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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Laurelwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Laurel Drive Elkton, MD 21921	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34484 Based on medical record review, observation and interview, the facility staff failed to provide residents a dignified existence (Resident #20, #50, #121, #594, #595, #596, #597, #598 and #599). This was evident for 9 of 42 residents reviewed during a recertification/complaint survey. The findings include: Review of a complaint from Resident #121's responsible party (RP) revealed the RP stated the Resident was forced to share a bathroom with a member of the opposite sex. Review of Resident #121's medical record on 8/2/24 revealed the Resident was admitted to the facility on [DATE] and was in room [ROOM NUMBER]. Observation on 8/5/24 at 8:00 AM revealed room [ROOM NUMBER] has a shared bathroom with room [ROOM NUMBER]. Further observation of room [ROOM NUMBER] and 121's shared bathroom revealed there are no locks on the interior bathroom doors leading from the bathroom to rooms [ROOM NUMBERS] to provide privacy from residents of the opposite sex. Observation on 8/5/24 at 8:00 AM of all the resident rooms and shared bathrooms on A wing and review of the facility's Midnight Census Report for 10/3/22 revealed in addition to Resident #122 the following residents had to share a bathroom with members of the opposite sex with no mechanism to lock the bathroom door: Resident #20, #50, #594, #595, #596, #597, #598 and #599. Further review of the facility's Midnight Census Report for 10/3/22 revealed the facility had 3 rooms without residents assigned on A wing. Interview with the Infection Preventionist on 8/5/24 at 8:10 AM confirmed it is not the facility's practice to have residents of the opposite sex share a bathroom that can not be locked.

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on a complaint, observation, interviews, and record reviews, it was determined the facility failed to provide services with reasonable accommodation of resident needs and preferences. This was evident for 2 (#6, #134) of 87 residents reviewed during a recertification and complaint survey. The findings include: A Hoyer lift is an assistive device used to help persons with mobility challenges get in and out of bed. It allows a person to be lifted and transferred with a minimum of physical effort between a bed and a chair and vice versa. 1) On 7/23/2024 11:22 AM, surveyor observed Resident #6 sitting in a bariatric wheelchair and working with therapy in their room. On 8/6/2024 at 12:40 PM, an interview was conducted with the Area Manager for Therapy (Staff #35). Staff #35 stated that Resident #6 was currently on PT (physical therapy) case load and PT has been working with the resident since January 2024 for bed mobility and transfers. Staff #35 further stated that the resident required standby assist for bed to wheelchair transfers. However, she added that Resident #6 needed more assistance (max assist of at least 2 staff members) for transfer from wheelchair to bed as it involved transferring from a lower surface (wheelchair) to a higher surface (bed). Staff #35 further stated that they (PT) have recommended for staff to use a Hoyer lift when transferring the resident from wheelchair to bed. On 8/7/2024 at 11:20 AM, a review of PT Recertification and Updated Plan of Treatment for certification period: 7/31/2024 - 8/27/2024 was completed: Under Assessment Summary: Progress & Response to Tx: Pt is making gains in standing tolerance. Pt, staff, NSG (nursing), and corporate staff have been educated to not txer (transfer) pt to wc (wheelchair) unless wc has Hoyer pad in it . On 8/7/2024 at 1:00 PM, an interview was conducted with Resident #6 in their room: Regarding resident transfers, Resident #6 stated that the facility had a bariatric Hoyer lift that they were using to get her/him in and out of bed, but the lift was broken since May 2023 and the facility has not been able to get another working lift. The resident further stated that the staff tried using a smaller lift, but it was too tight and very uncomfortable. S/he added that the Director of Nursing (DON) was aware and stated it wasn't safe for staff to be using the smaller lift for transfers. Resident #6 stated that last Friday (about 2 weeks ago), the staff tried using a sit-to-stand lift, but that did not work either. When asked how the staff were getting her/him in/out of bed, Resident #6 stated that they were now using multiple staff members to get her/him in and out of bed even though PT had recommended that the staff should use a larger Hoyer lift for transfers. Resident #6 confirmed that the facility did not have a suitable Hoyer lift available for staff to use when getting her/him in and out of bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/2024 at 8:00 AM, an interview was conducted with B-Wing Unit Manager (UM #4): When asked how Resident #6 was transferred in and out of bed, UM #4 stated that they were using 2 people assist and sometimes 3 with help from PT. When asked about the use of a Hoyer lift as recommended by PT, UM #4 stated that the staff was supposed to use a Hoyer lift for transfers, but they did not have a working bariatric Hoyer lift suitable for the resident. He stated that the one they had was broken, and the parts no longer available. UM #4 added that both the Maintenance Director (Staff #12) and Administrator were aware of the issue. UM #4 confirmed that they were not using the Hoyer lift for transfers even though PT had recommended that it be used particularly when transferring the resident from chair to bed (lower surface to a higher surface). On 8/8/2024 at 8:10 AM, an interview was completed with Maintenance Director (Staff #12) who has worked in the facility for about 3.5 years: Staff #12 confirmed that the facility did not have a suitable Hoyer lift for staff to use when transferring Resident #6 in and out of bed. He stated that the facility had a 1000 lb. bariatric Hoyer lift that broke down in May 2023 and facility has not been able to get it fixed. However, he added that they were now working with a new company to get the Hoyer lift fixed. On 8/8/2024 at 8:26 AM, in an interview with the DON, he stated that they have tried several lifts, but Resident #6 could not tolerate them. Regarding transfers, DON stated that the resident was able to transfer with staff assist from bed to chair. When asked about PT recommendation for use of a Hoyer lift during transfers specifically when transferring resident from chair to bed, DON stated he was going to follow up on that. He added that they were currently working with the Regional Director of Operations to get a new lift that would work for Resident #6. On 8/8/2024 at 10:40 AM, in a follow up interview with the DON and Nursing Home Administrator (NHA), surveyor shared concerns regarding facility's lack of a suitable/working bariatric Hoyer lift for Resident #6 and staff not following PT recommendations to use the lift during transfers. NHA stated that they have not been able to repair the one that was broken and did not know if they will be able to get another lift for Resident #6. 