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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure that a dependent resident was groomed in a manner that preserved the resident's dignity. This was evident for 1 (# 71) of 2 residents reviewed for dignity. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. Observations of Resident #71 on 1/9/24 at 9:40 AM and 1/16/24 at 9:42 AM showed that Resident #71 was lying in bed with facial hair on the chin and upper lip. On 1/24/24 at 11:17 AM, a medical record review revealed a Minimum Data Set (MDS) assessment, dated 7/18/23, which documented that Resident #71 depended on staff for all their self-care needs, including grooming and personal hygiene. Further record review showed an MDS, dated [DATE], which documented that Resident #71 had moderately impaired cognition and diagnoses including but not limited to Dementia. On 1/24/24 at 11:49 AM, a review of Resident #71's current plan of care and Geriatric Nurse Aide (GNA) task documentation from November 2023 to January 2024 failed to show that Resident #71 preferred to wear facial hair. On 1/9/24 at 9:40 AM, during an interview with Resident #71, they said they would like to have their facial hair shaved. On 1/16/24 at 9:43 AM, an interview was conducted with Staff #49, GNA. During the interview, s/he stated that Resident #71 depended on staff for all care needs. S/he also confirmed that Resident #71 had facial hair and indicated s/he would shave it after surveyor's intervention. On 1/22/24 at 11:59 AM, during an interview, Staff #32, Nurse Manager, stated s/he expected Resident #71's facial hair to be shaved if it was their preference to have it shaved. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/24 at 11:44 AM, an interview was done with the Director of Nursing (DON). During the interview, the DON stated that if it was not documented on a resident's plan of care to leave their facial hair, then Resident #71's facial hair should have been shaved.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 37276 Based on medical record review and staff interviews, it was determined that the facility 1) failed to ensure that the resident was informed of their right to formulate an advance directive. This was evident for 2 (#54, and #235) of 5 residents reviewed for advance directives. The findings include: Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual is not able to make their own decisions. 1) On 1/24/24 at 11:22 AM, a review of Resident #54's medical record revealed Resident #54 was admitted to the facility in August 2023 following an acute hospital stay. Resident #54's admission assessment with an assessment reference date (ARD) of 8/12/23, documented Resident #54's Brief Interview for Mental Status summary score was 13, indicating Resident #54 was cognitively intact. Further review of Resident #54's electronic medical record (EMR) and paper medical record failed to reveal evidence that Resident 54 had an advance directive in place, and no documentation was found to indicate Resident #54 resident had been informed of his/her right to formulate an advance directive or that the facility periodically reviewed with the resident and/or the resident representative regarding treatment, experimental research and any advance directive and its provisions, as preferences may change over time. On 1/23/24 at 3:35 PM, during an interview, the Social Service Director (SSD), Staff #9 stated that the resident and/or the resident's representative would be asked if the resident had an advance directive during a social service assessment, following the resident's admission to the facility. Staff #9 stated that, if a resident had an advance directive, the social worker would ask for a copy. Staff #9 indicated that social services did not provide residents and/or the resident representatives with written information about formulating an advance directive and residents were not provided assistance to formulate an advance directive. Staff #9 stated that, shortly after hire, s/he was told that social services could no longer help a resident complete advance directive documentation, or provide them with written information that explained how to formulate an advance directive. Staff #9 stated that when a resident expressed interest in formulating an advance directive, social services would help point the resident in the right direction, such as how to look up it up, or search on the internet for advance directives or power of attorney (POA), and s/he would direct the resident or resident representative to a bank for a finacial POA,. At that time, the surveyor requested the facility's Advance Directive Policy The above findings were discussed with the Social Service Director, Staff #9 on 1/24/24 at 11:45 AM, who indicated that at the time of Resident #54's social service assessment, the assessment tool did not include a section to document advance directives, and the current social service assessment tool now had a place to add advance directive questions. 2) On 1/24/24 at 11:30 AM, a review of Resident #235's medical record revealed Resident #235 was admitted to the facility in December 2023 following an acute hospitalization . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a Social Services Assessment and Documentation note, on 1/10/24 at 10:49 AM, the social worker documented that a Social Service Initial Assessment had been completed for Resident #235, and the resident was responsible for him/herself. The assessment documented Resident #235 did not have an Advance Directive in place, and that an opportunity to complete an advance directive had been offered, however, Advance Directive educational materials, including the state form, had not been provided to the resident. Further review of Resident #235's medical record failed to reveal documentation to indicate whether the resident wished to execute one or more directives. On 1/23/24 at 3:35 PM, during an interview, the Social Service Director (SSD), Staff #9 stated that the resident and/or the resident's representative would be asked if the resident had an advance directive during a social service assessment, following the resident's admission to the facility. Staff #9 stated that, if a resident had an advance directive, the social worker would ask for a copy. Staff #9 indicated that social services did not provide residents and/or the resident representatives with written information about formulating an advance directive and residents were not provided assistance to formulate an advance directive. Staff #9 stated that, shortly after hire, s/he was told that social services could no longer help a resident complete advance directive documentation, or provide them with written information that explained how to formulate an advance directive. Staff #9 stated that when a resident expressed interest in formulating an advance directive, social services would help point the resident in the right direction, such as how to look up it up, or search on the internet for advance directives or power of attorney (POA), and s/he would direct the resident or resident representative to a bank for a finacial POA,. At that time, the surveyor requested the facility's Advance Directive Policy Staff #9 was made aware of the above findings on 1/24/24 at 11:50 AM. In response, Staff #9 stated s/he had just reviewed the facility's advanced directive policy and the policy was different from what s/he had been taught when first hired, indicating s/he understood facility staff could provide a resident with writtten information information about formulating advanced directives and assistance in establishing advance directives.

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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. 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 48259 Based on record review and interviews, it was determined that the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to residents who were discharged from Medicare Part A services but had benefit days remaining and intended to remain at the nursing facility receiving non-skilled care. This was evident for 2 (#31, #106) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification. The findings include: Residents with Medicare Part A have certain rights and protections related to financial liability and appeals. The financial liability, appeal rights, and protections are communicated to beneficiaries through notices given by providers to residents who are being discharged from Medicare services but have Medicare benefit days remaining. The notices include: Notice of Medicare Non-Coverage (NOMNC)- To be issued at least two calendar days before the last covered day of Medicare. Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)- To be issued far enough before delivering potentially noncovered services to allow sufficient time for the beneficiary to consider all available options. On 1/23/24 at 2:41 PM, the facility provided the survey team with NOMNCs for 3 residents discharged from Medicare services with benefit days remaining in the last six months. A review of those resident records revealed that Resident #31 and Resident #106 remained in the facility after the last day of their Medicare coverage. However, the review did not show that Resident #31 and #106 were issued SNFABNs. On 1/23/24 at 3:31 PM, an interview was conducted with Staff #9, Social Services Director. During the interview, Staff #9 was asked about what notification residents received when Medicare services were ending while they had benefit days remaining and planned to continue to remain in the facility. Staff #9 stated that she issued NOMNCs. When asked if she issued SNFABN notifications, Staff #9 stated that she was unfamiliar with the SNFABN notification forms and did not issue them. On 1/24/24 at 10:59 AM, a review of the facility's policy entitled Advance Beneficiary Notices was done. The review noted a statement in the policy: If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary (custodial care), the facility shall issue an ABN prior to furnishing noncovered care. On 1/25/24 at 9:59 AM, during an interview with Staff #13, a Social Service Coordinator, she stated that she was unaware of the SNFABN form and did not issue them to residents who were coming off Medicare A, but had benefit days remaining and continued to stay in the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on observation and interview, it was determined that the facility failed to have an effective system in place to ensure that maintenance concerns are reported and addressed. This was found to be evident for rooms in 3 out of the 4 units in the facility. The findings include: During an initial tour of the facility, the surveyors made the following observations: - On 1/10/24 at 11:54 AM in room [ROOM NUMBER], the lower part of the wall, under the window, beside the A/C unit had 2 areas damaged, each measuring about 4x4 inches. This damage could be seen from the hallway. - On 1/10/24 at 1:50 PM in room [ROOM NUMBER], cracks were noted on several floor tiles and a broken corner guard on the left side under the sink. - On 1/11/24 at 9:47 AM in room [ROOM NUMBER], a broken corner guard was noted on the right side under the sink. - On 1/10/24 at 9:16 AM in room [ROOM NUMBER], Resident #32 complained that the clock had stopped working. The surveyor observed that the clock read 3:15 and the current time was 9:16 AM. - On 1/10/24 at 1:00 PM in room [ROOM NUMBER], a broken corner guard was noted on the right side under the sink and 2 holes/damage on the bathroom door measuring approximately 2x1 inches. On another tour of the units by a surveyor on 1/30/24 at 10:00 AM, the prior observations were verified and the following additional concerns were noted: - room [ROOM NUMBER] had a broken corner guard on left side under the sink and the grout between the sink and the left backsplash had separated; - room [ROOM NUMBER] had a broken corner guard on the left side under the sink; room [ROOM NUMBER] had a broken corner guard on the left side under the sink; - room [ROOM NUMBER] had a broken corner guard on the right side of the lower wall by the room entrance and a drywall metal corner bead with a length of approximately 2 feet was exposed on the wall beside bed 1; - room [ROOM NUMBER] had a broken corner guard on the right side under the sink; room [ROOM NUMBER] had a broken corner guard on the right side under the sink. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the same day at 11:25 AM, the Maintenance director (Staff #7) was interviewed about the facility's process for informing him/her about environmental concerns in the building. Staff #7 reported that the facility uses a system called TELS. The facility staff sends building concerns or service requests through the system and then proceeded to show the surveyor his mobile phone which he used to access the system and reported that he had 0 orders or concerns at that time. TELS is a web-based software designed to help maintenance teams in managing building tasks and tracking work orders for completion. A tour of the 4 units of the facility was conducted with Staff #7 and s/he verified all the concerns that were noted by the surveyors. Staff #7 indicated that most of the damage was caused by residents hitting the walls with their wheelchairs and that the building was old and in need of renovation to freshen up. Staff #7 also reported that s/he had already received a shipment of the corner guards a week prior and would start working on replacing the broken ones right away. On 2/2/24 at 11:37 AM, the surveyor discussed the concern with the Director of Nursing that environmental issues identified in the initial part of the survey had not been identified and/or reported by any staff to maintenance in the last 3 weeks.

