in the electronic health record system. She went on to report: We did an audit to make sure everybody matched. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) On [DATE] at 1:20 PM, review of Resident #91's medical record revealed the resident attended dialysis 3 days a week. Review of the paper chart found at the nursing station revealed a MOLST, dated [DATE], that included an order for No CPR Option B. Review of the dialysis communication book, also found at the nursing station, revealed a MOLST, dated [DATE], that included an order for No CPR Option A-2. On [DATE], at approximately 1:30 PM, the existence of the two active MOLSTs was reviewed with the corporate nurse (Staff #15) who reported that, moving forward, the MOLST would only be located on the paperchart. On [DATE] at approximately 2:20 PM, the DON and NHA confirmed that dialysis and facility staff have been educated to send the paperchart to dialysis with the resident, and that the MOLST was located on the paperchart only. On [DATE] at 2:25 PM, interview with nurse (Staff #22) confirmed that they have started sending the hard paper chart with the residents to dialysis.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 21859 Based on medical record review, facility investigation documentation, and interview with facility staff, it was determined the facility 1) failed to administer medication as ordered by the physician, 2) failed to ensure medications for cancer treatment were administered as needed, and 3) failed to provide care and treatment in accordance with the professional standards of practice for a resident with an unwitnessed fall. This was evident for 2 (#132, #332) of 13 residents reviewed for complaints, 1 (#183) of 21 residents reviewed for facility reported incidents, and 1 (#245) of 5 residents reviewed for accidents The findings include: 1) The facility failed to administer Guanfacine HCL as ordered by the physician for Resident #132. Review of Resident #132's medical record on 1/18/24 at 3:00 PM revealed a physician order, dated 4/9/22, to administer Guanfacine HCL 2mg (milligrams) by mouth for Hypertension. Guanfacine HCL is used to treat high blood pressure and attention deficit hyperactivity disorder. Further review of the medical record revealed a Medication Administration Record (MAR) for April 2022, in which Resident #132's Guanfacine HCL was coded on the MAR a (5) on 4/11/22, 4/14/22, 4/17/22 at 8am, and a (9) on 4/12/22 at 8am. Continued review of the MAR revealed a Chart Code which indicated a (5) means Hold/See Nurses Notes and an (9) means other/see Nurses Notes. Review of the medical record failed to reveal a nurse's note that indicated why the medication was not administered. During an interview with the Director of Nurses, on 1/18/24 at 4;00 PM, s/he stated she was unable to locate any documentation as to why this medication was not given. 2) The facility failed to administer Lacosamide as ordered by the physician for resident #332. Review of Resident #332's medical record on 1/18/24 at 4:30 PM revealed a physician order dated 10/22/22 to administer Lacosamide 300 MG (milligrams) via G-Tube every twelve hours for seizure disorder. Further review of the medical record revealed a Medication Administration Record (MAR) for October 2022, in which resident #332's Lacosamide was coded on the MAR as a (9) on 10/22/22, 10/23/22, at 8 AM, and a (9) on 10/22/22 at 8 PM. Continued review of the MAR revealed a Chart Code which indicated an (9) means other/see Nurses Notes. Review of the medical record revealed a nurse's note dated 10/22/22 at 8:47 AM that indicated the medication is awaiting delivery from the pharmacy. During an interview with the Director of Nurses, on 1/18/24 at 5:00 PM, s/he stated she was unable to locate any documentation as to why this medication was not available from pharmacy. S/he stated the nurses that documented the codes no longer work at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16218 3) Review of Resident #183's medical record revealed the resident was originally admitted in February 2023 with a brief re-hospitalization in March 2023. The resident's diagnosis included, but was not limited to, multiple myeloma (blood cancer), Parkinson's disease, diabetes, heart disease and blindness. Review of the 3/11/23 hospital discharge report revealed one of the medications at the time of discharge was pomalidomide 4 MG take one capsule by mouth daily for 21 days followed by a 7 day rest period. Pomalidomide, also known as Pomalyst, is an anticancer medication used to treat multiple myeloma. Review of the Medication Administration Record (MAR) for March 2023 revealed there was an order to start Pomalidomide 4 mg one time a day for cancer until 4/1/23, take for for 21 days and rest 7 days. This medication was not administered on 3/12/23 and was discontinued on 3/13/23. Review of a 3/14/23 progress note, written by nurse, Staff #16, revealed the resident's responsible representative reported the oncologist (cancer physician) had started the resident on Pomalyst 4 mg, the responsible representative would be bringing in a 2 week supply of the pomalyst to the facility