34484 2) Review of Resident #134's medical record on 8/5/24 revealed the Resident was admitted to the facility on [DATE] for rehabilitation following a hospitalization . The Resident was assessed by the facility staff on the admission MDS (Minimum Data Set) dated 1/22/24 to have a BIMS (Brief Interview for Mental Status) of 15/15, cognitively intact. Interview with Resident #134 on 8/5/24 at 4:05 PM the Resident stated after admission the facility staff failed to give him/her a shower for approximately 2 weeks and the only reason he/she got one was because his/her visitor gave the shower. Further review of Resident #134's medical record revealed a nurse's note on 1/28/24 at 6:05 PM: Resident has a shower in the evening. The friend did the shower for resident. A nurse's note on 1/29/24 stated: Resident states has a yeast infection from not being able to shower every day. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Nursing (DON) on 8/6/24 at 9:43 AM, the DON was asked how do the facility staff determine when residents receive showers. The DON stated on the nursing admission assessment the resident is asked how many showers they would like to receive a week. Review of Resident #134's Nursing Admission Evaluation dated 1/15/24 with the DON, the facility staff documented in Section 2E Preferences: the resident prefers a shower 3 times a week. Review of shower documentation provided by the facility on 8/6/24 revealed from 1/15/24 until discharge on [DATE] the facility staff only documented they provided 2 showers on 2/5/24 and 2/7/24. Interview with the Infection Preventionist on 8/6/24 at 10:52 AM confirmed Resident #134 received 3 showers from 1/15/24 until 2/13/24.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to convey resident funds to a resident at discharge (Resident #104). This was evident for 1 of 3 residents reviewed during an annual survey. The findings include: Review of Resident #104's medical record on 8/1/24 revealed the Resident was admitted to the facility on [DATE] from another facility and discharged to the hospital on 3/6/24. The Resident did not return to the facility after discharge. Further review of Resident #104's medical record revealed on 3/4/24 the previous facility the Resident resided in sent a check to the facility for $2132.12 payable to the Resident and evidence the Resident's RFMS (Resident Fund Management Service) account was closed by the previous facility on 3/4/24. Further review of Resident #104's medical record revealed on 3/14/24 the facility staff sent back a check to the previous facility for $2132.12 even though Resident #104 was not a resident at that facility. During interview with the Business Office Manager (BOM) on 8/1/24 at 11:40 AM, the BOM was asked why the facility sent back a check to the previous facility when the Resident was not there. The BOM stated they had not yet opened a RFMS account for the Resident and felt like the previous facility could reopen the Resident's RFMS account and deposit the funds. Interview with the Administrator on 8/2/24 at 8:30 AM confirmed the facility staff failed to return Resident #104's check to the Resident and incorrectly returned it to the previous facility the Resident had resided in.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of complaints, medical record review, policy review, and interview, it was determined the facility staff 1) failed to notify the physician in a timely manner when a resident had a fall and weight loss and, 2) failed to notify the responsible party when there was a significant change in weight and a change in residents condition. This was evident for 1 (#102) of 8 residents reviewed for accidents and 3 (#247, #125, #133) of 3 residents reviewed for nutrition and significant change in condition The findings include: 1) On 7/31/24 at 8:38 AM a review of complaint MD00204146, that was received by the State Survey Agency (SA), alleged that Resident #102 was unable to walk or move out of bed. The complaint alleged that staff were changing Resident #102 and apparently dropped Resident #102 resulting in a broken hip. On 7/31/24 at 8:38 AM a review of Resident #102's medical record was conducted and revealed a physician's progress note dated 3/25/24 which revealed the physician saw Resident #102 for an acute visit. The physician documented, seen today for left leg and hip pain. Patient was seen at the bedside; said [he/she] fell yesterday while being turned in bed. Patient was in severe pain at 8/10, was unable to move [his/her] left hip and leg and did not want provider to move them either. Tramadol was given to patient for [his/her] pain; continue to monitor pain. Stat Xray to be ordered to rule out fracture. Review of the fall's investigation revealed the resident had a fall on 3/21/24. There was no documentation that the fall was reported to the physician or responsible party until 4 days later on 3/25/24. Review of the Notification of Change in Condition policy that was given to the surveyor by Staff #30 documented, The center must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notification. Circumstances requiring notification including but not limited to 1. A. Accidents resulting in injury, b. potential to require physician intervention. On 7/31/24 at 11:36 AM an interview was conducted with the Director of Nursing (DON) who stated the resident was found on the floor wrapped in blankets on 3/21/24. The DON stated that Geriatric Nursing Assistant (GNA) #25 asked GNA #24 if she reported it to the nurse, and she stated she did. The DON stated the nurse on duty, RN #19 stated she was not aware of the fall and was not informed by the GNA. The DON confirmed the fall was not reported to administration, the physician, and the responsible party until they became aware of it 4 days later on 3/25/24. 