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review and staff interview, it was determined the facility failed to document what preparation and orientation was given to residents to ensure an orderly transfer to an acute care facility. This was evident for 1 (#241) of 4 residents reviewed for hospitalization . The findings include: 1) 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. On 12/24/23 at 8:54 PM, in an 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. Continued review of the medical record failed to reveal any documentation that the resident had received an explanation of why he/she was going to the emergency room and the potential response of the resident's understanding 2) 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. On 1/18/24 at 11:14 PM, in a nurse's note, the nurse documented that Resident #241 had a change in mental status, the physician was notified and recommended the resident sent out to the hospital. Continued review of the medical record failed to reveal any documentation that the resident had received an explanation of why he/she was going to the emergency room and the potential response of the resident's understanding. The above concerns were discussed with the Director of Nurses on 1/24/24 at 4:54 PM, who offered no comments 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and staff interviews, it was determined that the facility staff 1) failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory time frames to facilitate appropriate care planning and maintain current and accurate assessment records, and 2) failed to failed to assess a resident's cognition and mood on comprehensive and quarterly MDS assessments. This was evident for 8 (#98, #281, #130, #245, #282, #235, #241 and #54) of 67 residents reviewed during the survey. The findings include: The MDS is a federally mandated assessment tool nursing home staff use to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. The Admission MDS assessment is a comprehensive assessment for new residents and, under some circumstances, returning residents. It must be completed by the end of day 14, counting the date of admission to the facility as day 1. The Annual MDS assessment is a comprehensive assessment for a resident that must be completed annually (at least every 366 days) unless a Significant Change in Assessment has been completed since the most recent comprehensive assessment was completed. Completion of the Comprehensive Annual MDS assessment, including the Care Area Assessments (CAA), must be completed no later than 14 days after the Assessment Reference Date (ARD). The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods. 1a) On 1/19/24 at 1:17 PM, a medical record review for Resident #98 showed an MDS assessment, with ARD 12/10/23, that documented Resident #98 was admitted from an acute hospital to the facility on [DATE]. Continued review revealed that Resident #98's Admission MDS assessment with ARD 12/10/23 was signed as complete on 12/28/23, 21 days after Resident #98's admission to the facility and 7 days late. 1b) A review completed on 2/1/24 of Resident #281's Admission MDS assessment with ARD 1/12/24 revealed that Resident #281 was admitted to the facility on [DATE]. Further review of the MDS assessment revealed that the admission MDS assessment was due on 1/19/24; however, it was signed as completed on 1/28/24, 23 days after Resident #281's admission to the facility and 9 days late. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) A review completed on 2/1/24 of Resident #130's Admission MDS assessment, with ARD 9/21/23, revealed that Resident #130 was admitted to the facility on [DATE]. Further review of the MDS assessment revealed that the admission MDS assessment was due on 10/4/24; however, it was not completed until 10/10/23, on day 20 after Resident #130's admission to the facility and 4 days late. 1d) A review completed on 2/1/24 of Resident #245's Admission MDS assessment, with ARD 12/29/23 , revealed that Resident #245 was admitted to the facility on [DATE]. Further review of the MDS assessment revealed that the admission MDS assessment was due on 1/5/24. However, it was not completed until 1/6/24, on day 15, after Resident #245's admission to the facility and 1day late. 1e) A review of medical records for Resident #282 on 1/16/24 at 10:51 AM, revealed that Resident #282 was admitted to the facility on [DATE]. Further review of the MDS assessment revealed that the admission MDS assessment was due on 1/11/24. However, it was not completed until 1/19/24, on day 22, after Resident #282's admission to the facility and 8 days late. On 1/23/24, at 2:00 PM, during an interview with the Director of Nursing, she reported that several MDS assessments had been completed late in January 2024. On 2/1/24 at 12:44 PM, during an interview with the Nursing Home Administrator, she stated she was unaware of all the late MDS assessments and would call the Regional MDS person for an explanation. On 2/1/24 at 3:18 PM, the Nursing Home Administrator returned to the surveyor and stated that the Corporate MDS person indicated there were staffing challenges with the MDS department and was working on it to resolve them. On 2/2/24 at 9:33 AM, during an interview with staff #26, an MDS coordinator indicated that she was aware of all the late MDS assessments and needed to re-evaluate her time management. 37276 2a) Review of Resident #235's medical record on 1/24/24 at 10:15 AM, revealed that the resident's 5-day, Admission MDS with an Assessment Reference Date (ARD) of 12/25/23 was not fully completed. Section C, Cognitive Patterns was not assessed and Section D - Mood was not assessed. 2b) Review of Resident #241's medical record on 1/24/24 at 11:00 AM, revealed that the resident's 5-day, Admission MDS with an Assessment Reference Date (ARD) of 12/23/23 was not fully completed. Section C, Cognitive Patterns was not assessed and Section D - Mood was not assessed. On 1/24/24 at 12:56 PM, during an interview, the MDS Coordinator, Staff #26, RN confirmed the above assessments were not completed on the comprehensive assessments and stated that the Social Worker was responsible for assessing a resident's cognitive status and mood and completing those sections of the MDS. During an interview on 1/24/24 at 2:05 PM, the Social Service Director, Staff #9 confirmed that social work completed resident cognitive and mood assessments in the MDS. When made aware of the above MDS concerns, the Social Service Director stated that cognitive and mood assessments must be completed during the resident's MDS ARD observation or look back period to be captured in the MDS, and assessments that are not completed during the look back period cannot be added to the MDS. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, Staff #9 indicated that cognitive and mood assessments for Resident #235 were not completed in the resident's MDS ARD 12/25/23 look back period, and that Resident #235's cognitive status was assessed on 12/26/23, which was after the MDS ARD date. Staff #9 also indicated that cognitive and mood assessments for Resident #241 were not completed in the look back period of the resident's MDS ARD 12/23/23 and that a BIMS assessment was completed on Resident #241 on 1/10/24. 2c) Review of Resident #54's medical record on 1/30/24 at 11:11 AM, revealed that the resident's quarterly MDS with an Assessment Reference Date (ARD) of 11/12/23 was not fully completed. Section C, Cognitive Patterns was not assessed and Section D - Mood was not assessed. On 1/30/24 at 12:27 PM, the Social Services Director, Staff #9 confirmed Resident #54's cognitive and mood assessments were not completed in the MDS ARD 11/12/23. Staff #9 stated that Resident #54's had a Brief Interview for Mental Status (BIMS) assessment completed in the electronic health record (EMR), however, it had not been completed before the MDS ARD date. Staff #9 offered no further explanation as to the reason for the late assessments.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure that each resident's assessment is updated at least once every 3 months. 48259 Based on record review and interviews, it was determined that the facility failed to complete Quarterly Minimum Data Set (MDS) assessments for residents within the regulatory time frames to facilitate appropriate care planning and maintain current assessment records. This was evident for 11 (#85, #28, #65, #183, #59, #54, #43, #77, #18, #63, #3) of 67 residents reviewed during the survey. The findings include: The MDS is a federally mandated assessment tool nursing home staff use to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. The completion date of the Quarterly assessment must be within 92 days of the MDS Completion Date of the last OBRA assessment. The Quarterly assessment must be completed no later than 14 days after the ARD. That is the ARD + 14 days. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods. 1) The following quarterly MDS assessments were not completed within the regulatory timeframe based on their most recent OBRA assessment. 1a) A review of Resident #85's Quarterly MDS assessment with ARD 11/26/23 showed that it was due on 12/10/23. However, it was completed and signed in section Z0500B on 12/17/23, 21 days after the ARD. 1b) Review of Resident #28's Quarterly MDS assessment with ARD 12/19/23 showed that it was due on 1/2/24; however, it was completed and signed in section Z0500B on 1/12/24, 24 days after the ARD. 1c) A review of Resident #65's Quarterly MDS assessment with ARD 11/10/23 showed that it was due on 11/24/23; however, it was completed and signed in section Z0500B on 12/13/23, 33 days after the ARD. 1d) A review of Resident #183's Quarterly MDS assessment with ARD 9/4/23 showed that it was due on 9/18/23; however, it was completed and signed in section Z0500B on 10/9/23, 35 days after the ARD. 1e) A review of Resident #59's Quarterly MDS assessment with ARD 12/16/23 showed that it was due on 12/30/23; however, it was completed and signed in section Z0500B on 1/2/24, 17 days after the ARD. 1f) A review of Resident #54's Quarterly MDS assessment with ARD 11/12/23 showed that it was due on 11/26/23; however, it was completed and signed in section Z0500B on 12/13/24, 31 days after the ARD. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1g) A Review of Resident #43's Quarterly MDS with ARD 12/10/23 showed that it was due on 12/24/23; however, it was completed and signed in section Z0500B on 12/28/23, 18 days after the ARD. 1h) A Review of Resident #77's Quarterly MDS with ARD 11/12/23 showed that it was due on 11/26/23. However, it was completed and signed in section Z0500B on 12/7/23, 25 days after the ARD. 1i) Review of Resident #18 ' s Quarterly MDS with ARD 12/20/23 showed that it was due on 1/3/24 however, it was completed and signed in section Z0500B on 1/6/24, 17days after the ARD. 1j) Review of Resident #63 ' s Quarterly MDS with ARD 12/23/23 showed that it was due on 1/4/24 however, it was completed and signed in section Z0500B on 1/12/24, 20days after the ARD. 1k) Review of Resident #3 ' s Quarterly MDS with ARD 12/8/23 showed that it was due on 12/22/23 however, it was completed and signed in section Z0500B on 12/24/23, 16days after the ARD. On 2/1/24 at 3:18 PM, during an interview with the Nursing Home Administrator, she stated that the corporate person in charge of MDS was aware of the challenges with staffing and was trying to get help to catch up with the assessment and to be on time with their completion. On 2/2/24 at 9:33 AM, an interview with staff #26, an MDS Coordinator, revealed that she was aware of all the late MDSs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#91) of 2 residents reviewed for dental status, 1 (#98) of 3 residents reviewed for resident assessment, 2 (#65, #54) of 5 residents reviewed for unnecessary medications and 1 (#129) of 4 residents reviewed for hospitalization . The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. Active diagnoses documented on the MDS assessment are attending provider-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. The findings include: 1) A record review was completed for Resident #65 on 1/11/24 at 1:14 PM. The review noted that Resident #65 was admitted to the facility in September 2022. His/her diagnoses included Bipolar disorder, Atrial fibrillation, and Hypothyroidism per an attending provider's note of 7/25/23. A continued review revealed an order summary report for August 2023 that revealed an order initiated on 8/5/23 for Vancomycin IV 1.25 grams one time a day for Methicillin-resistant Staphylococcus aureus for four weeks (MRSA infection-caused by a type of staph bacteria that's become resistant to many antibiotics) and an order initiated on 8/5/23 for oxygen at 3 Liters per minute via nasal cannula. On 1/12/24 at 10:04 AM, the surveyor completed a record review for Resident #65. The review revealed an MDS assessment, dated 8/10/23, that documented an active diagnosis of deep vein thrombosis (DVT- blood clot in a deep vein, usually in the legs) in section I-Active diagnosis. However, further record review for Resident #65 failed to show evidence that the resident had an active diagnosis of deep vein thrombosis. A subsequent review of the MDS assessment for Resident #65 dated 8/10/23 was done on 1/16/24 at 12:56 PM. The review showed that the MDS assessment recorded six days of antibiotic use in section N-Medications and a No for oxygen use in section O. However, further review revealed Resident #65's medication and treatment administration record for August 2023 with documentation of five days of antibiotic use and six days of oxygen use for the observation period of the 8/10/23 MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/24 at 10:07 AM, an interview was conducted with Staff #26, MDS Coordinator. During the interview, s/he confirmed that six days of antibiotic use recorded on Resident #65's MDS assessment, dated 8/10/23, was documented in error and should have been recorded as five. S/he also confirmed that the diagnosis of DVT recorded on the MDS was inaccurate and that she would modify the MDS assessment. On 1/22/24 at 10:53 AM, during an interview with Staff #26, s/he stated that Resident #65's use of oxygen during the observation period for his/her MDS assessment, dated 8/10/23, was omitted in error. 2) On 1/19/24 at 1:17 PM, the surveyor completed a medical record review for Resident #98. The review revealed that Resident #98 was admitted to the facility in December 2023 with diagnoses including Pneumonia, Heart failure, and Diabetes. Continued review of the medical record for Resident #98 revealed an attending provider's order initiated on 12/8/23 for Oxygen at 2 liters per minute via nasal cannula continuously every shift and to notify the attending provider if oxygen saturation (Sp02-is a measurement of how much Oxygen your blood is carrying in percentage. For a healthy individual, the normal SpO2 should be between 96% to 99%) is less than 92%. On 1/19/24 at approximately 2:00 PM, a subsequent record review was completed for Resident #98. During the review, it was noted that Resident #98's medication and treatment administration record for December 2023 had documented oxygen therapy use from 12/8/23 to 12/10/23. However, further review of the record on the same day revealed that Resident #98's MDS assessment, dated 12/10/23, failed to capture the oxygen use from 12/8/23 to 12/10/23. Additionally, the MDS assessment had documented anticoagulation medication use in section N. However, the medication administration record and order summary report for December 2023 failed to show an attending provider's order for anticoagulant medication. On 1/22/24 at 10:31 AM, an interview was done with Staff #26, an MDS Coordinator. During the interview, s/he confirmed that the documentation of anticoagulant medication use on Resident #98's MDS assessment dated [DATE] was done in error. S/he also stated that Resident #98's use of Oxygen from 12/8/23 to 12/10/23 was missed on the 12/10/23 MDS assessment. 45139 3) On 1/10/24 at 9:36 AM, Resident # 91, a long-term resident of the facility was interviewed. During the interview s/he reported that s/he had upper dentures, however, Resident #91 reported s/he had not taken them out to clean because s/he had nowhere to put them. An observation during the interview failed to reveal a denture cup on the bedside table or in the bed side table drawer. On 1/11/24, a review of Residents #91 MDS section GG dated 12/31/23, revealed that Resident #91 required substantial maximal assistance from the facility staff for oral hygiene which would include: placing and removing dentures to/from his/her mouth, and managing the soaking and rinsing of the dentures if a resident had dentures. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/12/24 at 12:19 PM, a review of the initial admission nursing assessment dated [DATE], revealed a section designated to the evaluation of the resident oral health. The assessment provided a check off box for partial dentures. Further review of the document failed to reveal the partial denture box had checked off indicating the presence of partial dentures. On 1/12/24 at 2:56 PM, GNA, Staff #21 reported that s/he had taken care of Resident #91 regularly for months on the first floor, Clear Spring unit, where s/he was first admitted . She reported that Resident #91 did not have dentures, but had his/her own teeth. On 1/17/24 at 11:16 AM, a review of Resident #91's hard chart revealed a document titled Inventory of Personal Effect, dated 6/27/23 was performed. Review of this document failed to reveal the resident had dentures present on admission. On 1/17/24 at 10:28 AM, a review of the speech therapy (SLP) evaluation and plan of treatment for Resident #91 provided by the Director of Therapy on 1/17/24 at 10:10. AM, failed to reveal that the resident had partial upper dentures. On 1/24/24 at 8:09 AM, during an interview with the Director of Rehabilitation, s/he reported that Resident #99 had received a swallowing evaluation by the speech therapist. In addition, the Director of Rehabilitation reported that the expectation would have been that a speech therapist would document the presence of dentures when documenting a swallowing evlauation. On 1/24/24 at 7:53 AM, the nurse unit manager, Staff #23, was interviewed. During the interview, Staff #23 reported that s/he had recently an visualized upper denture on Resident #91. Staff #23 reported that s/he had provided the resident with a denture cup. 01/24/24 at 8:31 AM, an interview with the Director of Nursing (DON) reported that dentures, hearing aids and glasses should be included on the personal effects inventory checklist completed by the admission nurse. In addition, the use of hearing aids, glasses and upper or lower dentures should be part of the resident's admission assessment. The DON confirmed that the assessments failed to reveal the resident had dentures and reported that this had been corrected. -- 37276 4) On 1/19/24 at 11:30 AM, a review of Resident #129's electronic medical record (EMR) revealed documentation that Resident #129 was admitted to the facility in late October 2023 and discharged from the facility in November 2023. In the medical record, there was a physician's order to discharge Resident #129 11/8/23. On 11/8/23 at 1:42 PM, the nurse documented that Resident #129 had been discharged home with the resident's family. Review of Resident # 129's discharge MDS with an ARD of 11/8/23, Section A2000. discharge date documented Resident #129 was discharged on [DATE]. Section A2105 Discharge Status was coded 04, Short-Term General Hospital, indicating Resident #129 had been discharged to the hospital. This was inaccurate as Resident #129 had been discharged home. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/24 at 12:56 PM, when made aware of the above concern, Staff #26, RN, MDS Coordinator confirmed the MDS inaccuracy and stated that the MDS had been completed by remote MDS staff. 5) On 1/29/24 at 2:20 PM, a review of Resident #54's medical record revealed documentation that Resident #54 was admitted to the facility in August for 2023 following an acute hospitalization and had diagnoses which included depression. On 8/10/22 at 4:22 PM, in a NP (nurse practitioner) progress note, the practitioner documented Resident #54 had depression and was on an antidepressant (escitalopram). On 8/21/23, in a Psychiatry Note, the Certified Registered Nurse Practitioner/psychiatric Mental Health (CRNP-PMH) documented Resident #54's an International Classification of Diseases (ICD) code of Bipolar I disorder (mood disorder which causes unusual shifts in mood including depression) depressed, mild, indicating the resident had a diagnosis of bipolar disorder and was depressed. On 11/9/23 at 3:00 PM, in a progress note, the physician documented Resident #54 had a history of depression. Review of Resident #54's physician orders revealed an active order for Escitalopram (Lexapro) (anti-depressant) by mouth one time a day for depression which was ordered on 8/8/23, indicating Resident #54 received the antidepressant by mouth every day since 8/8/23. Review of Resident #54's Quarterly MDS with an ARD of 11/12/23, Section N. Medications N0415. High Risk Drug classes: use and indication, documented Resident #54 was taking an antidepressant. Further review of the MDS revealed Section I, Active Diagnosis, Psychiatric/Mood Disorder I5800. Depression (other than bipolar) was blank, indicating Resident #54 did not have an active diagnose of depression, and Section I5900 Bipolar disorder was blank, indicating the resident did not have an active diagnose of bipolar disorder. The MDS failed to capture Resident #54's diagnosis of depression. On 1/30/24 at 1:46 PM, during an interview, when made aware of the above concerns related to the MDS's failure to capture Resident #54's depression diagnoses, Staff #26, RN, MDS Coordinator, responded that s/he would modify the MDS.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on medical record review and interview, it was determined that the facility failed to ensure a new Preadmission Screening and Resident Review (PASRR) was completed when it was determined that a resident would remain in the facility for long term care. This was found to be evident for 1 (Resident #63) out of 1 resident reviewed for PASRR during the survey. The findings include: On 1/18/24 review of Resident #63's medical record revealed the resident was originally admitted to the facility in June of 2022. The resident's diagnoses included, but were not limited to, Schizoaffective Disorder Bipolar type. The resident had a brief hospitalization in August 2023, after which s/he was readmitted to the facility. The PASRR form includes four sections. Section A includes 3 questions: 1. Is the individual admitted to a NF [nursing facility] directly from a hospital after receiving acute inpatient care? 2. Does the individual require NF services for the condition for which he received care in the hospital? and 3. Has the attending physician certified before admission to the NF that the resident is likely to require less than 30 days in NF services? If any of these three questions are answered NO the remaining portions of the form must be completed as per the directions. Section C of the PASRR has questions to identify if the resident has serious mental illness and include: 1. Diagnosis- Does the individual have a major mental disorder; 2. Level of Impairment - Has the disorder resulted in serious functional limitations in major life activities within the past 3-6 months; and 3. Recent treatment-In the past 2 years, has the individual had psychiatric treatment more intensive than outpatient care more than once or inpatient hospitalization ; or experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials. On 1/18/24 a review of a 11/20/23 psychiatric nurse practitioner note (NP#54) revealed the resident had a past psychiatric admission at one of the state's psychiatric hospitals. No date was found as to when this admission occurred. On 1/22/24 at 10:30 AM, the psychiatric NP (#54) confirmed that the resident did report an inpatient admission in the past, but was unable to provide additional information regarding the dates of admission. On 1/18/24, review of the paper chart revealed one PASRR form that included a facility admitted [DATE]. The PASRR failed to include a signature to indicate who completed the form, or a date to indicate when it was completed. On 1/18/24 at 10:39 AM, the unit nurse manager (Staff #23) reported previous screens should be uploaded to the electronic health record (EHR). Review of the EHR at this time failed to reveal a previously completed PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/24 at 10:54 AM, the social service coordinator (SSC Staff #13) reported that they receive the PASRRs from the hospital and that they check to see if they are completed correctly and if not, they will re-do them. Surveyor then reviewed the PASRR that is currently on the chart, dated 9/1/23, with no signature as to who completed the screen. The SSC #13 reported that it would havebeen her signature on that screen and reported all of her PASRRs are in the back of the chart. Surveyor and SSC #13 reviewed the chart together and SSC #13 confirmed that the only PASRR present was the 9/1/23 screen. SSC #13 reported the chart may have been thinned and surveyor requested a copy of previous PASRR for this resident. On 1/23/24 at 3:42 PM, surveyor requested any previous PASRR from the social work director (SSD Staff #9). Sureyor informed the SSD #9 that the psychiatric note indicated there had been a previous psychiatric inpatient admission, but the notes did not indicate when. On 1/23/24 at 4:27 PM, the SSD #9 provided a PASRR, dated 6/15/22. This PASRR revealed all three questions in Section 1 were answered Yes, indicating the resident's stay was going to be less than 30 days. When asked what should occur if a resident transitions to long term care, the SSD #9 replied that a new PASRR should be completed. She indicated she would check to see if another PASRR was completed. On 1/31/24 at 3:45 PM, surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure the PASRR screen was re-done when it was determined that the resident would be remaining in the facility for more than 30 days. As of time of survey exit on 2/2/24 at 5:15 PM, no documentation was provided to indicate that a new PASRR screen was completed in 2022 when it was evident that the resident would remain in the facility for more than 30 days.

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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 37276 Based on medical record review and resident and staff interview, it was determined the facility failed to provide a resident and/or a resident's representative with a summary of the baseline care plan that included a summary of the resident's medications. This was evident for 2 (#54, #235) of 6 residents reviewed careplanning. The findings include: A baseline care plan must be completed within 48 hours of a resident's admission to the facility and must include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the baseline care plan as well as a list of the resident's current medications must be given to each resident. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 1/24/24 at 10:20 AM, during an interview, the Director of Nurses (DON) stated that baseline care plans were developed for a resident upon the resident's admission to the facility, that the resident or resident representative was given a copy of the care plan along with summary of their medications during their care plan meeting and to check the social services notes for documentation. On 1/24/24 at 11:22 AM, a review of Resident #54's electronic medical record (EMR) was conducted and revealed Resident #54 was admitted to the facility in August 2023 following an acute hospital stay. Resident #54's admission assessment with an assessment reference date (ARD) of 8/12/23, documented Resident #54's Brief Interview for Mental Status summary score was 13, indicating Resident #54 was cognitively intact A review of Resident #54 paper medical record revealed a care plan signature sheet, dated 8/24/23, that listed the signatures of the persons who attended the resident's care plan meeting and signed by members of the facility's interdisciplinary team and signed by the resident's spouse. On 8/24/23 at 8:04 AM, in a care plan note, the nurse documented that a care conference was held and attended by activities, dietary, nursing, rehab and social services, and that Resident #54 was unable to participate due to cognitive limitations. The nurse also documented that a copy of the care plan was provided. Continued review of Resident #54's medical record failed to reveal documentation that a summary of the resident's medications had been provided to the resident and/or resident representative, when provided a copy of their care plan. On 1/24/24 at 11:50 AM, during an interview, Staff #9, Social Services Director stated that during the resident's care plan meeting, a resident or their representative would be given a copy of their care plan and indicated s/he did not give them any other documents, including a summary of their medications. 2) On 1/10/24 at 10:19 AM, when asked if the resident had received a copy of his/her base line care plan, along with a summary of his/her medications, Resident #235 stated the s/he could not recall getting a copy of a care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24 at 10:12 AM, review of Resident #235's medical record revealed a completed admission assessment with an ARD of 12/24/24. Continued review of the medical record failed to reveal documentation that, following the completion of the resident's admission assessment, a care plan meeting had been conducted, and there was no documentation found to indicate that Resident #54 had been provided a copy of his/her base line care plan along with a summary of his/her medications. On 1/25/24 at 11:10 AM, Staff #9, Social Service Director was made aware of the above concerns and indicated s/he would look into it. As of the time of exit on 2/2/24 at 5:15 PM, no additional documentation was provided to indicate Resident #235 had received a copy of his/her care plan along with a summary of the resident's medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 16218 Based on medical record review and staff interview, it was determined that facility staff failed to develop and implement comprehensive, person-centered care plans, with measurable goals and non-pharmacological approaches. This was found to be evident for for 1 (#63) of 4 residents reviewed for position and mobility, and 2 (#54, #21) of 5 residents reviewed for unnecessary medications The findings include: The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) Review of Resident #63's medical record revealed that the resident was originally admitted to the facility in June of 2022. The resident's diagnosis included, but was not limited to, Schizoaffective Disorder Bipolar type and lung disease. On 1/17/24 at 10:48 AM, review of the 6/24/23 annual Minimum Data Set Assessment revealed the resident was interviewed in regard to the Preferences for Routine and Activities (Section F). Review of this assessment revealed it was very important to the resident to have books, newspapers and magazines to read; to listen to music s/he likes, to keep up with the news and to do his/her favorite activities. The assessment also revealed it was somewhat important to go outside when the weather was good, to be around animals such as pets and to attend religious activities. Review of the resident's current care plan failed to reveal a plan or any interventions to address the residents activity preferences. Further review of the medical record revealed that an interdisciplinary care plan meeting was held on 10/10/23. The corresponding note for this meeting indicated that a representative from the activities department attended the meeting. On 1/23/24 at 12:01 PM, the Activity Director, Staff #6 confirmed that s/he had attended care plan meetings for Resident #63. When asked if there was a care plan addressing activities for Resident #63, the Activity Director responded that there should be one for everyone. After surveyor reviewed the concern that no care plan addressing activities was found for this resident, the Activity Director reported that no one had mentioned to them that there was no care plan. As of time of survey exit on 2/2/24 at 5:15 PM no documentation was provided to indicate the resident had a care plan addressing activities prior to 1/17/24. Cross reference to F 679 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37276 2) On 1/18/24 at 12:00 PM, a review of Resident #54's medical record revealed the resident was admitted to the facility in August 2023 and had diagnoses which included dementia, depression, mood disorder, and anxiety. Review of Resident #54's January 2024 MAR revealed the resident received psychotropic medications, which included 2 antipsychotics, an antidepressant and an antianxiety medication. The orders were: - Aripiprazole (Abilify) (antipsychotic) 10 MG by mouth one time a day for anxiety disorder and unspecified dementia with dementia symptoms, start date 8/8/23, discontinued on 1/16/24, that was documented as given every day from 1/1/24 to 1/16/24 - Aripiprazole10 MG by mouth one time a day for negativism/repetitive sentences/questions, start date 1/17/24 that was documented as given on 1/17/24 and 1/18/24. - Olanzapine (Zyprexa) (Antipsychotic) 2.5 MG by mouth two times a day for depression/mood disorder, start date 8/7/23, that was documented as given twice a day, every day from 1/1/24 thru 1/17/24, and 1/18/24 at 8:00 AM. - Buspirone HCl (Buspar) (anti-anxiety medication)10 MG by mouth every 8 hours for anxiety, start date 8/7/23, that was documented as given 3 times a day, every day from 1/1/24 to 1/17/24, and twice on 1/18/24. - Escitalopram Oxalate (Lexapro) (antidepressant) 10 MG by mouth one time a day for depression, start date 8/8/23, that was documented as given every day from 1/1/24 to 1/18/24. Review of Resident #54's care plans revealed a care plan, At risk for adverse effects related to: antipsychotic, anti-anxiety, antidepressant medication with the goal, to show minimal/ no side effects of medications taken. Continued review of Resident #54's care plans failed to reveal a comprehensive care plan, with resident centered measurable goals and interventions that addressed Resident #54's use of the psychotropic medications, including the targeted behaviors for which the psychotropic medications had been prescribed, and non-pharmacological approaches and interventions. On 1/30/24 at 2:30 PM, the DON was made aware of the above concerns, and offered no further comments at that time 3) On 1/29/24 at 12:00 PM, a review Resident #21's medical record revealed the resident currently resided in the facility for long term care and had diagnosis which included schizophrenia (mental disorder characterized by reoccurring episodes of psychosis that were correlated with a general misperception of reality), major depressive disorder (mood disorder), bipolar disorder (manic depression) (mood disorder that causes intense mood swings), and unspecified dementia, moderate, with other behavioral disturbance (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's January 2024 Medication Administration Record (MAR) revealed a 9/22/21 order for Escitalopram Oxalate (Lexapro) (antidepressant) tablet 10 milligrams (MG) Give 1 tablet by mouth one time a day for depression, that was signed off as given every day in January, from 1/1/24 to 1/23/24, then discontinued, and there was 1/24/24 order for Lexapro 5 MG by mouth one time a day for major depressive disorder, that was signed off as given every day from 1/24/24 to 1/29/24. Review of Resident #21's January 2024 Medication Administration Record (MAR) revealed Resident #21 received psychotropic medications (drugs that affect brain activities and are used to treat mental health disorders). There was a 9/22/21 order for Escitalopram Oxalate (Lexapro) (antidepressant) tablet 10 milligrams (MG) Give 1 tablet by mouth one time a day for depression, that was signed off as given every day from 1/1/24 to 1/23/24 in January, then discontinued, and there was a 1/24/24 order for Lexapro 5 MG by mouth one time a day for major depressive disorder, that was signed off as given every day from 1/24/24 to 1/29/24. The MAR also documented a 5/2/23 order for Mirtazapine (antidepressant) by mouth at bedtime for appetite/depression that was signed off as given every day from 1/24/24 to 1/28/24, and there was a 1/21/22 order for Olanzapine Tablet (Zyprexa) (antipsychotic) (treats mental/mood disorders) 7.5 MG Give 1 tablet by mouth at bedtime for Schizophrenia that was signed off as given every day from 1/24/24 to 1/29/24 in January 2024. Review of Resident #21's care plans revealed a care plan, At risk for behavior symptoms r/t dementia, schizophrenia, anxiety, major depression, initiated on 6/9/21, with the goal, will accept care and medications as prescribed, and the interventions, 1) Administer medications per physician order, 3) 'Psych referral as needed', and 4) Use consistent approaches when giving care. The care plan was not specific to Resident #21 and failed to identify the resident's behaviors for which an antipsychotic and antidepressant medications had been prescribed and failed to include non-pharmaceutical interventions or actions to help with the resident's behaviors for which psychotropic medication had been prescribed. Continued review of Resident #21s care plans failed to reveal a comprehensive care plan, with resident centered measurable goals and interventions that addressed Resident #21's use of the psychotropic medications, including the targeted behaviors for which the psychotropic medications had been prescribed, and non-pharmacological approaches and interventions. The above concerns were discussed with the Director of Nurses on 1/29/24 at 1:32 PM and the DON offered no comments at that time.