later that day and the resident had a return appointment with the oncologist later in March. This note also indicated the primary care physician was made aware and provided a prescription. Further review of the EHR revealed a note written by the nurse (Staff #60) on 3/28/23 which states: Resident went for oncology appointmnet and returned. New recommendation not legible. To contact doctor [name of oncologist Staff #61]. On 1/22/24 at 2:59 PM the surveyor informed the unit nurse manager (Staff #23) that no documentation was found that a clarification was obtained in regard to the illegible 3/28 oncologist note. Review of the paper chart on 1/23/24 at 3:24 PM revealed a hand written Consultation Report for the visit with the oncologist on 3/28/23. The recommendations section of the note is not clearly legible. Further review of the paper chart and the electronic health record (EHR) failed to reveal a final report from the 3/28/23 oncology visit. Surveyor then requested this report from the Director of Nursing (DON). During an interview with Nurse (Staff #16) on 1/22/24 at 2:12 PM surveyor provided the hand written Consultation Report for 3/28/23 visit with the oncologist. After review of the note, Nurse #16 reported s/he would call for clarification if this was all that the resident came back with and that s/he would have them send something typed. The DON reported on 1/24/24 at 10:23 AM that the oncologist office will be sending over the March note. Review of the typed 3/28/23 oncologist note revealed in the Medication list section: pomalidomide 4 mg one capsule by mouth daily for 21 days followed by a 7 day rest period. There is also a notation, from 2/14/23: . will start 4 mg PO [by mouth] pomalidomide on days 1 to 21 of 28 day cycles. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the MAR revealed an order, with a start date of 3/14/23, for Pomalidomide 4 mg one capsule one time a day for multiple myeloma for 21 days. This order was discontinued on 4/2/23. The MAR revealed the medication was administered daily from 3/15 through 3/31/23 but was not administered on 4/1 or 4/2/23. The MAR indicated there were nurse's notes related to the doses due 4/1 and 4/2. Review of the corresponding progress notes revealed that on 4/1/23 the nurse contacted the pharmacy who reported the medication needed to be ordered from a specialty pharmacy. No further follow up documentation was found for 4/1/23 regarding the unavailability of the medication. Review of the 4/2/23 progress note revealed the primary care physician, Staff #59, was made aware that pomalyst 4 mg was unavailable from the pharmacy and will need to be ordered from specialty pharmacy, and that all documents were faxed to the specialty pharmacy. Review of a 4/2/23 progress note, written by nurse, Staff #16, revealed the nurse had a conversation with the responsible representative about the pomalyst and included: .This week should be is [a] 7 day off period for the medication resident to resume on fri 4/7 for 3 weeks thewn [then] another 7 days off, per the oncologist per [responsible representative], [PCP #59] made aware and agreeable, orders updated, resident did not miss any doses according to schedule, [Responsible Representative] is expecting medication to be delivered to [him/her] Tues 4/4 and will bring to facility . Review of a 4/5/23 nursing progress note revealed a family member brought the resident's medication to the facility. However, further review of the medical record failed to reveal how much of the medication was received. Further review of the MAR revealed an order, with a start date of 4/7/23, for Pomalidomide 4 mg capsules - Give 1 capsule by mouth one time a day for multiple myeloma for 21 days. The MAR revealed documentation that the Pomalidomide was administered as ordered from 4/7 through 4/27/23. Further review of the medical record failed to reveal documentation to indicate the resident restarted the Pomalidomide 21 day cycle after a 7 day rest period. The next order found for the Pomalidomide is dated 10/20/23. Further review of the medical record revealed a progress note written by nurse, Staff #53, on 10/19/23 that revealed a call was placed to the oncologist office for clarification regarding the Pomalidomide Oral Capsule 4 MG PO [by mouth] daily 21 days for multiple myeloma and 7 days rest period. The note indicates the order should continue with the same cycle. Nurse, Staff #53, was interviewed about Resident #183 on 1/23/24 at 11:37 AM. S/he reported the responsible representative had brought him/her the specialty medicine but s/he did not see the order so s/he called the cancer doctor. Nurse, Staff #53 confirmed that the cancer doctor's office indicated the order should be indefinite. S/he then spoke with the primary care physician here and they put the resident back on the Pomalidomide. On 1/22/24 at 2:12 PM, nurse, Staff #16, was interviewed. When asked how s/he would enter an order for a medication that required a 7 day stop then a restart on a continuous cycle, s/he reported s/he would have to put in a restart after 7 days; I would have to keep doing it over and over again. Nurse, Staff #16, concluded that s/he would have to check with the higher ups. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit nurse manager, Staff #23, was interviewed on 1/22/24 at 2:48 PM about the Pomalidomide order for Resident #183. When asked how s/he would put an order like this into the EHR, s/he reported s/he would put in a stop date then another order to start after 7 days, might be able to schedule; people put it in differently, it's only good for as long as you put it in for, or you can re-write it each time it's due. S/he concluded with: regardless how entered, every morning there is a report. Interview with the Medical Director, Staff #5, revealed that s/he was familiar with Resident #183 and aware that the medication was missed. S/he reported the order should of been written 3 weeks on, one week off and continue. Review of MD00198905, revealed the facility reported that on 10/20/23 while being transferred to another unit within the facility a nurse on the receiving unit observed several unopened bottles of Pomalidomide. A review of the medical records revealed the order had not been restarted. The primary care physician and the oncologist were made aware and new orders were received to restart the medication. On 10/20/23 the facility initiated education to nursing staff on medication management, medication storage and medication transcription. Additionally, all residents that were on specialty medications had their records reviewed to ensure medication was given as ordered. On 1/22/24 at 9:30 AM, after initial review of the documentation provided by the facility regarding MD00198905 surveyor requested from the DON any additional documentation regarding the self report that they would like the surveyor to review. No documentation was provided regarding the specific education that was provided to staff or credible evidence that the training occurred. On 1/30/24 at 3:52 PM surveyor reviewed with the DON that the investigation report stated that education was given to nursing staff on medication administration, medication storage, and specialty medication. When asked what that education consisted of the DON responded: what we were telling them was if family brought in any kind of medication to give it to the manager. On 1/30/24 at 3:47 PM the DON was interviewed. When asked about the process when medication orders originate from a specialist, the DON reported that there was no special process, just put the order in and fax it to the pharmacy. S/he went on to report that a lot of times if the resident is on a medication in the community they get an OK from the physician to use the resident's own supply. In regard to Resident #183, the DON reported that she believed the responsible representative brought in all of the doses. S/he was unable to recall at this time how much unused Pomalidomide was discovered in October. During the 1/30/24 interview, when asked if the root cause of this error was identified, the DON reported: The order dropped and they didn't put it back in and the nurse who received the meds didn't report that she received them. When asked what has changed to prevent this from occurring again, the DON reported they are looking more into the order listing summary which is part of the morning meeting, and confirmed this is an ongoing process. On 1/30/24 at 3:52 PM surveyor reviewed with the DON the concern that interview with different staff during this survey have revealed different responses in regard to putting in an order similar to the Pomalidomide order for Resident #183. On 1/31/24 at 3:45 PM surveyor reviewed with the DON the concern regarding failure to ensure a specialist recommendations were clarified and orders were entered correctly for a anticancer medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48470 4) Resident #245 was admitted to the facility in late 2023 and had left sided weakness following a stroke. On 2/01/2024 at 11:52 AM, Resident #245's medical record was reviewed and revealed the resident had a fall on 1/22/24 during the evening shift and no nursing or physician assessment was documented on the day of the incident. On 2/1/24 at 1:57 PM, a review of Resident #245's electronic medical record (EMR) revealed a progress note with a reference date of 1/23/24 at 4:36 PM that indicated the resident had complained of pain in the left hip and was assessed by the physician. The physician ordered an X-ray related to the resident's pain. A review of the X-ray report indicated that it was conducted on 1/24/24 at 4:09 PM. Further review of Resident #245's medical records revealed that assessments and documentation by the Registered nurse (RN), Staff #47, began on 1/24/24, starting with: fall risk evaluation at 6:06 PM; vitals and pain evaluation at 6:20 PM; change in condition evaluation at 6:36 PM. Further review of the progress note with a reference date of 1/25/24 at 12:58 PM, indicated that Resident #245's Left hip X-ray showed a fracture and was reported to the Nurse Practitioner and ordered for the resident to be sent to the emergency department for further evaluation. To this date, Resident #245 had not returned to the facility. On 