2) On 7/30/24 at12:30 PM review of complaint MD00186837 revealed a concern that Resident #247 entered the facility at a much higher weight and that the facility failed to monitor the resident's nutritional needs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 12:30 PM Resident #247's medical record was reviewed and revealed the resident was admitted to the facility in November 2022 for rehabilitation following hospitalization . Review of the weight section of Resident #247's medical record revealed on 11/6/22 Resident #247's weight was documented at 137.0 lbs. On 11/7/22 the recorded weight was 137 lbs. On 11/14/22 the weight was documented as 128.4 lbs. and on 11/21/22 the weight was documented as 132.4 lbs. Review of the admission dietary assessment dated [DATE] documented, Most recent wt.128.4# (11/14/22) show wt. loss 8.6# compared to wt. 137# on 11/6/22 and 11/7/22. Weight on 11/6 and 11/7 questionable. Resident on weekly wts. x 4 weeks to monitor wt. trend. Review of the physician's progress note of 11/20/22 documented, Weight loss. Currently being monitored closely. Multiple contributing factors including cognitive impairment as well as poor appetite and dysphagia. Continue multidisciplinary approach along with dietitian team. Review of the Notification of Change in Condition policy that was given to the surveyor by Staff #30 documented, The center must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notification. Circumstances requiring notification including but not limited to 3. Circumstances that require a need to alter treatment which may include a. new treatment b. discontinuation of current treatment, adverse consequences, acute condition, exacerbation of a chronic condition. Notifications: When a change in condition is noted, the nursing staff will contact the resident representative. There was no documentation that Resident #247's responsible party was notified of the weight loss. On 7/31/24 at 10:13 AM the issue was discussed with the Director of Nursing (DON). The DON stated they have had issues with the weights and that they were aware. 3) On 7/31/24 at 11:03 AM a review of complaint MD00185198 revealed a concern that Resident #125, who was on a feeding tube (gastrostomy) was extremely malnourished. A G-tube (gastrostomy) is a small, soft tube that surgically is inserted through the abdomen and into the stomach to provide direct access for feeding, hydration, or medicine. Review of the weight section of the electronic medical record documented on 10/25/22 there were (2) weights; (1) was 82.28 lbs. and (1) was 82.6 lbs. On 11/7/22 the weight was 68.8 lbs. and on 11/10/22 the weight was 69.0 lbs. Review of the admission nutritional assessment on 11/8/24 documented, weight trend since admission show weight loss of -16.7%/-13.8# compared to 82.6# on 10/25/22. The dietician documented, Requests reweigh; BMI classification underweight; Most current wt. show sig wt. loss. Change in wt. discussed with nursing and reweigh requested. Will adjust enteral nutrition using current wt. 68.8# to provide 41 kcal/day and 1.7 gm pro. Review of a 11/9/22 skilled note documented, weight loss of > 10 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/1/24 at 9:17 AM an interview was conducted with the RD about Resident #125's weight. When asked about physician notification the RD stated that the weights were discussed in risk meetings which are held once a week on Wednesdays but not documented in the medical record. The RD was asked what happened if a weight was noticed out of parameters on a Thursday and the risk meeting was not held until the following Wednesday. The RD stated that she would talk to the nurses but not the physician and the physician would not be made aware until the following Wednesday, therefore if the nurses don't notify the physician, then there is a delay. Review of the Notification of Change in Condition policy that was given to the surveyor by Staff #30 documented, The center must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notification. Circumstances requiring notification including but not limited to 3. Circumstances that require a need to alter treatment which may include a. new treatment b. discontinuation of current treatment, adverse consequences, acute condition, exacerbation of a chronic condition. Notifications: The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. When a change in condition is noted, the nursing staff will contact the resident representative. Further review of the medical record failed to have documentation that the physician and responsible party were made aware of the documented weight loss. On 8/1/24 at 10:05 AM discussed the weights and process issues with the DON who confirmed the findings. On 8/6/24 at 2:15 PM the Nursing Home Administrator was informed of the process issues with weights and nutrition. 44441 4) On 8/1/24 at 11:00 AM a review of a complaint incident MD00183575, stated that Resident #133 had a change in medical condition, was seen by a physician and that new treatments and medications were ordered for this resident. However, the family was not notified of this change in condition, or of the new treatments. Review of the nurses note dated 5/26/22 on 8/1/24 at 12:41 AM confirmed that resident had a change in condition and that new treatments and medications were ordered. The note however, did not state that the family members or their representatives were notified. In an Interview with the Director of Nursing (DON) on 8/1/24 at 12:54PM, he was asked the expectation for family notification when a change in condition occurs. The DON stated that for any change in condition, the family should be notified, that they don't have to be the residents Power of Attorney (POA), just the Emergency contact person. On 8/1/24 at 1:08 PM The DON was made aware that Resident #133's family members were not notified when resident had a change in condition and that this was a concern.