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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. 16218 Based on medical record review and staff interview, it was determined that facility 1) failed to ensure interdisciplinary team meetings to review and revise the care plans following each assessment, 2) failed to evaluate and update a resident's plan of care after each assessment and 3) failed to ensure that a resident and resident representative, if applicable, had the opportunity to participate in the development, review, and revision of his/her care plan after each assessment. This was evident for 4 (#53, #59, #54, #235) of 6 residents reviewed for care plan timing and revision, 1 (#68) of 6 residents reviewed for communication and sensory problems, and 1 (#106) of 2 residents reviewed for behavioral and emotional status and 1 (#21) of 5 residents reviewed for unnecessary medications. The findings include: The Minimum Data Set (MDS) is part of the Resident Assessment Instrument, federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. The resident's MDS assessment provides the facility with the 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. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences (meetings) at a time the resident representative is available to participate, holding conference calls or video conferencing. 1) Review of Resident #53's medical record revealed that 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 15/15. Review of the medical record revealed MDS assessments with Assessment Reference Dates of 6/30/23 and 9/30/23. Further review of the medical record failed to reveal documentation to indicate that a care plan meeting occurred between these two assessments. On 1/12/24 at 12:03 PM, the Social Service Coordinator (SSC), Staff #13, reported that the care plan meetings were scheduled through the MDS. When surveyor reviewed the concern that there was no documentation found to indicate a meeting occurred between the June and September MDS assessments, the SSC responded that she doesn't do the scheduling, she gets the list from MDS. She then confirmed that the meeting was missed. The concern regarding the failure to have the care plan meeting after the MDS assessment was reviewed with the DON on 1/31/24 at 3:45 PM. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of Resident #68's medical record revealed an admitted in 2022. The resident has diagnoses of, but were not limited to, dementia, heart failure, hypothyroidism and high cholesterol. The resident was seen by an ENT physician on 12/1/23, found to have a mild hearing loss with a recommendation for an audiology appointment for a hearing aide. Review of the current care plans revealed a plan with a focus of: Difficulty communicating related to left and right ear wax build up. This plan was initiated on 10/23/23. Further review of the medical record revealed that a care plan meeting occurred on 12/12/23. No documentation was found in this, or any of the residents other care plans, to indicate that the ENT appointment had occurred, identified a hearing loss and that there was recommendation for an audiology appointment for a hearing aide. Further review of the medical record revealed an MDS with an ARD of 12/16/23 but failed to reveal documentation to indicate that a care plan meeting occurred after the completion of the December MDS. On 1/31/24 at 3:45 PM the concern regarding failure to have a care plan meeting after the December MDS was reviewed with the Director of Nursing. Cross Reference to F 685 3) Review of Resident #59's medical record revealed an admitted in 2020. On 1/16/24, review of the electronic health record revealed a MDS, with an Assessment Reference Date of 12/16/23, but no documentation was found to indicate that a care plan meeting had occurred since the completion of that assessment or that one was currently scheduled. On 1/18/24 at 2:16 PM, the SSC #13, when asked if there has been a care plan meeting since the last MDS assessment, reported the resident's last MDS was 12/16 and that no meeting was scheduled but that she can get him/her added. She reported MDS usually sends the schedules but confirmed this resident was missed. 4) Review of Resident #106 medical record revealed an admitted in April 2023 with diagnosis that include, but not limited to, history of stroke, high blood pressure, diabetes, lung disease and dementia. On 1/12/24, review of the electronic health record revealed documentation of one care plan meeting, held 5/18/23, since the resident's admission in April. Further review of the medical record revealed an MDS with an ARD of 10/27/23 but no documentation was found to indicate that a meeting was held or was currently scheduled to review the care plan. On 1/12/24 at 12:26 PM, surveyor reviewed the concern with the Social Service Coordinator (Staff #13) that only one care plan meeting had occurred for the resident's entire stay at the facility. On 1/31/24 at 3:45 PM, surveyor reviewed the concern with the DON of the failure to have a care plan meeting after an MDS assessment. As of time of survey exit on 2/2/24 at 5:15 PM, no additional documentation was provided to indicate any additional care plan meetings were held for this resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross reference to F 740. 37276 5) On 1/11/24 at 9:18 AM, during an interview, when asked if the resident attended his/her care plan meetings, Resident #54 stated s/he was not aware of care plan meetings. On 1/11/24 at 9:55 AM, review of Resident #54 paper medical record revealed a care plan signature sheet dated 8/24/23, that listed the facility's interdisciplinary team and the resident's spouse. There was no resident signature indicating Resident #54 did not attend his/her 8/24/23 care plan. On 1/24/24 at 11:22 AM, a review of Resident #54's medical record revealed that Resident #54 was admitted to the facility in August 2023 following an acute hospital stay. Resident #54's admission assessment with an assessment reference date (ARD) of 8/12/23, documented Resident #54's Brief Interview for Mental Status summary score was 13, indicating Resident #54 was cognitively intact. Review of Resident #54's progress notes revealed on 8/23/24 at 6:09 PM, in a skilled nursing note, the nurse documented that Resident #54 was alert and oriented. In a progress note on 8/24/23 at 8:04 AM, in a care plan note, the nurse documented that a care conference was held, and that Resident #54 was unable to participate due to cognitive limitations. Continued review of the resident's medical record failed to reveal documentation that Resident #54 was provided advance notice of the care plan conference to enable the resident to participate and no further documentation was found to indicate the reason for excluding Resident #54 from the opportunity to participate in the development and review of his/her care plan. On 1/24/24 at 11:50 AM, during an interview, Staff #9, Social Service Director stated that a resident had the right to come to their own care plan meeting, and the resident was the one to decide who they wanted to come to their meeting. Staff #9 was made aware of the above concerns and stated at the time the resident's care conference was held, s/he didn't work at the facility and the nurse who wrote the care plan note was not in facility. Staff #9 indicated Resident #54 should have been invited to his/her care plan meeting and that s/he was unsure why the resident had not been invited. 6) On 1/12/24 at, a 9:45 AM, a review of Resident #21's medical record revealed that the resident resided in the facility for long term care and had diagnoses which included dementia, schizophrenia (mental disorder characterized by reoccurring episodes of psychosis that are correlated with a general misperception of reality), major depressive disorder (mood disorder), and bipolar disorder (manic depression) (mood disorder that causes intense mood swings). Review of Resident #21's quarterly MDS assessment with Assessment Reference Date (ARD) of 8/14/23 documented Resident #21's Brief Interview for Mental Status (BIMS) score was 6, and the resident's quarterly MDS with an ARD of 11/14/23 documented Resident #21's BIMS score was 5, indicating Resident #21 had severe cognitive impairment. Review of Resident #21's care plans revealed a care plan initiated on 5/5/21, Cognitive loss as evidenced by confusion related to dementia, had the goal, will be able to follow simple instruction, with the interventions, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Allow adequate time to respond. Do not rush or supply words, (2) Approach/speak in a calm, positive/reassuring manner, (3) Attempt to provide consistent routines/care givers, (4) Use patients name when addressing. The care plan was not comprehensive with a resident specific measurable goal, and the care plan did not identify what Resident #21's current level of cognitive function was.-+ Continued review of Resident #21's medical record failed to reveal documentation to indicate that staff evaluated the residents progress toward reaching his/her goal or evaluated Resident #21's response to the care plan interventions following the resident's quarterly assessments on 8/14/23 and 11/14/23. On 1/12/24 at 3:17 PM, the Director of Nurses was made aware of the above findings and that there was no evidence in the medical record that the care plans was evaluated following the resident's assessments. The DON offered no further comments at that time. 7) On 1/25/24 at 10:12 AM, review of Resident #235's medical record was conducted and revealed the resident was admitted to the facility December 2023, following an acute hospitalization . On 12/21/23 at 4:53, in an admission note, the nurse documented Resident #235 was oriented to person, place and situation, and the resident's cognition was intact. Further review of the medical record revealed an admission assessment with an assessment reference date (ARD) of 12/25/24 had been completed for Resident #235. Continued review of Resident #235's medical record failed to reveal documentation to indicate a care plan meeting had been conducted following the resident's admission to the facility and completion of the resident's admission assessment, ARD of 12/25/24. On 1/25/24 at 11:10 AM, Staff #9, Social Service Director was made aware of the concerns that a medical record review failed to reveal evidence that a care plan meeting had been held for Resident #235 following his/her admission assessment. Staff #9 responded, stating s/he would look into it. On 1/26/24 at 11:36, Staff #9 reported to the surveyor that s/he was out on medical leave when Resident #235's care plan meeting was due. Staff #9 stated s/he spoke with the social worker and the rehab director who had been in the facility at the time Resident #235's care plan was due, and s/he was told by both that a care plan meeting with Resident #235 had been conducted, however the meeting had not been documented and there was no attendance sign-in sheet for the meeting. As of the time of exit on 2/2/24 at 5:15 PM, no additional documentation was provided to indicate a care plan meeting had been conducted with Resident #235 followng his/her admission assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45139 Based on interviews and pertinent document review, it was determined that the facility failed to provide incontinent care to a dependent resident. This was evident for 1 (#282) of 3 residents reviewed for pressure injury. The findings include: A review of medical records on 1/16/24 at 11:06 AM, revealed that Resident #282 was admitted to the facility for rehabilitation and was dependent on the facility staff for all activities of daily living. On 1/10/24 at 2:38 PM, during an interview with Resident #282's family member s/he reported that Resident #282 was not getting the incontinent care that s/he needed. S/he reported that s/he remembers that this occurred more frequently on holidays and weekends. On 1/24/24 at 11:28 AM, during an interview with nurse, RN, Staff #16 reported that s/he is familiar with Resident #282's daily care and that s/he consistently needs incontinent care twice a shift. On 1/16/24 at 11:00 AM, review of Resident # 282's medical records under Geriatric Nursing Assistant (GNA) tasks, failed to reveal documentation that Resident #282 received incontinent care on the following shifts: 1/1/24 day shift (7AM-3PM). Evening shift (3PM-11PM), and night shift (11PM-7AM). 1/2/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/4/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/9/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/10/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/12/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/22/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/23/24 evening shift (3PM-11PM), and night shift (11PM-7AM). 1/24/24 evening shift (3PM-11PM), and night shift (11PM-7AM). On 1/24/24 at 6:31 AM, GNA #42 was interviewed. During the interview she reported that sometimes s/he is too busy to complete all the required documentation during her shift. S/he continued that when this happens, s/he can complete the documentation that next day. S/he reported that there have been shifts where s/he was unable to complete incontinent care for all the residents under his/her care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24 at 1:54 PM, review of incontinent care tasks sheets for Resident #282 were reviewed with the Director of Nursing (DON) and Corporate Clinical Nurse (CCN) and the concerns discussed. The DON and the CCN reported they had no additional information or documentation to provide.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observations, medical record review, and interviews with the staff, it was determined that the facility failed to develop and implement an activities program to meet the needs and preferences of residents. This was evident for 4(#43, #71, #63, #91) of 6 residents reviewed for activites. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. 1) Observations made of Resident #43 on 1/9/24 at 11:55 AM, 1/10/24 at 1:30 PM, and 1/10/24 at 3:16 PM revealed that Resident #43 was lying in bed and not involved in any meaningful activity program. A medical record review completed on 1/16/24 at 10:30 AM revealed a care plan for Resident #43, initiated on 9/25/2020. The focus of the care plan included the Patient enjoys listening to music and religious programming. The interventions on the care plan included offer friendly visits of known interest. A continued record review for Resident #43 revealed an attending provider's note, dated 10/10/23, that recorded that Resident #43 was bedbound (confined to bed) and nonverbal. Further review revealed a Recreation/Activity evaluation dated and completed on 10/10/23 that recorded Resident #43's current leisure interests were music, religious involvement, and TV/radio. On 1/18/24 at 11:26 AM, a review of activity logs for Resident #43 for the months of December 2023 and January 2024 was completed. -The logs only recorded leisure cart visits (a visit with a cart with magazines, pens, supplies, and lotions for residents who do not communicate). However, the review failed to show that the activities provided to Resident #43 included music and religious services or practices previously documented as their current leisure interest during the Recreation/ Activity evaluation. On 1/18/24 at 8.43 AM, an interview was completed with Staff #25, an Activity Assistant. During the interview, s/he said that s/he did not know what activities to do for Resident #43 due to his/her medical conditions. S/he added that s/he did not do much with Resident #43 but passed by his/her room occasionally to ensure s/he was doing fine. On 1/23/24 at 3:11 PM, during an interview with Staff #6, the Activity Director, s/he stated that the Activity logs that were presented to the surveyor earlier did not always mean the documented activity occurred. However, they suggested that an activity staff passed by the Resident's room and some form of Activity was happening for the Resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Several observations made of Resident #71 on 1/09/24 at 9:40 AM, 1/10/24 at 2:05 PM, and 1/11/24 at 3:05 PM showed that Resident #71 was not involved in any meaningful activity. On 1/12/24 at 11:18 AM, a medical record review noted an MDS assessment dated [DATE] had recorded that Resident #71 had a diagnosis of Dementia and moderately impaired cognition. On 1/23/24 at 11:31 AM, during a medical record review, it was noted that a Recreation/Activity evaluation completed on 10/12/23 for Resident #71, had recorded that Resident #71's current leisure interests included quilting, children, television, music, and puzzle words. However, continued review of activity logs presented to surveyor for November 2023 to January 2024 failed to show that Resident #71 was involved in activities that included quilting, children, television, music, or puzzle words activities previously identified as her/his current leisure interest on the annual Recreation/Activity evaluation. On 1/16/24 at 10:53 AM, during an interview with Staff # 6, Activity Director, s/he stated that the activities provided to residents were based on preferences noted during the activity assessment. However, s/he provided no rationale for why Resident #71's activity logs for November 2023 and January 2024 did not include activities related to his/her current leisure interest. A subsequent interview was done on 1/18/24 at 8.43 AM with Staff #25, Activity Assistant. During the interview, s/he stated that for residents who had been diagnosed with Dementia, s/he just passed by their rooms and made sure they were doing okay and not necessarily providing them with activities based on their current preferences. On 1/23/24 at 11:54 AM, during an interview with Staff #6, s/he was made aware of concerns about not personalizing Resident #71's activities based on his/her current activity interest. Staff #6 indicated a new way of doing activities had been implemented during this survey after surveyor's intervention. 