2/1/24 at approximately 3:00 PM, a review of the staff posting for 1/22/24 (3-11 shift) confirmed that Staff #47 was on duty at the time of the incident. On 2/2/24 at 9:45 AM, an interview with Registered nurse (RN), Staff #19, was conducted regarding the process for unwitnessed falls. Staff #19 reported his/her process and reasoning whether to transfer the resident out via 911 or to keep the resident for further observation. Staff #19 indicated that a 72-hour neuro check would be initiated for all unwitnessed falls regardless if there was indication or report of the resident hitting their head. Then, s/he would start the incident report which would trigger documentation for change in condition, fall assessment, and pain assessment. Staff #19 also reported that all these assessments and documentation should be done on the same shift. Documentation for Resident #245's unwitnessed fall was reviewed with Staff #19 and s/he indicated that the process was done 2 days late. On 2/2/24 at 11:37 AM, the Director of Nursing (DON) was interviewed, and s/he verified the process for resident falls as Staff #19 had reported. When the DON was asked specifically about Resident #245's incident on 1/22/24, s/he reported that Staff #47 knew about the fall and had to be called to come into the facility to initiate the facility's process for unwitnessed falls. The DON also reported that the 72-hour neuro check was not done for Resident #245. The concern was discussed with the DON that Staff #47 failed to act upon, per professional standards of practice, Resident #245's incident regarding an unwitnessed fall. CROSS REFERENCE F-580

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on a review of facility self report MD00181520 investigation documentation, medical records, observations, and interviews, it was determined that the facility failed to ensure nursing staff had the appropriate competencies and skills to access a permacath for the IV administration of antibiotics. This was found to be evident for 1 (#184) of 2 residents reviewed for death during the survey. This deficient practice led to an immediate jeopardy for Resident #184. The facility implemented effective and thorough corrective measures following this incident. The facility's plan and action were verified during this survey, therefore this deficiency will be cited as past noncompliance. The date of correction was 8/14/22. The findings include: Review of Resident #184's medical record revealed the resident was admitted to the facility secondary to the initiation of hemodialysis. The resident's diagnoses included but was not limited to, chronic kidney disease, heart disease, high blood pressure, blindness, and diabetes. The resident was cognitively intact as evidenced by a BIMS (Brief Interview for Mental Status) score of 15/15 and was his/her own responsible party. Observations made throughout the survey revealed a dialysis center is located within the facility's building but is a separate entity run by dialysis center staff. Hemodialysis is a process in which blood is removed from the body, passed through a machine to clean out waste products and then returned to the body. This procedure can take several hours and is often required to be completed 3 times per week. To access a resident's blood for the hemodialysis procedure an AV (arteriovenous) fistula is usually created which is a connection between an artery and a vein. A surgical procedure is required to create the AV fistula and it can take up to several months for the fistula to mature and be used for dialysis. Prior to the creation and maturation of the fistula, a permacath can be utilized to access the resident's blood during hemodialysis. Review of the December 2021 hospital discharge summary revealed a PermCath (also known as a permacath) was placed prior to discharge to the facility. The permacath is a tube inserted into a vein in the neck and the tip is located in or near the right atrium of the heart. It consists of two channels, each channel has its own clamp and a cap. One channel has a red cap used to withdraw blood during dialysis and the other with a blue cap is used to return blood during dialysis. Permacaths can remain in place for several months. Review of the primary care physician notes revealed an AV (arteriovenous) fistula was created by 1/11/22. The 7/19/22 PCP note revealed the AV fistula was now being used for dialysis. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 7/28/22 NP (Staff #37) progress note revealed the patient remained on dialysis Monday - Wednesday- Friday, and that the permacath that was placed in December 2021 needed to be removed because the left arm fistula was now being utilized for dialysis. The resident had an upcoming appointment to have the permacath removed on 8/4/22. This note also revealed a plan to obtain a culture of a foot ulcer and to start pt on Vanco to treat empirically for Osteomyelitis [bone infection]. Review of a wound care consultation progress note, completed by the Medical Director, Staff #5, on 7/28/22, revealed a plan to start vancomycin and Zosyn according to dialysis parameters after a wound culture was obtained. Review of nursing progress notes revealed that, on 7/28/22 at 4:20 PM, the licensed practical nurse (LPN) Staff #35, documented that the Nurse Practitioner (NP) gave orders for a midline insertion for antibiotic therapy and wound treatment. A midline is type of intravenous access line that can be used for the administration of medicine or fluids. A midline is usually inserted in a vein in the resident's arm and can remain in place for 2 - 4 weeks. A regular IV would need to be changed every few days. Further review of the nursing progress notes revealed the following, documented by LPN #35 on 7/28/22 at 10:03 PM: Resident alert and oriented x3. [name of infusion company] was in the building, to access the dialysis line to see if it can be used for the ABT [antibiotic] therapy. [infusion company] personnel stated that type of dialysis line can only be accessed at dialysis. Resident was given an option for a midline insertion, resident declined, [s/he] stated 'I do not want it, I want the antibiotic to be done at dialysis, if not it can wait till Monday. Supervisor was also present when the resident made the above statement Review of the physician orders revealed that, on 7/29/22, there was an order for Zosyn 2.25 grams intravenously two times a day for Osteomyelitis for 4 weeks. Review of the Medication Administration Record (MAR) revealed the doses were scheduled to be given at 12 noon and 10:00 PM. The first dose was documented as administered by LPN #36 on 7/29/22 at 12 noon. Review of the progress notes revealed that on 7/29/22, LPN #36 wrote that the Zosyn was given via right chest perma cath and flush with NS [normal saline], with no issue, no adverse effect noted or reported. Further review of the MAR revealed five IV Zosyn doses were administered when due from the evening of 7/29 through the evening of 7/31 by LPN #35. On 1/23/24 at 3:50 PM, LPN #35 was interviewed, s/he confirmed s/he had previously administered an antibiotic through a dialysis site and named Resident #184. When asked if anyone had instructed her, LPN #35 replied : we had an order so I did like a regular IV. At the end of the interview, LPN #35 was given her statement from 8/4/22 for review, s/he then confirmed the accuracy of the statement. Review of this statement revealed that s/he had administered the Zosyn over the weekend and that s/he knew what to do with the IV line because [name of LPN #36] told me what port to use, I double checked to be sure I was doing the right thing. Further review of the medical record revealed a progress note for a visit conducted by the NP #37 on 7/30/22. This note revealed the following statement: .Pt initially refused to use the perma cath on Rt upper chest (formal [former] dialysis port) for ABT [antibiotic] but later agreed. Staff administered the Zosyn as ordered . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the nursing progress notes revealed a note written by LPN #34 on 8/1/22 at 4:07 PM. This note revealed that around 2:00 PM, the nurse attempted to administer the resident's Zosyn but the machine was faulty and she was having a hard time getting the infusion to run. The patient was alert and oriented at that time. At about 2:20 PM, the nurse left the resident for a few minutes and when s/he returned the patient was not responsive. The nurse lifted the resident's shirt and saw blood and immediately called for help. Review of a progress note written by the unit nurse manager (#23) on 8/1/22 at 4:25 PM revealed they were unable to stop the resident's bleeding, the paramedics arrived and pronounced the resident dead at 2:30 PM. The medical director (Staff #5) was interviewed regarding Resident #184 on 1/24/24 at 4:22 PM. The medical director reported he remembered the resident because he used to do the wound care for the facility. He reported having consulted with the nephrologist regarding the use of the permacath for the antibiotic administration since the resident was refusing another IV access line and indicated that the nephrologist was in agreement with using the permacath. The medical director went on to report that it was his understanding that the nurses here were instructed by the dialysis nurses and if the nurses were trained by dialysis it would be safe. LPN #36 was interviewed regarding Resident #184 on 1/25/24 at 1:22 PM. The LPN reviewed the statement s/he signed on 8/4/22 regarding the use of the resident's permacath for the IV administration of Zosyn and confirmed it's accuracy. Review of the statement revealed that, on 7/29/22, the NP #37 and LPN #36 went to the dialysis center where a nurse showed them which port to use and to clamp it after use. During the interview on 1/25/24, LPN Staff #36 reported that she told the NP directly that s/he had never done that before [accessed a permacath] and was not comfortable and then the two of them went to the dialysis center. S/he was not sure if his/her supervisor was aware of this or not. S/he went on to report that s/he actually observed the dialysis nurse set up the Zosyn and then the LPN took the resident to his/her unit. S/he reported s/he did not give the dose, but did do the