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43096 Based on the facility's self-reported incident, residents' medical record review, and interview, it was determined that the facility failed to prevent incident of abuse that was related to a resident kissing an opposite-gender resident who did not want to. This was evident for one (Resident #16) of 13 abuse investigations, including complaints and facility-reported incidents. The findings include: A review of the facility reported incident MD00205715 on 8/01/24 at 9:00 AM revealed that a sexual abuse alleged on 5/14/24 by Resident #98 kissed Resident #16 (an opposite gender resident) on his/her lip, which Resident #16 did not consent to. On 8/01/24 at 9:27 AM, the surveyor reviewed the medical record of Resident #98 and #16. Resident #98's medical records revealed the resident was alert and oriented. BIMS (Brief Interview for Mental Status: an assessment used in nursing homes and other long-term care facilities to monitor cognition) was 12 out of 15 on 3/26/24. Also, Resident #98's records showed that a social worker (Staff #5) wrote a progress note on 5/15/24 (late entry; the note was for 5/14/24) as Resident was found in another resident's room by the Unit Manager and was advised that [Resident #98] has been advised on several occasions that he/she is not to enter into any other resident's room. The resident's room that [Resident #98] had entered into advised [another resident] does not want this resident in his/her room [Resident #98] continuously is kissing [another resident] when it is not wanted. Further review of Resident #16's progress note revealed that Staff #5 wrote on 5/14/24, the resident expressed that a certain male/female resident was bothering Resident #16 and she/he did not want this resident in their room because Resident #98 kisses Resident #16 all the time even though Resident #16 does not want to. During an interview with a social worker (Staff #5) on 8/01/24 at 12:39 PM, Staff #5 stated that Resident #98 had sexual behavior issues before the May 2024 incident. Staff #5 said, I overheard that Resident #98 kissed other residents. But no one witnessed it. The surveyor reviewed Resident #98's progress notes on 8/01/24 at 12:45 PM. The review revealed that Staff #5 wrote a progress note on 11/01/23 stating, Met with resident with DON (Director of Nursing) concerning the unwanted inappropriate sexual behaviors. Resident was advised of what the outcome could be with such behaviors (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 8/01/24 at 12:52 PM, the DON said that the facility staff asked another resident who was abused by Resident #98. Since the other resident denied the incident, the facility staff were not able to verify this incident. The DON was asked what the facility did after Resident #98's sexual abuse incident on 5/14/24. The DON stated that Resident #98's room was changed to the end of the hall. The surveyor questioned what precautions were provided for Resident #16, who did not want Resident #98's inappropriate sexual touching and/or entering rooms. The DON said, Since we moved Resident #98 to another room, he/she was unable to enter the room. The DON confirmed that no other intervention was provided to Resident #16. The above concern was shared with the nursing home administrator (NHA) on 8/07/24 at 11:05 AM, and the NHA validated it.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31145 Based on policy review, facility investigation review, medical record review, and staff interview, it was determined that the facility failed to implement the abuse policy by failing to timely report and conduct a thorough investigation of alleged abuse and a documented unwitnessed fall with injury. This was evident for 1 (#129) of 26 facility reported incidents reviewed and 1 (#102) of 8 residents reviewed for accidents. The findings include: On 7/22/24 at 9:25 AM an entrance conference was conducted with the Director of Nursing (DON), the Nursing Home Administrator (NHA) and the [NAME] President of Clinical Operations. The entrance conference sheet was provided which included a request for a copy of the Abuse Policy. Review of the Abuse, Neglect and Misappropriation Policy revealed, IV. Identification of incidents and allegations 2. The following procedure will assist the staff in the identification of incidents and direct them to appropriate steps of intervention. A. Each occurrence of resident incident, bruise, abrasion or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. B. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately. Required notification of agencies, physician, and resident representative will be completed. Investigation of Incidents: c: The Executive Director, Director of Nursing, or designee will report immediately to the appropriate agencies, and document the time and date of that report on the investigation form. D. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should be in writing, signed and dated at the time it is written. G. By the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the Executive Director or designee and submitted to the state. F. This file will be accessible for follow-up and state or local police review of the investigation. VII. Reporting of incidents and facility response. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 2. The results of the facility's investigation must be reported to the survey agency, the ED/designee and other officials in accordance with state law, within five working days of the incident. 1) On 7/30/24 at 8:47 AM a review of facility reported incident MD00187669 revealed on 1/11/23, it was reported that Resident #129 alleged that Staff #34 spoke to the resident, in a nasty manner and mean manner and screamed at the resident. (continued on next page)

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	215111	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelwood Healthcare Center	100 Laurel Drive Elkton, MD 21921

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigative packet that was given to the surveyor on 7/30/24 revealed (6) employee statements, (1) resident statement, care plans and the Medication Administration Record (MAR) for Resident #129. There were no other resident interviews on the unit where Resident #129 was located and there was no training in the file. There was no confirmation as to when the initial and 5-day reports were sent to the state agency, The Office of Health Care Quality (OHCQ). On 7/30/24 at 9:10 AM the Director of Nursing (DON) was interviewed and stated that he was having issues with self-reports. The DON stated, we saved them on my computer and my computer shot off and the files were wiped off. That is the issue I had. I do not have any documentation of when it was sent. Discussed the lack of investigation. There was no date and time of the alleged incident. There were no other resident interviews. There was no documentation of suspension or education in the packet provided to the surveyor. On 8/6/24 at 2:15 PM the Nursing Home Administrator was informed. 