16218 3) Review of Resident #63's medical record revealed the resident was originally admitted to the facility in June of 2022. The resident's diagnoses included, but were not limited to, Schizoaffective Disorder Bipolar type and lung disease. Review of the December 2023 Minimum Data Set Assessment revealed the resident had minimal hearing difficulty in some environments, had clear speech and was able to make self understood and to understand others. The resident had adequate vision to see fine details such as regular print in newspapers and books. The resident was dependant on staff for assistance with dressing and transfers from the bed to a chair. The resident utilized a wheelchair for mobility.The resident only required set up or clean up assistance with eating. The resident was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15/15. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Minimum Data Set (MDS) is part of the Resident Assessment Instrument, federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as scheduled to meet the needs of each resident. On 1/09/24 at 12:03 PM, the resident was observed in bed, awake and talkative. No music or other activity was observed at this time. On 1/10/24 at 11:51 AM, resident was observed in bed, roommate's TV was on. At 12:15 PM a brief interview was conducted with the resident who, when asked about attending activities, reported that s/he would like to go and that she really liked to read in the past. On 1/17/24 at 10:48 AM, review of the 6/24/23 annual Minimum Data Set Assessment revealed the resident was interviewed in regard to the Preferences for Routine and Activities (Section F). Review of this assessment revealed it was very important to the resident to have books, newspapers and magazines to read; to listen to music s/he likes, to keep up with the news and to do his/her favorite activities. The assessment also revealed it was somewhat important to go outside when the weather was good, to be around animals such as pets and to attend religious activities. Review of the resident's current care plan failed to reveal a plan or any interventions to address the residents activity preferences. On 1/17/24 at 11:17 AM, resident was observed in bed, no music or other activity was observed at this time. Resident stated: this is my life, I need to go to physical therapy and I need to go to activities. On 1/17/24 at 11:24 AM the activity assistant, Staff #25, when asked how s/he knows a resident's preferences or what they will provide a resident, reported they do an assessment for every resident in the building. When asked about Resident #63 specifically, the activity assistant reported the resident liked to stay in bed. When the surveyor requested the assessment for Resident #63, the Activity Assistant was unable to locate it at this time, stating the resident has been in the facility for a long time and the assessment might be in the computer and confirmed s/he did not have access to the resident's assessment. During the 1/17/24 interview, the Activity Assistant, Staff #25, reported they do document when they visit the resident. Review of the documentation provided for December revealed it consisted of a copy of the activity calendar for the month which included Leisure Cart Visit listed every Tuesday and Thursday only. The activity assistant reported they mark (via highlighter) if the resident takes anything from the leisure cart. Surveyor then reviewed the documentation for January and December with Activity Assistant who confirmed two room visits in January, on the 2nd and 4th; and five visits in December on 7th, 12th, 14th, 19th and 21st. On 1/17/24 at 11:46 AM, surveyor reviewed with the Nursing Home Administrator the concern that no care plan was found addressing activities; the Activity Assistant indicated s/he did not have access to the assessment; review of the documentation for provision of services only revealed leisure cart visits on 5 occasions for December; and only 2 visits so far this month. Also informed him/her the resident had indicated s/he would like to go to physical therapy and activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/24 at 12:01 PM, the Activity Director, Staff #6, confirmed s/he had attended care plan meetings for Resident #63. When asked if there was a care plan addressing activities for Resident #63, the Activity Director responded that there should be one for everyone. After surveyor reviewed the concern that no care plan addressing activities was found for this resident, the Activity Director reported that no one had mention to him/her that there was no care plan. During this interview the Activity Director also reported that up until two months ago they had electronic documentation, surveyor requested any activity documentation for Resident #63 since September. As of time of survey exit on 2/2/24 at 5:15 PM no additional documentation of provision of activities was provided for Resident #63. 45139 4) Based on medical records review, Resident #91 was a long-term resident of the facility. The resident was interviewed on 1/10/24 at 9:29 AM. Resident #91 reported that it had been a couple months since s/he had participated in activities. S/he reported that s/he liked to play bingo. On 1/17/24 at 12:11 PM, the activities assistant, Staff #25 was interviewed. During the interview s/he provided documentation of Resident #91's activity participation for December 2023. Review of the documentation revealed that each resident had a paper calendar with their name on the calendars and all calendars had been kept in a binder in the activities room. The individual resident calendars had all the activities provided by the facilitated list for each day. Staff #25 reported that when a resident participated in an activity, the activity staff would highlight the activity in yellow on the resident's calendar. Review of the highlighted activities on Resident #91's calendar revealed that s/he participated in leisure cart activities on the 7th, 12th, 14th ,19th and 21st of December 2023. 01/23/24 at 3:11 PM, the Act. Director, Staff #6, was interviewed. During the interview s/he clarified that the highlighted activities on the residents individual activity calendar indicated that an activity was done with the resident or that the resident was witnessed by the activity staff doing an activity independently. On 1/26/24 at 12:59 PM, the activities calendars for December 2023 and the Rossville Rehabilitation and Healthcare Center Admission/Discharge To/From Reports 12/01/23 to 12/31/23 was reviewed with the Director of Nursing and the Corporate Clinical Nurse. The DON and Corporate Clinical Nurse confirmed that there was no additional documentation to confirm that Resident #91 participated in activities.

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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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Rossville Rehabilitation and Healthcare Center	6600 Ridge Road Baltimore, MD 21237

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 16218 Based on medical record review and interviews, it was determined that the facility failed to have an effective system in place to ensure that orders for eye doctor and audiology appointments were scheduled in a timely manner. This was found to be evident for 2 (Resident #68 and #59) of 5 residents reviewed for vision and hearing. The findings include: 1) Review of Resident #68's medical record revealed an admitted in 2022. The resident had diagnoses of, but not limited to, dementia, heart failure, hypothyroidism and high cholesterol. Review of a 12/1/23 nurse progress note revealed the resident had an ENT (ear, nose and throat) appointment for a hearing test which revealed bilateral mild to severe hearing loss. The nurse practitioner (NP) was made aware of recommendations with orders for inhouse audiology consult for hearing aide. A corresponding order, by NP, Staff #37, dated 12/1/23 for: Please schedule appt with In-house Audiologist for hearing aides. On 1/10/24, review of the medical record failed to reveal documentation to indicate this audiology appointment had been scheduled or completed. Review of the current care plans revealed a plan with a focus of: Difficulty communicating related to left and right ear wax build up. This plan was initiated on 10/23/23. Further review of the medical record revealed a care plan meeting occurred on 12/12/23. No documentation was found in this, or any of the residents other care plans, to indicate the ENT appointment had occurred, identified a hearing loss and a recommendation for audiology appointment for a hearing aide. On 1/17/24 at 12:39 PM, the unit nurse manager, Staff #23, reported in regard to appointments for hearing issues, they have to have a couple of patients needing to be seen then they will put it in the communication board and then an appointment will be scheduled. On 1/17/24 at 3:25 PM, the unit nurse manager reported there was an appointment for 1/22/24 with an outside provider. Not sure if was scheduled prior to today, indicating they do not notify nursing until closer to the date of the appointment. Surveyor requested to speak to the individual who completes the scheduling. On 1/17/24, at approximately 3:30 PM, the Medical Records clerk, Staff #24, reported s/he schedules appointments. S/he reported s/he works from the communication board on the computer and that all the nurses have access to this board. When asked when was s/he made aware of the need to schedule an audiology appointment for Resident #68, Staff #24 responded that s/he read the communication board today and made the appointment. S/he confirmed that s/he was not aware prior to today and stated it may have been there and dropped off before s/he was able to see it. On 1/31/24 at 3:45 PM, the surveyor reviewed the concern with the Director of Nursing regarding the failure to schedule an ordered audiology appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of Resident #59's medical record revealed an admitted in 2020. Review of the 12/16/23 Minimum Data Set assessment revealed the resident was cognitively intact as evidenced by a BIMS score of 15/15. On 1/10/24 at 10:48 PM, the Resident reported that s/he had not seen an eye doctor for three years and that prior to admission s/he was seen multiple times a year. On 1/17/24 review of the medical record revealed an active order, dated 10/7/22 for an optometry appointment. No documentation was found to indicate the resident was seen by the optometrist as a result of this October 2022 order. On 1/17/24 at 12:34 PM, the unit nurse manager, Staff #23, when asked how an order for optometry would be implemented, reported they use to have a provider come in to see the patients but now they make an outside appointment. On 1/17/24 at 3:22 PM, the unit nurse manager, Staff #23, confirmed that the resident had not had an optometry appointment since the order. S/he went on to report that the resident now had an appointment for later this month and confirmed it was just scheduled today. On 1/31/24 at 3:45 PM, the surveyor reviewed the concern with the Director of Nursing regarding the failure to schedule an ordered optometry appointment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on observation, record review, and interviews, it was determined that the facility 1) failed to ensure splints for the prevention of contracture development were re-implemented after a resident was readmitted after a brief hospitalization , and 2) failed to ensure that a resident with a limited range of motion received treatment and services as ordered by the attending provider to prevent further decline in the range of motion. This was evident for 2 (#63, #43) of 4 residents reviewed for position and mobility. The findings include: 1) Review of Resident #63's medical record revealed that the resident was originally admitted to the facility in June of 2022. The resident had a brief hospitalization in August 2023 after which s/he was readmitted to the facility. On 01/09/24 at 12:03 PM, surveyor observed a sign on the wall near the head of the resident's bed about using a splint. Review of the 12/23/23 Minimum Data Set Assessment Section O 0500 Restorative Nursing revealed no splint or brace assistance was being provided. On 1/10/23 at 12:12 PM, review of the medical record failed to reveal a current order for the use of a splint, but an old order with a start date of 5/4/23 and end date of 8/29/23 was found. The order stated: Left Static hand/wrist orthosis [brace] to prevent further contracture. Recommend to wear ~[about] 2 hours around meal times and while sleeping (if able to tolerate). Skin checks following each wear. If redness/abrasion discovered remove and notify OT [occupational therapy]. On 1/10/24 at 12:15 PM, the surveyor observed a wrist brace on the resident's over bed table. The resident reported that the brace was for his/her hand, that the nurse or aide have to put it on, it stays on for two hours and that s/he removes it after two hours. On 1/11/24 at 2:11 PM, the surveyor requested the most recent discharge summaries for Resident #63 for Physical therapy (PT) and Occupational therapy (OT) from the Rehab Director (Staff #10). These summaries were provided on 1/12/24. Review of the OT discharge summary revealed service from 4/18/23 with a discharge date of [DATE]. The discharge summary revealed that a Splint and Brace Program was established and included recommendation for the splints to be used 3 times daily for approximately 2 hours in each instance. Further review of the medical record revealed that a new order for the splints was put in place on 1/16/24 and the resident's care plan was also updated on 1/16/23 to include the use of the hand splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/24 at 12:01 PM, the Occupational Therapist, (OT), Staff #27, who had completed the 5/17/23 discharge summary was interviewed. After review of the discharge summary, the OT confirmed the recommendation for the splints two hours 3 times a day was to help prevent contracture development. After surveyor reveiwed the concern that there was no documentation to indicate the splints had been used since the September re-admission and that they were just recently re-ordered, the OT reported s/he was not aware of that and had not conducted a recent re-evaluation of the resident. The concerns regarding the failure to ensure an order for the splints for the prevention of contracture was re-established after a brief hospitalization was addressed with the corporate nurse, Staff #15, on 1/18/24 at 1:45 PM. 48259 2) The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. Palm Protectors offer relief from curling fingers, hand contractures, and cramping. The Palm Protector is put over the thumb and around the hand, providing a cushioning pad for the fingers to curl onto, preventing the nails from digging into the palms and keeping the fingers warm and supported. On 1/9/24 at 11:55 AM, observation of Resident #43 revealed that the resident's left and right hands had contractures (fingers bent at the knuckle joints), and no splint or device was in place. The surveyor reviewed an Occupational Therapy (OT) evaluation and Treatment plan for Resident #43 dated 11/1/2022 on 1/18/24 at 12:40 PM. The OT evaluation and treatment plan documented that Resident #43 had contractures to both sides of his/her upper extremities at the metacarpophalangeal joints (knuckle joints) flexed to 90 degrees. The recommendation was to apply palm protectors to both hands on the day shift and remove them only for hand hygiene. On 1/18/24 at 1:20 PM, a record review revealed an attending provider's order for Resident #43 initiated on 11/18/22 that stated, Don (put on) left and right palm protectors after AM (morning) care and redon after hand hygiene on day shift. However, an observation of Resident #43 on the same day at 1:23 PM showed Resident lying in bed with a palm protector only on his/her right hand, and none noted on the left hand. On 1/9/24 at 12:30 PM, a medical record review for Resident #43 showed a Minimum Data Set (MDS) assessment dated [DATE]. The MDS had recorded in section GG that Resident #43 depended on staff for all his/her self-care needs. Further review of the MDS showed that Resident #43 had functional limitations to both sides of his/her upper and lower extremities. A subsequent record review, on 1/9/24 at 1:00 PM, for Resident #43 showed an attending Provider's note dated 10/10/23, that had recorded that Resident #43 was bedbound, nonverbal, with ongoing contractures to hands and arms. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/24 at 1:26 PM, during an interview with Staff # 56, Registered Nurse (RN), s/he stated that Resident #43 was supposed to have a palm protector only on the right hand and confirmed that s/he did not have a palm protector on the left hand. In a continued interview on the same day at 1:29 PM with Staff #14, a Geriatric Nurse Aide (GNA), stated that s/he only put the palm protector on Resident #43's right hand and never the left hand. On 1/18/24 at 3:08 PM, an interview was done with Staff #32, Unit Manager for the second-floor unit. During the interview, s/he stated that s/he expected nurses to complete treatments as ordered and notify the attending provider when the orders were not completed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45139 Based on pertinent document review and interviews, it was determined that the facility failed to accurately document and address a physician's recommendation for a resident to receive a urology consult. This was evident for 1 (#38) of 1 resident reviewed for urinary catheter. The findings include: On 1/11/24 at 1:54 PM, a review of medical records revealed that the Resident #38 was admitted to the facility with a indwelling urinary catheter in place. On 01/12/24, a review of Resident #38'Ss hard chart revealed the resident had a physician consultation at a local hospital during his/her stay at the facility on 11/29/23. However, further review failed to reveal the facility obtained a written recommendation from the consultation. On 1/12/24 at 2:12 PM, during an interview, second floor unit manager Staff #23, RN, confirmed that the consulting physician written recommendations were not available in Resident #38's medical records. On 1/12/24 at 3:15 PM, review of a nursing progress notes revealed a note dated 11/29/23 which stated, Resident returned from his ORTHO appointment with this recommendation from- THE ORTHO. DOCTOR - DR. XXXXX, RECOMMENDED THAT PATIENT RETURN TO UROLOGY APPOINTMENT IN 6 MONTHS. TO CALL THIS PHONE NUMBER TO SCHEDULE-- xxxxxxx100. On 1/19/24 at 10:41 AM, a review of medical records revealed an order, dated 1/12/2024, that revealed the resident had a urological consultation appointment the first week of May 2024. On 1/12/24 at 3:00 PM, the second-floor unit manager provided the written physicians consultation recommendations from the consulting physician regarding the 11/29/23 visit. Review of the documents revealed that a referral to urology was placed, and he was to follow up in 6 months. On 1/12/24 at 3:25 PM, during an interview with Director of Nursing (DON), she reviewed the physician consultation from 11/29/23, and the progress notes on 11/29/23. The DON confirmed that the information in the referral and on the progress,note was not the same. The progress note was inaccurate regarding the referral. She would get back to me when the Resident #38 had a referral to the urologist. 01/17/24 at 11:06 AM, during an interview RN staff #8 reported that it was the responsibility of the resident's nurse to ensure that the documentation from a consulting physician is obtained and available for the facility physician for review and comment on the recommendations. 01/19/24 at 12:28 PM, during an interview, the DON provided a note that resident had an appointment on 1/24/24 at 11:00 AM. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/24 at 12:49 PM, during an interview, Resident #38 reported that the removal of his/her indwelling urinary catheter had successful results. On 1/24/24, a review of Resident #38's urology consultation communication form provided by the DON, revealed that the indwelling urinary catheter was removed. On 1/24/24, review of residents treatment administration record revealed that Resident #38 was able to void without the use of the indwelling catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48259 Based on observation, record review, and interview, it was determined that the facility failed to maintain respiratory care equipment for a resident who required continuous oxygen via nasal cannula. This was evident for 1 (#85) out of 4 residents reviewed for respiratory care. The findings include: A prefilled humidifier with sterile water is used with oxygen concentrators to offer comfortable humidity and moisture to continuous flow oxygen therapy to prevent upper airway dryness. On 1/10/24 at 9:14 AM, an observation was made of Resident #85 receiving 3 Liters (L) of continuous oxygen via nasal cannula. The tubing or nasal cannula was neither initialed nor dated. Continued observation revealed an empty bottle of a prefilled humidifier with sterile water attached to Resident #85's oxygen concentrator, which was neither dated nor initialed. Resident #85 was interviewed at that time. During the interview, he/she said the night shift nurse had told him/her that there were no more prefilled humidifier water bottles. A subsequent observation was made on the same day at 10:55 AM by the surveyor with Staff #31, a Registered Nurse (RN) present in Resident #85's room. The observation showed that Resident #85 continued to receive continuous oxygen. At the same time, the humidifier bottle prefilled with sterile water remained empty. Staff #31 confirmed that the prefilled humidifier sterile water was finished. On 1/17/24 at 8:20 AM, the facility's oxygen administration policy was reviewed. The review noted a policy statement stating, Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. On 1/18/24 at 2:59 PM, an interview was conducted with Staff #31. During the interview, s/he said the night shift nurse typically changed the prefilled humidifier water weekly, and it should have been replaced on 1/10/24 by the night shift. A subsequent interview done with Staff #32, a unit manager for the second-floor unit, on 1/18/24 at 3:05 PM showed that her expectation from the nurses was to change the humidifier water whenever it was low or empty. S/he stated that she should have been notified if there was no supply of prefilled humidifier water. However, she was not made aware.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 42886 Based on medical record review and staff interview, it was determined that a facility provider failed to make their visit notes available after a visit with a resident (resident #515). This was evident for 1 (#515) of 4 residents reviewed for provider visit note availability during a facility's revisit survey. Findings includes: Review of resident #515's medical records on 4/25/24 at 8:30am revealed resident #515 received a new order for Ativan (.5 mg (milligrams) 1 tablet daily) for Anxiety. Further review of resident #515's medical records on 4/25/24 at 9:00am revealed no evidence of a diagnosis of Anxiety in the resident's list of active diagnosis. An interview with the Director of Nursing (DON) on 4/25/24 at 12:58 pm, the surveyor pointed out that resident #515 received a new order for a medication for Anxiety on 4/23/24 but the medical record had no evidence that the resident was seen by the provider. The DON revealed the Certified Nurse Practitioner (CRNP) #5 saw the resident on 4/23/24. The DON also admitted that CRNP #5 failed to provide a provider note to the facility detailing the visit. On 4/26/24 at 1:30 pm, the surveyor expressed concern to the DON that the facility failed to place a provider visit note in resident #515's medical record in a reasonable amount of time after the provider's visit with the resident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 16218 Based on medical record review, observation and interview, it was determined that the facility failed to ensure recommendations from the psychiatric provider was reported to the primary care provider and failed to ensure abnormal behaviors were reported to either the primary care provider or the psychiatric provider in a timely manner. This was found to be evident for 1(#106) of two residents reviewed for behavioral health services during the survey. The findings include: 1) Review of Resident #106's medical record revealed an admitted in April 2023 with diagnoses that included, but were not limited to, history of stroke, high blood pressure, diabetes, lung disease and dementia. On 1/9/24 at 1:39 PM the resident was observed in bed, the resident did not verbally respond to surveyor greeting. Further review of the medical record revealed an order dated 7/26/23 for a psychiatric consult. On 1/17/23 at 12:32 PM, the surveyor reviewed with the unit nurse manager, Staff #23, that there was an order for a psychiatric consult in July, but no documentation was found to indicate the resident was seen as a result of the July order. At 3:16 PM, the unit nurse managaer, Staff #23, reported the resident was seen after the 7/26 order and that the psychiatric nurse practitioner will be providing the notes the next day. Review of the 7/31/23 psychiatric nurse practitioner (NP), Staff #54, note revealed the resident was seen for follow up management of anxiety. The note included the following: .Based on this visit, which included patient assessment, reports from staff/caregiver, and clinical record review, the patient's psychiatric symptoms are worsening and require close follow up & intervention. Assessment / Plan / Orders / Recommendations: Patient with anxiety s/p [status post] gdr [gradual dose reduction] of seroquel [an antipsychotic medication] currently on hydroxyzine [an antihistamine used to treat anxiety] until 8/8/23. GDR of seroquel might have failed will recommend buspar [a medication used to treat anxiety disorders] but if not effective will consider re initiating seroquel. Recommend Buspar 5 mg po [by mouth] tid [three times a day] -[for] anxiety . Further review of the medical record failed to reveal documentation to indicate this recommendation was discussed with or reviewed by the primary care physician. No order was found for Buspar following the July psychiatric NP visit on 7/31/23. The corporate nurse, Staff #15, reported, on 1/18/24 at 1:46 PM, that when the psychiatric NP makes a recommendation the process is that the recommendation is to be communicated to the physician or nurse pratitioner and they will concur or disagree. S/he confirmed that s/he did see the note about the Buspar and that they contacted the NP last night about the recommendation. The corporate nurse also confirmed that s/he did not see any documentation to indicate the July recommendation was reviewed with the primary care providers. Surveyor requested to see any psychiatric notes since the July note. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of time of survey exit on 2/2/24 at 5:15 PM no documentation was provided to indicate the psychiatric NP had a visit with the resident between 8/1/23 and 1/10/24. The psychiatric NP, Staff #54, was interviewed on 1/22/24 at 10:24 AM about Resident #106. The NP reported s/he saw the resident when first admitted for a few visits then the resident was off the psych meds, saw the resident maybe one more time, then did not see the resident again until last Monday when asked to see the resident. After review of the 7/31/23 note, the NP reported she emails the notes to the facility, the DON, the ADON and unit manager and s/he thinks they call the primary care provider who will say yes or no [to the recommendations]. The NP went on to report that s/he will come back to see how a resident is doing, to see if the medications were initiated or not and see how the resident was doing. The NP was unable to say if she had followed up after the 7/31/23 visit or not. On 1/11/24 at 9:44 AM, the resident was observed by two surveyors in bed with several brownish spots observed on the bed sheet at the resident's head level and on side of the mattress, the privacy curtain was noted to have brownish stains and their was splatter on a chair located near the bed. A feces odor was noted in the room at this time. On 1/11/24 at 1:58 PM, review of the medical record revealed a change in condition nursing note, written earlier on 1/11/24 that included: Resident noted splashing stools on the floor, rubbing stools on [his/her] nose, has medical history of Vascular Dementia, Unspecified Severity, Psychotic Disturbance. MD made aware of this recent change in condition, N.O [new order] given for Psych consult; CBC/CMP/UA/C&S [lab tests] on 01/12/24 and Seroquel 12.5mg BID [twice a day] for Dementia with behavior disturbance. On 1/12/24 at 10:43 AM interview with Geriatric Nursing Assistant (GNA), Staff #12. about Resident #106 revealed the behavior of throwing fecal matter was not new and was a known behavior. The GNA went on to report they rarely take the resident out of their room because they do not want to take any chances with the resident throwing feces. Further review of the medical record failed to reveal documentation to indicate that an interdisciplinary care plan meeting was held since May 2023. On 1/15/24 the resident was seen by the psychiatric NP, Staff #54. The note for this visit included: .Patient seen per urgent request for abnormal behaviors, patient has been shooting feces across the room and also smearing it all over. Patient has labs ordered for today and seroquel 12.5 mg po bid has been initiated, will defer further medication adjustments until labs are reviewed. On 1/17/24 at 12:24 PM the unit nurse manager, Staff #23, reported that recently when the resident has a bowel movement s/he will smear it, that the resident was seen by psychiatic provider on Monday and that the resident is calmer since the start of the seroquel. The unit nurse manager confirmed that the 11th was the first time the fecal smearing behavior was reported to her. Review of the Behavior Monitoring and Interventions documentation completed by the GNAs starting in mid November 2023 (new electronic health documentation was initiated when new ownership took over) revealed BW- Throwing/Smearing Bodily Waste was documented on the following occassions: November 17th at 8:00 PM (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 18th at 9:52 PM December 1st at 7:01 PM December 15th at 7:28 PM December 26th at 9:15 PM January 3rd at 10:52 PM January 11 at 11: 57 AM On 1/17/24 at 3:16 PM, the surveyor reviewed the concern with the unit nurse manager that a GNA had reported the throwing of feces was a known behavior and review of GNA documentation revealed it had occurred on several occassions prior to the incident on 1/11/24. The unit nurse manager indicated she was not previously aware of the behavior and reported that the resident use to sit out in the hallway. During the 1/22/24 at 10:24 AM interview with the psychiatric NP, s/he confirmed that last week was the first time s/he was made aware of the fecal smearing. On 1/31/24 at 3:45 PM, surveyor reviewed with the Director of Nursing the concerns regarding the failure to ensure the NP followed up after making a recommendation to start a new medication to treat anxiety; failure of nursing staff to notify the primary care provider of the psychiatric NP recommendation to start a new medication; and failure of staff to report the incidents of fecal smearing to either the psychiatric or primary care provider.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48259 Based on medical record review and interview, it was determined that the facility failed to have an effective system in place to ensure that the attending physician reviewed and responded to pharmacist identified irregularities and recommendations in a timely manner. This was evident for 1 (#65) of 5 residents reviewed for unnecessary medications, and 1 (#53) of 2 residents reviewed for insulin The findings include: 1) On 1/11/24 at 1:14 PM, a medical record review was conducted for Resident # 65.The review revealed pharmacy progress notes that indicated a medication regimen review (MRR) was completed on 8/9/23 for Resident #65 with the recommendation to attempt a gradual dose reduction of an antidepressant. Continued record review revealed that Resident #65 was visited by attending physician # 51 on 8/25/23. However, the review did not show that attending Physician# 51 had reviewed or responded to the pharmacy recommendation for Resident #65. Further review of Resident #51's physician orders revealed that Resident #51's antidepressant dose had never decreased since the MRR was completed on 8/9/23. On 1/22/24 at 11:19 AM, an interview was done with the Director of Nursing (DON). During the interview, she stated that the facility received and reviewed the medication regimen review reports with the attending physicians, who signed them and indicated on the reports whether they agreed or disagreed with the recommendations. However, an attending physician did not sign Resident #65's medication regimen review for 8/9/23. The DON was questioned about what happened to Resident #65's MRR of 8/9/23, and she responded that it was not addressed with the provider. On 1/22/24 at 1:36 PM, during an interview with Provider #51, he indicated that the nurses usually gave him the medication regimen reviews, which he signed and indicated whether he agreed with the recommendations. Provider # 51 was questioned why Resident #65's MRR of 8/9/23 was not signed, and no indication was noted whether or not he agreed with the recommendation. And he responded that the nurses did not inform him of the MRR. 16218 2) Review of Resident #53's medical record revealed the resident was admitted to the facility in February of 2023. The resident received multiple medications daily including insulin. On 1/12/24 at 9:00 AM, review of the electronic health record (EHR) revealed documentation in the progress notes of monthly pharmacy reviews having been completed from February through September 2023. No documentation of reviews were found for October, November or December 2023. On 1/12/24 at 9:09 AM, the Director of Nursing (DON) reported that, after November 15th 202, the reviews would be found on paper and that they were in the process of uploading them in to the EHR. Surveyor reviewed the concern that no reviews were found for October, November or December. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/24 at 1:55 PM, the DON provided documentation to indicate that a pharmacy review was completed in November with no irregularities found. S/he indicated she was still working on finding the October and December reviews. Documentation was later provided to indicate that a review was conducted for December with no irregularities noted. On 1/18/24 at 11:42 AM, review of a report for 10/29/23 revealed there was a recommendation made to discontinue a PRN (as needed) medication, but surveyor was unable to determine which medication the recommendation was referring to from the summary report provided. Surveyor then requested the actual pharmacy recommendation from the Nursing Home Administrator (NHA). On 1/18/24, review of Resident #53's medical record revealed a nurse's progress note that the resident was seen by the physician on 11/21/23, however, further review of the medical record failed to reveal a corresponding physician note. No documentation was found to indicate the physician was aware of or addressed the 10/29/23 recommendation. On 1/18/24 at 12:15 PM, the NHA provided a copy of the Consultant Pharmacist Medication Regimen Review form, dated 10/29/23, that revealed a recommendation to discontinue the PRN use of Melatonin. This form included a hand written notation, by unit nurse manager, Staff #23, that the NP, Staff #37, had disagreed with the recommendation on 1/15/24. On 1/18/24 at 12:30 PM, surveyor requested the specific Medication Regimen Review (MRR) policy from corporate nurse, Staff #15. Review of the provided policy revealed the following: 7f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. On 1/18/24 at 1:17 PM, surveyor asked corporate nurse, Staff #15 if there was a written policy/procedure as referenced in 7f and s/he indicated there was not. Surveyor then reviewed with the corporate nurse the concern that the policy does not include a timeframe for when provider should address the recommendation. On 1/31/24 at 3:45 PM, surveyor reviewed with the DON the concern regarding the failure to ensure the pharmacy recommendations were addressed in a timely manner.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 37276 Based on medical record review and staff interview, it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by 1) failing to ensure orders for a topical anesthetic patch included the duration the patch should be applied, and 2) failing to implement physician orders for blood pressure and pulse parameters prior to administering a blood pressure medication. This was evident for 1 (#21) of 5 residents reviewed for unnecessary medications. The findings include: 1) A Lidocaine (local anesthetic) patch, when applied to the skin, helps reduce pain by causing a temporary loss of feeling in the area where the patch was applied. Depending on the Lidocaine patch product, the patch may be left on the skin for up to 8 or 12 hours. According to MedlinePlus a division of the National Institutes of Health (NIH), Lidocaine 4% patches can be applied up to 3 times daily and for no more than 8 hours per application. Applying too many patches or topical systems or leaving them on for too long may cause serious side effects. 1a) On 1/12/24 at 12:25 PM, a review of Resident #21's medical record was conducted. Review of Resident #21's September 2023 treatment administration record (TAR) revealed a 9/10/23 order for Lidocaine Patch 4%, apply to right shoulder topically (on the skin) one time a day for pain and remove per schedule. The order did not indicate the patch removal schedule or the time the patch should be removed. Following the order, the TAR documented the Lidocaine patch was to be applied at 10:00 AM and removed at 9:59 AM, which was 23 hours and 59 minutes after the patch was applied. The Lidocaine order was signed off as applied every day at 10:00 AM and removed at 9:59 AM every day from 9/10/23 to 9/17/23 in September. Following the order, the TAR indicated that on 9/18/23, the patch was to be removed at 1:00 PM. The TAR documented on 9/18/23 a Lidocaine patch was removed at 9:59 AM, a Lidocaine patch was applied at 10:00 AM, and the patch was removed at 1:00 PM. The order was discontinued on 9/18/23. Resident #21's September 2023 TAR documented a 9/19/23 order for Lidocaine Patch 4%, apply to right shoulder topically one time a day for pain and remove per schedule. The order did not indicate the patch removal schedule or the time the patch should be removed. Following the order, the TAR documented the Lidocaine patch was to be applied at 10:00 AM, and the patch was to be removed at 12:01 AM, and to remove the patch at 9:59 AM. The TAR documented the Lidocaine patch was applied to the resident on 9/19/23 at 10:00 AM, and on 9/20/23 the patch was removed at 12:01 AM, and the patch was removed at 9:59 AM. The order was discontinued on 9/20/23. The September 2023 TAR documented a 9/21/23 order for Lidocaine Patch 4%, apply to right shoulder topically in the morning for pain and remove per schedule with a start date of 9/21/23 at 9:00 AM. The order did not indicate the patch removal schedule or the time the patch should be removed. Following the order, the TAR documented the Lidocaine patch was to be applied at 9:00 AM and removed at 9:59 PM, which was 12 hours and 59 minutes after the application of the patch. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order was signed off as applied at 9:00 AM every day from 9/21/23 to 9/30/23 and removed at 9:59 PM on 8 (9/21, 9/22, 9/23, 9/25, 9/26, 9/27, 9/28, 9/29 and 9/30/2023) of 10 days in September 2023. In the TAR, the order to remove the patch was not signed off as being done on 9/24/23 and on 9/26/23, indicating Resident #21's Lidocaine patch had not been removed on those two days. Review of Resident #21's January 2024 TAR, revealed a 9/21/23 order for Lidocaine Patch 4%, apply to right shoulder topically in the morning for pain and remove per schedule, with no indication in the order when the patch should be removed. Following the order, the TAR documented the Lidocaine patch was to be applied at 9:00 AM and removed at 9:59 PM, which was 12 hours and 59 minutes after the application of the patch and documented as a done on 12 of 12 days in January 2024. The facility staff failed to ensure that Resident #21's Lidocaine order included the length of time the Lidocaine patch could be applied to the resident and when the patch should be removed. In addition, there was no evidence that the time to remove the patch had been clarified with the physician resulting in the application of a lidocaine patch for greater than the recommended 8 to 12 hours before removal. The above concerns were discussed with the Director of Nurses (DON) on 1/12/24 at 12:24 PM, and the DON offered no explanation at that time. 2) On 1/29/24 at 2:04 PM, a further review of Resident #21's medical record was conducted. Review of Resident #21's December 2023 MAR revealed an order for Amlodipine Besylate (Norvasc) (lowers blood pressure) by mouth two times a day for (HTN) (high blood pressure (BP), hold for systolic (1st number of a BP) less than 110 and heart rate (HR) less than 60, that had a start date of 5/5/21. The MAR documented that Resident #21 received Amlodipine by mouth two times a day every day in December 2023. There was no documentation found in the MAR or in the medical record to indicate the resident's BP and HR were monitored prior to the administration of Amlodipine, and that the Amlodipine was administered within the parameters in the physician's order. Review of Resident #21 January 2024 Medication MAR revealed an order for Amlodipine Besylate by mouth two times a day for HTN hold for systolic less than 110 and HR less than 60, that had a start date of 5/5/21. The MAR documented that Resident #21 received Amlodipine by mouth two times a day every day from January 1 to 30, 2024. There was no documentation in the MAR to indicate that Resident #21's blood pressure and heart rate were monitored as per the physician's order prior to receiving the amlodipine. The facility failed to follow the physician's order to monitor Resident #21's blood pressure and heart rate and administer or hold the resident's medication according to the prescribed parameters. The above concerns were discussed with the DON on 1/29/24 at 1:45 PM, with no response offered at that time.

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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. 37276 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 administering psychotropic medications without adequate monitoring for behavior. This was evident for 2 (#54, #21) of 5 residents reviewed for unnecessary medications. The findings include: Psychotropic medications are any drug that affects brain activities associated with mental process and behavior, and include, but not limited to anti-psychotics, anti-depressants, anti-anxiety, and hypnotics. 1) On 1/18/24 at 12:00 PM, a review of Resident #54's medical record revealed the resident was admitted to the facility in August 2023 with diagnoses which included dementia, depression, mood disorder, and anxiety. Review of Resident #54's January 2024 MAR revealed that the resident received psychotropic medications, which included 2 antipsychotics, an antidepressant and an antianxiety medication. The MAR documented that Resident #54 recieved the following psychotropic medications: - Aripiprazole (Abilify) (antipsychotic) 10 MG by mouth one time a day for anxiety disorder and unspecified dementia with dementia symptoms, start date 8/8/23, discontinued on 1/16/24, that was documented as given every day from 1/1/24 to 1/16/24 - Aripiprazole10 MG by mouth one time a day for negativism/repetitive sentences/questions, start date 1/17/24 that was documented as given on 1/17/24 and 1/18/24. - Olanzapine (Zyprexa) (Antipsychotic) 2.5 MG by mouth two times a day for depression/mood disorder, start date 8/7/23, that was documented as given twice a day, every day from 1/1/24 thru 1/17/24, and 1/18/24 at 8:00 AM. - Buspirone HCl (Buspar) (anti-anxiety medication)10 MG by mouth every 8 hours for anxiety, start date 8/7/23, that was documented as given 3 times a day, every day from 1/1/24 to 1/17/24, and twice on 1/18/24. - Escitalopram Oxalate (Lexapro) (antidepressant) 10 MG by mouth one time a day for depression, start date 8/8/23, that was documented as given every day from 1/1/24 to 1/18/24. Continued review of Resident #45's medical record failed to reveal evidence the facility staff monitored Resident #45 for the resident specific behavior that necessitated the use of the prescribed psychotropic medications or that person-centered, non-pharmacological approaches had been implemented in the attempt to reduce or discontinue a psychotropic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 1/29/24 at 12:00 PM AM, a review of Resident #21's medical record was conducted and revealed documentation that Resident #21 had diagnosis that included schizophrenia (mental disorder characterized by reoccurring episodes of psychosis that are correlated with a general misperception of reality), major depressive disorder (mood disorder), bipolar disorder (manic depression) (mood disorder that causes intense mood swings), unspecified dementia with other behavioral disturbance Review of Resident #21's January 2024 Medication Administration Record (MAR) revealed a 9/22/21 order for Escitalopram Oxalate (Lexapro) (antidepressant) tablet 10 milligrams (MG) Give 1 tablet by mouth one time a day for depression, that was signed off as given every day in January, from 1/1/24 to 1/23/24, then discontinued, and there was a 1/24/24 order for Lexapro 5 MG by mouth one time a day for major depressive disorder, that was signed off as given every day from 1/24/24 to 1/29/24. The MAR also documented a 5/2/23 order for Mirtazapine (antidepressant) by mouth at bedtime for appetite/depression that was signed off as given every day from 1/24/24 to 1/28/24, and there was a 1/21/22 order for Olanzapine Tablet (Zyprexa) (antipsychotic) (treats mental/mood disorders) 7.5 MG Give 1 tablet by mouth at bedtime for Schizophrenia that was signed off as given every day from 1/24/24 to 1/29/24 in January 2024. Continued review of Resident #21's medical record failed to reveal evidence the facility staff monitored Resident #21 for the resident specific behavior that necessitated the use of the prescribed psychotropic medications or that person-centered, non-pharmacological approaches had been implemented in the attempt to reduce or discontinue a psychotropic medication. On 1/29/24 at 1:32 PM, during an interview, the Director of Nurses (DON) was made aware of the above findings. When asked how a resident who was prescribed psychotropic medications were monitored for the targeted behaviors for which psychotropic medications had been prescribed, the DON indicated that monitoring a resident's behavior was episodic, and the facility did not currently have a process in place for monitoring resident specific behaviors. The DON stated that the facility staff previously documented resident behaviors on behavior monitoring sheets however, that was no longer the facility's process.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45139 Based on observation, interview and pertinent document review, the facility staff failed to ensure a medication error rate of less than 5 percent for 3 (#287, #292, #42) of 5 residents observed with 31 medication administration opportunities which resulted in a error rate of 9.6 percent. The findings include: 1} A medication administration observation of Resident #287 was made on 1/18/24 at 9:39 AM. Nurse, LPN, Staff #12, was observed administering Resident # 287 a Calcium + D 600mg/10mcg(400iu) tablets, with the instructions to chew the tablets. Resident attempted to chew the tablets and reported to the nurse they were not the chewable tablets and spit the medication out. On 1/18/24 at 9:40 AM, during a brief interview with Nurse, Staff #12, s/he reported that s/he was made aware by a nurse on the floor, that the Calcium + D 600mg/10mcg(400iu) tablets s/he provided Resident #287 was not a chewable medication. S/he reported that s/he will notify the physician to obtain the correct form of the medication. On 1/18/24 at 10:30 AM, review of Resident # 287s orders revealed an order with a start date of 1/11/24 for Calcium Carbonate-Vit D-Min Oral Tablet Cheweable 1200-1000MG- UNIT (Calcium Carbonate-Vitamin D w/ Minerals) give 1200 mg by mouth one time a day for Supplement. 2) A medication administration was observed on Resident #292 on 1/18/24 at 9:59AM. During the observation nurse, Staff #12 crushed the resident's medications prior to administration. Included in the crushed medications was the medication Metoprolol succinate 25 mg ER (extended release) 1/2 tab. Crushing extended-release meds can result in administration of a large dose all at once. On 1/18/24 at 10:48 PM, Nurse Practitioner (NP), Staff #44 was interviewed. During the interview s/he reported each med cart contains a list of medications that should not be crushed. NP # 44 confirmed that Metoprolol succinate 25 mg ER 1/2 tab is a medication that should not be crushed. In addition, s/he reported that s/he would monitor Resident #292's blood pressure and educate the staff on the proper procedure to identify medications that can be crushed. 3. On 1/18/24 at 12:48 PM. a medication observation was made for Resident #42. During the observation nurse, Staff #43, applied a lidocaine patch to lower leg. On 1/18/24 at 1:22 PM, review of Residents #42's physician orders revealed an order,with a start date of 3/18/23, for Bengay Ultra strength pad (Menthol topical analgesic). Further review failed to reveal an order for lidocaine. On 1/18/24 at 2:00 PM, during an interview with nurse, Staff #43, s/he confirmed that s/he administered a lidocaine patch in error. In addition, Staff # 43 confirmed the order for a Bengay Ultra pad for Resident #42. Staff #42 reported s/he would notify the physician of the error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24 at 9:37 AM, the above medication errors were reviewed with the Director of nursing (DON). The DON reported that s/he was aware of the errors and that corrective staff education had already been started.