flush when it was finished. S/he also reported that s/he explained to the nurse that relieved him/her what the dialysis nurse told him/her about accessing the permacath. During an interview on 1/24/24 at 3:32 PM, the NP #37 confirmed that only one nurse had gone with him/her for training by the dialysis staff and reported that the training included how to clamp, how to open and to use sterile technique. The NP #37 also confirmed that when she arrived at the facility on the weekend (7/30/22 was a Saturday) the morning dose was already administered and that the resident had reported that the nurse did very well. During an interview with unit nurse manager, RN, Staff #23 on 1/26/24 at 10:59 AM revealed that s/he was off duty on Friday 7/29/22 and returned to work on Monday 8/1/22. S/he reported s/he was not aware that [name of infusion company] came out and said they could not use the permacath and that the note on Thursday should of raised an alarm somewhere. S/he reported that it was not until after the event that s/he realized the only IV access was the permacath. The unit nurse manager reported if s/he had known the permacath was the only access s/he would of objected to the order. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/24/24 at 3:32 PM, an interview was conducted with NP #37. S/he confirmed his/her statement, dated 8/3/22, which states: . On Friday afternoon, I took the nurse [name of LPN #36] to the dialysis room and the dialysis nurse gave training on how to use the catheter. A decision was made after talking to [Name of Medical Director #5] on the route of administration. Since the patient didn't want to be stuck for an IV line, and [s/he] had the permacath that was due to be removed, it was decided to use the permacath . During the 1/24/24 interview, the NP reported that she did not know if there was documentation of the education but that the Director of Nursing (DON) (Staff #52) and the Assistant Director of Nursing (ADON) (Staff #4) told him/her on Friday if they were going to use the permacath there would have to be education. The NP reported that they asked me if I got training and that is why I wrote that statement. The NP went on to state that she was not aware that the nurse who was administering the IV antibiotic was not the nurse who was trained. Review of the investigation documentation revealed a statement signed by Registered Nurse (RN), Staff #53, on 8/1/22. This statement revealed that, at around 2:30 PM, a staff member indicated they needed help, RN, Staff #53 responded and Resident [name of Resident #184] was observed unresponsive, the nurse assigned was next to the resident clamping the port. Further review of the investigation documentation revealed a witness statement dated 8/1/22, that consisted of LPN, Staff #34 answering questions from ADON, Staff #4. The ADON, Staff #4 confirmed the accuracy of the documentation during an interview on 1/24/24 at 11:39 AM. This statement revealed the following from LPN, Staff #34: I went to give the IV antibiotic around 2 PM and I flushed the site and forgot to clamp the site; I went to get the IV pump and came back at 2:20 and saw the blood. Attempts to interview LPN, Staff #34 on 1/23/24 and 1/24/24 were unsuccessful. During an interview on 1/24/24 at 11:39 AM, ADON Staff #4 reported s/he had not been aware the staff was accessing the permacath for the administration of IV antibiotics prior to the event on 8/1/22. On 1/24/24, review of the skills assessment documentation for LPN, Staff #34 revealed a self-assessment dated [DATE], which was after the incident occurred. On 1/24/24 at 9:40 AM, the concern that the facility was unable to provide documentation of basic IV skills assessment prior to the incident was reviewed with the DON. The DON reported s/he would contact the staffing agency that had sent LPN, Staff #34. Further review of the documentation provided by the facility revealed that starting on 8/1/22 they began education of licensed staff on: Management of Central Venous device complications Change in Condition Licensed Nurses Skills and Techniques Evaluation - Phlebotomy/infusion therapy. Do not access the dialysis site: permacath or fistula Providers were educated not to write orders for floor nurses to access dialysis catheters. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All like residents in the facility with IV access or dialysis access devices were evaluated. A quality assurance (QA) plan was put in place for ongoing monitoring of the planned interventions. Documentation was provided that the LPN, Staff #34 was put on the do not return list and a report was submitted to the state board of nursing. On 1/25/24 at 3:45 PM, after review of the credible evidence of education, QA audits, and interviews with multiple staff it was determined that the facility had recognized this deficient practice and implemented interventions to prevent re-occurrence. The date of compliance, as identified by the date on which the training was completed was determined to be 8/14/22. The DON and corporate nurse were made aware of the determination of immediate jeopardy past non-compliance at this time. -