2) On 7/31/24 at 8:38 AM a review of complaint MD00204146 revealed an allegation that staff were changing Resident #102 and during that process dropped the resident onto the floor which resulted in a fractured hip. Review of the facility's investigation into the fall revealed that the fall was unwitnessed. The facility failed to report the unwitnessed fall with hip fracture to OHCQ. On 7/31/24 at 12:15 PM a review was conducted of the fall investigation given to the surveyor by the DON. The investigation consisted of a word document that stated, Resident presented with pain to hip to nursing staff, nursing staff reports resident had fallen 3 days prior. The document stated pain evaluation and x-rays were done, family was notified, resident discharged to ER (emergency room) and then to another facility from the ER. In the investigation there were only 3 witness statements, from RN #19 and GNA #25. There was a document that stated, multiple attempts made, and agency called several times. Would not locate GNA. Also included was a copy of the 3/25/24 nursing schedule. The DON was asked if there was any other information related to the fall and the response was, that's all I have. The investigation was incomplete. On 8/1/24 at 11:10 AM the complaint was discussed with the Corporate Nurse #36 who confirmed that the incident was not thoroughly investigated.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43096 Based on record review, interview with staff and facility reported incidents, it was determined the facility failed to ensure that allegations of abuse, neglect, exploitation, injuries of unknown origin, an elopement and unwitnessed fall were reported to the state agency within required timeframe. This was evident for 3 (Resident #101, #27, #129) of 26 residents reviewed for the facility's self-reported incidents and 1 (#102) of 8 residents reviewed for accidents. The findings include: 1) On 7/24/24 at 2:46 PM, a review of facility-reported incident MD00179979 revealed that on 6/23/22 Resident #101 alleged that the resident did not receive care timely when he/she had respiratory issue. Further review of Resident #101's statement for the incident on 7/24/24 at 3:00 PM revealed that the resident pushed the call bell several times for help because his/her oxygen bottle was empty and he/she did not get any oxygen through his/her nasal cannula on 6/23/22 around 5:45 AM. Resident #101 also reported that a nursing staff member approached him/her around 6:23 AM. The review of Registered Nurse (RN #27)'s statement on 7/24/24 at 3:05 PM showed that she heard someone yell help around 6:30 AM on 6/23/22 from [Resident #101's room], checked the room, and provided care for the resident. However, the review of the facility-reported incident form for this incident on 7/25/24 at 9:10 AM revealed that the initial report was submitted to OHCQ (Office of Health Care Quality) on 6/27/22 and the follow-up report was submitted on 7/02/22. On 7/25/24 at 10:10 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA said, Any abuse, neglect, and injury of unknown origin should be reported immediately or, in some cases, within 2 hours. The surveyor asked the report timing for the above incident. The NHA said, I don't know how it was reported a few days later. The surveyor shared concerns regarding self-incident reporting time, and the NHA validated it. 44441 2) On 7/24/24 at 11:30 AM, review of a facility report MD00193085 had that on 9/1/22, Resident #27 was in his room, opened his window and walked to the gas station in front of the facility to buy a cigarette. Resident was found by one of the staff members and assisted back to the facility. A complete head to toe assessment was completed. No injuries were noted, local law enforcement was notified. Resident was moved to a different room with the window facing a courtyard. Other appropriate interventions were initiated to prevent future elopement. Further review of the investigative report on 7/26/24 at 11:08 AM did not however show that the initial and final report was sent timely to the office of healthcare quality . The report was not in the investigative folder. The facility was asked to provide the missing document. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 at 1:25PM the Director of Nursing (DON) was asked again about the missing documents and he stated that his computer was down at some point and was sent out for repair, but when it was returned, all the documents stored within were wiped out. That he sent the computer back for the documents to be retrieved and still waiting to hear back from them. He was told that there was no proof that the incident was reported timely and that this was a concern. 31145 3) On 7/30/24 at 8:47 AM a review of facility reported incident MD00187669 revealed on 1/11/23, Resident #129 alleged that Staff #34 spoke to the resident, in a nasty manner and mean manner and screamed at the resident. Review of the facility's investigation failed to produce documentation as to when the initial report and 5-day report were sent into OHCQ. On 7/30/24 at 9:10 AM the Director of Nursing (DON) was interviewed and stated that he was having issues with self-reports. The DON stated, we saved them on my computer and my computer shot off and the files were wiped off. That is the issue I had. I do not have any documentation of when it was sent. On 8/6/24 at 2:15 PM the Nursing Home Administrator was informed. 4) On 7/31/24 at 8:38 AM a review of complaint MD00204146 revealed an allegation that staff were changing Resident #102 and during that process dropped the resident onto the floor which resulted in a fractured hip. Review of the facility's investigation into the fall revealed that the fall was unwitnessed. The facility failed to report the unwitnessed fall with hip fracture to OHCQ. On 8/1/24 at 11:10 AM the complaint was discussed with the Corporate Nurse #36 who confirmed that the incident was not reported to OHCQ.