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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** 45139 Based on observation and interview, it was determined that the facility failed to maintain locked carts where medications were stored. This was evident for 3 carts out of 9 carts observed during the survey. The findings include: 1) On 1/09/24 at 8:31 AM, an observation was made of a unlocked treatment cart near the first floor [NAME] unit nurses' station. A second observation at 8:32 AM revealed that Nurse, RN, Staff #19 was cleaning the top of a medication cart down the hall from the treatment cart. The surveyor requested that Nurse, Staff #19, join her at the treatment cart. The surveyor opened several treatment carts doors in the presence of Nurse, Staff #19. Nurse, Staff #19 confirmed that the treatment cart was unlocked, and s/he immediately locked the cart. 2) On 1/10/23 at 7:44 AM, an observation on the first floor Clear Spring unit revealed that a treatment cart was not locked. The treatment cart was observed to remain unlocked until 7:52 AM and Staff #16, RN, who was working as the unit manager for the day, confirmed the unlock treatment cart. On 1/10/23 at 7:52 AM, the surveyor and the nurse, Staff #16, observed the contents of the treatment cart. Observations of the contents of the treatment cart revealed the following prescription medications: Hydrocortisone Butyral USP1% and Triamcinolone. On 1/10/23 at 7:53 AM, an interview with nurse, Staff # 16 confirmed that the expectation was that treatment cart should be locked. 3) On 1/24/24 at 6:22 AM, an observation was made on the second floor, outside of room [ROOM NUMBER]. The observation revealed an unlocked medication cart. The observation failed to reveal a nurse near the medication cart. Further observation revealed a nurse, Staff #62, down the hall, standing by a different medication cart. On 2/24/24 at 6:26 AM, during an interview, the nurse, Staff #62, reported that the medication cart outside room [ROOM NUMBER] was unlocked and that it was one of the two carts that nurse, Staff #62 was responisble for that shift. Staff #62 immediately locked the medication cart.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 16218 Based on medical record review and interview, it was determined that the facility failed to ensure that primary care and specialty provider notes were placed in the medical record for review by other health care professionals. This was found to be evident for 1 (#106) of 2 residents reviewed for behavioral and emotional status, 2 (#63, #59) of 6 residents reveiwed for communication and sensory problems, 1 (#53) of 2 residents reviewed for insulin, and 2 (#184, #183) of 20 residents reviewed for facility reported incidents. The findings include: 1) Review of Resident #106 medical record revealed an admitted in April 2023 with diagnoses that included, but were not limited to, history of stroke, high blood pressure, diabetes, lung disease and dementia. Review of the medical record on 1/17/24 revealed an order dated 7/26/23 for a psychiatric consult. On 1/17/23 at 12:32 PM surveyor reviewed with the unit nurse manager (Staff #23) that there was an order for a psychiatric consult in July but no documentation was found to indicate the resident was seen as a result of the July order. At 3:16 PM, the unit nurse manager, Staff #23, reported the resident was seen after the 7/26 order and that the psychiatric nurse practitioner would be providing the notes the next day. Review of the 7/31/23 psychiatric nurse practitioner (NP) Staff #54, note revealed the resident was seen for follow up management of anxiety. The note includes the following: .Based on this visit, which included patient assessment, reports from staff/caregiver, and clinical record review, the patient's psychiatric symptoms are worsening and require close follow up & intervention. Assessment / Plan / Orders / Recommendations: Patient with anxiety s/p [status post] gdr [gradual dose reduction] of seroquel [an antipsychotic medication] currently on hydroxyzine [an antihistamine used to treat anxiety] until 8/8/23. GDR of seroquel might have failed will recommend buspar [a medication used to treat anxiety disorders] but if not effective will consider re initiating seroquel. Recommend Buspar 5 mg po [by mouth] tid [three times a day] -[for] anxiety . Further review of the medical record failed to reveal documentation to indicate this recommendation was discussed with or reviewed by the primary care physician. No order was found for Buspar following the July psychiatric NP visit on 7/31/23. The psychiatric NP, Staff #54, was interviewed on 1/22/24 at 10:24 AM. After review of the 7/31/23 note, the NP reported she emails the notes to the facility; the DON, the ADON and unit manager and she thinks they call the primary care provider who will say yes or no [to the recommendations]. Cross reference to F 740 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 1/18/24, review of Resident #63's electronic health record (EHR) revealed a Psychoactive Review note, completed by the unit nurse manager (Staff #23) on 1/9/24. Review of this note revealed the resident was seen by a psychiartric nurse practitioner on 1/8/24. Further review of the EHR and the paper chart failed to reveal the psychiatric NP notes for the visit conducted on 1/8/24. The most recent psychiatric note found in the medical record was from October 2022. Further review of the medical record revealed an order, dated 9/11/23 for a psych consult. On 1/18/24 at 10:50 AM, surveyor interviewed the unit nurse manager, Staff #23, about the psychiatric notes. The unit nurse manager indicated the notes are sent to her via email. When surveyor asked about the note for the ordered consult, the unit nurse manager referenced a progress note that stated resident was seen by psych on 10/31/23 and indicated she would get the note for surveyor. On 1/18/24 at 11:16 AM, the unit nurse manager presented with a psychiatric NP note from a 11/20/23 visit and reported she obtained the note from her email. S/he went on to report that the notes are supposed to be scanned in by medical records and previously she would print and put them in the chart, but now everything was supposed to be scanned so she was no longer printing. On 1/31/24 at 1:40 PM, surveyor requested in writing the 1/8/24 psychiatric NP note from the administrative staff. The note was provided for review after the request was given to the administrative staff. On 1/31/24 at 3:45 PM, surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure that psychiatric providers notes were available in the medical record. 3) Review of Resident #53's medical record revealed the resident was admitted to the facility in February of 2023. The resident received multiple medications daily, including insulin. On 1/12/23, the Director of Nursing provided a primary care physician note for a visit on 10/9/23 that consisted of 22 pages. Surveyor informed the DON at 3:10 PM that this note was from October and asked if there were any notes from November or December. The DON indicated she would check with medical records. On 1/18/24, review of Resident #53's medical record revealed a nurse's progress note that the resident was seen by the physician on 11/21/23, however, further review of the medical record failed to reveal a corresponding physician note. Further review of the medical record failed to reveal a primary care physician note since October 2023. On 1/18/24 at 12:26 PM, surveyor reveiwed the concern with corporate nurse, Staff #15, that there were no primary care notes since October. Corporate nurse reported that the physician's office was sending them over and that a lot of the doctors had issues with the conversion [new ownership]. S/he reported the wound physician also had issues. 4) On 1/10/24, review of Resident #59's medical record revealed that the resident currently had pressure ulcers and there were orders for regularly scheduled dressing changes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/24, review of the electronic health record (EHR) revealed nursing progress notes that indicated the resident was seen by a wound physician in November and December 2023. Further review of the EHR failed to reveal documentation by a wound physician for the dates referenced in the progress notes. On 1/18/24, further review of the EHR and the paperchart failed to reveal the wound provider notes for November or December. Additionally, no primary care provider notes were found since October 2023. On 1/18/24 at 10:14 AM, surveyor requested the past three months of wound provider notes from corporate nurse (Staff #15) and reviewed the concern regarding the missing primary care physician notes for November and December 2023. On the afternoon of 1/18/24, the facility provided a large volume of notes for Resident #59 to the survey team. On 1/23/24, review of the provided notes revealed they were primary care physician notes for visits that occurred on November 7, 14, 21, 28, 2023 and December 5, and 12, 2023. No wound physician notes were found in the documentation provided. However, multiple copies of the primary care physician notes were found for most of the dates listed. Each of the PCP notes were 14 pages in length. The surveyor returned the extra copies to the corporate representative, Staff #3. On 1/23/24 at 2:40 PM, surveyor reviewed with the DON that they had provided multiple copies of resident's PCP notes, but none of the wound physician notes that had also been requested. On 1/30/24 at 10:47 AM, surveyor reviewed the concern with the DON, NHA and corporate nurse, Staff #15, that the wound physician notes were requested on 1/18/24. Review of the progress notes indicated that the resident had been seen by the wound MD, but further review of the medical record today again failed to reveal documentation of the wound MD notes since November 2023. Surveyor explained review of these notes were required in order to complete the investigation of the resident's pressure ulcers. They indicated they would follow up with the wound physician. On 1/31/24 at 10:30 AM, the DON provided copies of the wound physician notes for October 25, 2023, November 1, 9, 21, 29, 2023, December 6 and 13, 2023. 5) Review of Resident #184 medical record revealed the resident was admitted to the facility in December 2021. The resident's diagnoses included, but were not limited to, chronic kidney disease, heart disease, high blood pressure and diabetes. The facility submitted a self report (MD00181520) for an incident involving the resident on 8/1/22. Review of witness statements related to this incident revealed that a nurse practitioner (NP), Staff #37) was involved in the resident's care. On 1/24/24, review of both the paper chart and the electronic health record (EHR) failed to reveal progress notes completed by NP, Staff #37. On 1/24/24 at 3:32 PM during an interview with NP, Staff #37, s/he also was unable to find his/her notes in the paper chart. Surveyor then requested the notes for July 2022. On 1/25/23 at 2:34 PM, the NP, Staff #37 provided copies of notes for visits on 7/4/22, 7/28/22 and 7/30/22. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/25/24 at 3:45 PM, surveyor reviewed the concern with the DON and corporate nurse, Staff #15, that the facility failed to ensure that NP, Staff #37's visit notes were in either the EHR or the paperchart. Cross reference to F 726 and F 678. 6) Review of Resident #183's medical record revealed the resident was originally admitted in February 2023. The resident's diagnoses included, but were not limited to, multiple myeloma (blood cancer), Parkinson's disease, diabetes, heart disease and blindness. Review of MD00198905, revealed that 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 a medication used to treat cancer. Review of the investigation documentation and the resident's medical record revealed the order originated from the oncologist (Staff #61). 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 [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 3/28 oncologist note. Further review of the medical record, including the EHR and the paper chart, on 1/23/24 failed to reveal a typed/legible notes from the oncologist. Further review of the paper chart revealed multiple reports from the hospital where the resident saw several specialists. Reports from these specialist appointments revealed upcoming appointments for the resident with other specialists, including oncology. At least three appointments with the oncologist (Staff #61) were identified: 4/25/23, 7/26/23 and 10/25/23. Further review of the medical record failed to reveal documentation regarding the July or October appointments. On 1/23/24, the surveyor requested information regarding these appointments from the DON. The DON reported on 1/24/24 at 10:23 AM that the oncologist office will be sending over the March note, they reported the resident missed one appointment. Surveyor requested the DON to confirm the dates the resident was seen by the oncologist. The DON later provided a list of dates that included: 4/25/23, 5/30/23, 7/3/23 and 7/26/23. She reported that the resident was seen by oncology on all of these dates. The October date was not included in the list provided. There was no hand written or typed consultation report from the oncologist found in the medical record for these additional appointments with the oncologist. Cross reference to F 684

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation, record review, and interviews, it was determined that the facility failed to 1) have a physical barrier between the clean and soiled areas of the laundry room to prevent cross-contamination and 2) clean/replace a dirty nebulizer mask. This was evident for 2 out of 2 observations of the laundry room and 1 (#65) of 2 residents observed for oxygen use. The findings include: A nebulizer is a small machine that turns liquid medicine into a mist to be inhaled through a mouthpiece or mask and enters the lungs directly. After use, the mask or mouthpiece is washed with mild soap, rinsed under running water, dried on a paper towel, and kept in a sealable plastic bag. 1) On 1/17/24 at 9:35 AM, during a tour of the facility's laundry rooms, an observation was made of an opening between the clean and soiled areas of the laundry room with no door or physical barrier while laundry was being processed. Continued observation showed uncovered soiled linens in bins on the dirty side of the laundry room; then, after an opening space, dryers and clean folded linens were noted on a folding table on the clean side of the laundry room. An interview was done with Staff #58, a laundry aide, on the same day at 9:41 AM. During the interview, s/he confirmed that after dirty linens were received, they were placed into open bins on the dirty side of the laundry room and then into the washers. Staff #58 also confirmed that clean laundry was folded in the area where the dryers were and that there was no physical barrier between the clean and dirty areas of the laundry room. On 1/17/24 at 11:11 AM, an interview was conducted with Staff #57, Director of Environmental Services. During the interview, s/he verbalized understanding of the concern. S/he stated s/he would find out how to correct the concern. 2) On 1/9/24 at 12:39 PM, during a tour of the 2nd-floor unit, Resident #65 was observed wearing oxygen through a nasal cannula tubing attached to an oxygen concentrator set at 3 L (liters). Continued observation noted a nebulizer mask lying bare on a machine with no covering. A subsequent observation on 1/16/24 at 9:52 AM showed a nebulizer mask lying bare on Resident #65's bedside table. On 1/16/24 at 2:18 PM, a continued observation was made in Resident #65's room of a nebulizer mask lying on the floor on the right side of Resident #65's bed with no covering. On 1/11/24 at 1:14 PM, a medical record review for Resident #65 showed an attending provider note dated 7/25/23 that recorded diagnoses that included chronic obstructive pulmonary disease (COPD- a chronic inflammatory lung disease that obstructs airflow from the lungs). A continued review revealed an attending provider's order for Albuterol Sulfate Nebulization Solution via nebulizer for shortness of breath initiated on 10/13/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/24 at 12:56 PM, a subsequent record review for Resident #65 revealed an MDS assessment dated [DATE] that recorded that Resident #65 had intact cognitive status. A continued review revealed an attending provider's order for Albuterol Sulfate Nebulization Solution via nebulizer for shortness of breath initiated on 10/13/23. On 1/16/24 at 9:52 AM, during an interview with Resident #65, s/he stated that the nurses did not usually place the nebulizer mask in any covering. On 1/16/24 at 2:19 PM, during an interview, Staff #56, registered nurse (RN), stated that after administering the nebulizer to a resident, s/he usually rinsed off the mask, dried it on a paper napkin then placed the mask in a plastic bag. However, Resident #65's nebulizer mask was not placed in a bag from an earlier observation. When Staff #56 was asked about what happened to Resident #65's nebulizer mask that fell on the floor, s/he said s/he picked it up and placed it in a plastic bag on Resident #65's bedside table. Upon further questioning, Staff #56 stated that s/he should not have put it in the plastic bag after s/he picked it up from the floor and proceeded to the Resident's bathroom to wash it after the surveyor's intervention. On 1/22/24 at 12:16 PM, an interview was conducted with Staff # 32, unit manager. During the interview, s/he stated that his/her expectation of the nurses, when a nebulizer mask fell to the floor, was to change the mask and not put it back into a bag or rinse it off. On 1/29/24 at 1:46 PM, the above finding was reviewed with the Director of Nursing and s/he agreed with the surveyor's concern.