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on interviews, record reviews and a review of facility-reported incident investigations, it was determined that the facility failed to thoroughly investigate allegations of abuse, neglect, injury of unknown origin, unusual occurrence, elopements, and falls. This was evident for 9 (Resident #18, #101, #109, #112, #20, #27, #129 and #102) of 26 residents reviewed for facility self-reported incidents and 1 (#102) of 8 residents reviewed for accidents during a recertification/complaint survey. The findings include: 1)A portion of reviewing the facility reported incident MD00188036 on 7/22/24 at 12:04 PM revealed that Resident #18 exited the facility building without staff knowledge and was found outside of the building by other residents' family member on 1/20/23 around 5:45 PM. Further review of the facility's investigation revealed that the facility's investigation documentation contained that Resident #18 had a wander guard applied after the incident, care plan revised, psychology followed-up, and staff education provided. However, there was no documentation to explain how Resident #18 was eloped from the building. During an interview with the Director of Nursing (DON) on 7/24/24 at 10:18 AM, the DON stated that the facility did not have video footage to prove how Resident #18 exited through the kitchen door and followed the kitchen staff to get out. He said the kitchen door was the only one that was not secured then. However, the facility's investigation documentation did not include how they concluded Resident #18's exit. On 7/24/24 at 3:33 PM, the surveyor interviewed with the DON. The DON was informed that the self-reported incident MD00186359 was not thoroughly investigated to explain how it occurred. He validated it. 2) On 7/24/24 at 1:00 PM, a review of facility-reported incident MD00182626 revealed that on 4/26/22 Resident #101 alleged that the resident was neglected by a nurse evident by not received care when she/he had a respiratory distress. Further review of the facility's investigation for Resident #101's neglect incident on 7/24/24 at 1:20 PM revealed that the facility staff conducted staff interviews seventy of other residents and filled out 'resident interview & resident observation' forms. However, these forms did not include the date and information of who documented them. Also, no statement was obtained from Resident #101. During an interview with the Director of Nursing (DON) on 7/24/24 at 2:30 PM, the DON stated that if a resident had an issue and the facility reported a self-reported incident, the facility should interview the resident, staff, and other residents with a documenting date. The surveyor shared concerns about Resident #101's neglect incident, which was not investigated with the resident's interview and other residents' statements. The DON validated the above concern. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 7/24/24 at 2:46 PM, a review of facility-reported incident MD00179979 revealed that on 6/23/22 Resident #101 alleged that the resident did not receive care timely when his/her had respiratory issue. Further review of the facility's investigation of this incident on 7/24/24 at 2:50 PM revealed that the facility staff conducted interviews with Resident #101 and four nursing staff who cared for this resident, and other residents interviewed. The residents' interview form had sections of 'resident interview' and 'resident observation.' The facility staff filled out the form with each resident's name. However, none of these forms had a date, who conducted the interview, and/or observation. During an interview with the Director of Nursing (DON) on 7/24/24 at 3:24 PM, the surveyor asked about the other residents' interview regarding Resident #101's neglect incident that occurred on 6/23/22. The DON stated that the facility should interview other residents regarding this. The surveyor reviewed with the DON other residents' interview/observation forms, which did not contain the date and who performed. The DON said that it should be documented dates and interviewees. On 7/25/24 at 10:10 AM, the surveyor shared the above concerns with the nursing home administrator in an interview, and she validated them. 4) A review of the facility self-reported incident MD00180959 on 7/26/24 at 10:01 AM revealed that Resident #109 reported that a lady came into his/her room and put something into his/her rectum. On 7/26/24 at 9:45 AM, the surveyor interviewed the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON explained that Resident #109 kept reporting a rape since he/she was in the hospital. Resident #109's family member confirmed that the resident had been reporting a rape for a long time. However, there was no incident at the hospital or the facility. The surveyor requested facility self reported incident documentation for Resident #109's case. The NHA said, We were not able to find the file for this case. I wish I had a files for you. But I don't have. The NHA stated that any reportable incidents should be investigated by the Director of Nursing and/or Nursing Home Administrator, and they are supposed to keep the files. 5) On 7/25/24 at 1:20 PM, a review of facility-reported incident MD00186359 revealed that on 11/28/22 Resident #112 reported that a Geriatric Nursing Assistant hit his/her hand. Further review of the facility's investigation on 7/25/24 at 1:30 PM revealed that the facility submitted an initial self-reported incident on 11/28/22. However, there was no follow-up report. Also, 56 other residents' interview/observation forms were found without a written date and information about who conducted the interviews or observations. In an interview with the Director of Nursing (DON) on 7/25/24 at 3:28 PM, the DON stated that the facility should have documentation of follow up report of each self reported incident. The surveyor shared concerns regarding the leak of the investigation about Resident #112's abuse incident. The DON validated this. 48168 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 7/23/24 at 2:41 PM a review of the Office of Health Care Quality's (OHCQ) report of FRI #MD00207558 described an incident that occurred on 7/11/24 when Resident #20 was found to be excessively sleepy and was subsequently treated with Narcan. On 7/23/24 at 2:43 PM a review of the facility's investigation records of the incident revealed a copy of the initial report to OHCQ which indicated a date but lacked the time the report was made. The file also contained medical records that documented the nurse's assessment of the resident's condition and collaboration with the on-call physician, a list of Resident #20's medications, a list of other residents who had orders for narcotic medications, a handwritten notice that listed a police case number and officer name from Elkton PD. There was also an education sheet with the topic Use of Narcan; Hospice (when to call) with an attached attendance form, but both were undated. No staff or resident interviews or statements were included in the file and no explanation for the incident was documented in the file. Although a copy of the initial report to OHCQ was present, the final 5-day report to OHCQ was not present in the investigation file. On 7/29/24 at 1:30 PM an interview with the Director of Nursing (DON) was conducted. When asked about the incident, he explained that Resident #20 was under hospice care for a terminal condition and had been very lethargic. He also explained that the nurse who worked with the resident on 7/11/24 called the on-call physician to report the resident's lethargy/excessive sleepiness, and was given an order to administer Narcan to reverse the effects of the narcotic medication. However, the nurse did not consult with any hospice staff regarding the resident's condition. The DON further explained that during the facility investigation, the primary physician was interviewed who said he did not agree that the resident should have received Narcan since the resident's lethargy was not due to the narcotics, but was due to a decline in condition. The DON confirmed that the facility's investigation file did not contain any written statement from the primary physician, or explanation of the facility's conclusion regarding their investigation. He also confirmed that the documentation of education provided to staff lacked the date that the education was provided, and he could not validate when the education occurred. On 8/08/24 at 9:10 AM an interview with the Nursing Home Administrator (NHA) was conducted and she acknowledged and validated that the facility's investigation of incident # MD00207558 was incomplete. 44441 7) On 7/24/24 at 11:30 AM, review of a facility reports MD00193085 had that on 9/1/22, Resident #27 was in his room, opened his window and walked to the gas station in front of the facility to buy a cigarette. Resident was found by one of the staff members and assisted back to the facility. A complete head to toe assessment was completed. No injuries were noted, local law enforcement was notified. Resident was moved to a different room with a window facing a courtyard. Other appropriate interventions were initiated to prevent future elopement. Further review of the investigative file documents was done on 7/26/24 at 11:08AM. Some of the documents could not be found such as, copies of the initial and final reports, copies of the one-on-one supervision provided to the resident and the post elopement staff education sign in sheets. The facility was asked to provide the missing documents. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 at 1:25PM the Director of Nursing (DON) was asked again about the missing documents. He stated that his computer was down at some point, he sent it out for repairs but when it came back, all the documents stored within was wiped out. The DON said he sent it back to be retrieved and is still waiting to find out if that was possible. He was made aware that this was a concern as the facility was unable to provide proof that a thorough investigation was conducted. 31145 8) On 7/30/24 at 8:47 AM a review of facility reported incident MD00187669 revealed on 1/11/23, Resident #129 alleged that Staff #34 spoke to the resident, in a nasty manner and mean manner and screamed at the resident. Review of the facility's investigative packet that was given to the surveyor on 7/30/24 revealed (6) employee statements, (1) resident statement, care plans and the Medication Administration Record (MAR) for Resident #129. There were no other resident interviews on the unit and there was no training in the file. On 7/30/24 at 9:10 AM the Director of Nursing (DON) was interviewed and stated there was no other documentation regarding the incident. The DON was informed that there was no documentation as to the date of the incident, no resident interviews, and no documentation of suspension of the employee or staff education. On 8/6/24 at 2:15 PM the Nursing Home Administrator was informed. 9) On 7/31/24 at 8:38 AM a review of complaint MD00204146 revealed an allegation that staff were changing Resident #102 and during that process dropped the resident onto the floor which resulted in a fractured hip. Review of the facility's investigation into the fall revealed that the fall was unwitnessed. On 7/31/24 at 12:15 PM a review was conducted of the fall investigation given to the surveyor by the DON. The investigation consisted of a word document that stated, Resident presented with pain to hip to nursing staff, nursing staff reports resident had fallen 3 days prior. The document stated pain evaluation and x-rays were done, family was notified, resident discharged to ER (emergency room) and then to another facility from the ER. In the investigation there were only 3 witness statements, from RN #19 and GNA #25. There was a document that stated, multiple attempts made, and agency called several times. Would not locate GNA. Also included was a copy of the 3/25/24 nursing schedule. The DON was asked if there was any other information related to the fall and the response was, that's all I have. On 8/1/24 at 11:10 AM the complaint was discussed with the Corporate Nurse #36 who confirmed that the incident was not thoroughly investigated. 34484 10) Review of Resident #120's medical record on 8/2/24 revealed Resident #120 was admitted to the facility on [DATE] following a hospitalization and on 1/6/23 at 10:00 PM the Resident was found on the floor. At that time the facility staff were asked if there was any investigation into Resident #120's unwitnessed fall to the ground. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Infection Preventionist on 8/2/24 at 8:55 AM confirmed the facility had no staff interviews or investigation of Resident #120's fall on 1/6/23.

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42507

Based on observation, medical record review, and interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2 (#38, #125) of 82 residents reviewed during a recertification/complaint survey.

The findings include:

The MDS 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.

Ventilator (Vent) /Ventilator support: A ventilator (Vent) is a machine that helps you breathe or breathes for you.

Oxygen therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider.

1) On 7/22/2024 at 10:00 AM and 2:00 PM respectively, surveyor observed Resident #38 lying in bed with eyes closed. There was no Ventilator/equipment noted in the resident's room. Resident #38 was on room air (no oxygen and/or ventilator setup in room).

On 7/22/2024 at 2:29 PM, review of Resident #38's quarterly MDS with an assessment reference date (ARD) of 7/5/2024 was completed. Section O (special Treatments/Procedures/Programs) under C1 coded Yes for Oxygen therapy while a resident in the facility. Section F1: Invasive Mechanical Ventilator coded Yes while a resident in the facility.

On 7/23/2024 at 9:29 AM, Surveyors again observed Resident #38 in bed and the resident was on room air (No vent, no Oxygen and/or vent/oxygen setup in their room). In an interview with Resident #38, the resident stated that s/he has never had a tube put in while in the facility and denied using oxygen.

On 7/23/2024 at 1:07 PM, a review of Resident #38's clinical records revealed the Resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with medical diagnoses that included but not limited to seizures, atrial fibrillation, alcohol dependence with other alcohol-induced disorder, dementia, mild cognitive impairment, insomnia.

On 7/23/2024 at 3:31 PM, an interview was completed with the Director of Nursing (DON). DON confirmed that Resident #38 was not on a vent and/or oxygen therapy. Surveyor reviewed resident's quarterly MDS with ARD date of 7/5/2024, Section O. DON reviewed and confirmed that the MDS was inaccurate as Resident #38 was not on a vent and/or oxygen. He added that the facility did not have any resident on a vent: Nobody in the building is on a vent.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/2024 at 9:56 AM, in an interview with the MDS Coordinator (Staff #1), surveyor reviewed Section O of Resident #38's quarterly MDS with ARD of 7/5/2024. Staff #1 verified and confirmed that Resident #38's MDS assessment was inaccurate. She further confirmed that Resident #38 has never had a vent while a resident in the facility and added that the Vent coding on the quarterly MDS with ARD date of 7/5/2024 was an error and wrong. Regarding the coding for Oxygen therapy, Staff #1 reviewed and confirmed that the resident was not on Oxygen and the MDS coding for oxygen was an error. She stated she was going to correct it. On 7/24/2024 at 10:10 AM, Staff #1 brought surveyor revised copies of the MDS that indicated Resident #38 was not on a vent and/or oxygen. 31145 2) On 7/31/24 at 11:03 AM Resident #125's medical record was reviewed. The weights and vital sign section of the electronic medical record documented a 10/25/22 admission weight as 82.6 lbs. On 11/7/22 the weight was documented as 68.8 lbs. and on 11/20/22 the weight was documented as 69.0 lbs. Review of the 10/26/22 dietary progress note documented Resident #125's weight as 82.6 lbs. Review of the 11/7/22 at 3:20 PM change in condition note documented Resident #125's weight as 68.8 pounds. Review of the 11/8/24 nutritional admission assessment documented, weight trend since admission show weight loss of -16.7%/-13.8# compared to 82.6# on 10/25/22. Review of the admission MDS with an assessment reference date (ARD) of 10/30/22 documented in section K0200B a weight of 83 lbs. Review of the MDS with an ARD of 11/12/22, Section K0200B documented a weight of 69 lbs. In section K0300, Loss of 5% or more in the last month or loss of 10% or more in last 6 months was documented as, no or unknown. The facility failed to capture the 13.6 lb. weight loss from 10/25/22 to 11/12/22. On 8/6/24 at 9:22 AM RN #1, the MDS Coordinator was interviewed and stated that there was no weight loss, only a 5 lb. weight loss because the dietician did not go off the hospital record. RN #1 stated there was a discrepancy with the documentation. RN #1 stated the hospital weight upon admission was 73 lbs. and she just uploaded the hospital documentation in the medical record on 8/1/24 after being informed of the error. However, the admission MDS with an ARD of 10/30/22 documented the weight as 83 lbs. and was completed by RN #1. The Nursing Home Administrator was informed on 8/6/24 at 2:15 PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on medical record review, staff interviews and a complaint, it was determined that the facility staff failed to develop, initiate and implement a comprehensive person-centered care plans for residents. This was evident for 7 (Resident #35,#30, #92, #72, #247, #125 and #113) of 87 residents reviewed for care plan during the facility's recertification/complaint survey. 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. Legal blindness is visual acuity less than 20/200, but to fit the definition, the person must not be able to attain 20/200 vision even with prescription eyewear. Normal vision is 20/20. That means you can clearly see an object 20 feet away. If you're legally blind, your vision is 20/200 or less in your better eye or your field of vision is less than 20 degrees. That means if an object is 200 feet away, you have to stand 20 feet from it to see it clearly. 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. 1) On 7/22/2024 at 10:24 AM, during an initial pool screening of Resident #35, the resident stated that s/he was blind. On 7/25/2024 at 8:51 AM, a review of Resident #35's clinical records revealed the resident was originally admitted to the facility on [DATE] with medical diagnoses that included but not limited to LEGAL BLINDNESS, AS DEFINED IN USA On 7/30/2024 at 8:32 AM, a review of quarterly MDS with Assessment Reference Date (ARD) of 6/27/2024 revealed Resident#35 was coded under section B1000 (Vision) as follows: -Ability to see in adequate light (with glasses or other visual appliances), Highly Impaired -How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? Always On 7/30/2024 at 9:00 AM, a review of nurses' progress notes revealed the following documentation on 7/19/2024 at 17:15 (5:15 PM): Always require someone to assist with reading instructions, pamphlets and other written material by Physician or Pharmacy. On 7/30/24 at 1:55 PM, further review of Resident #35's medical record revealed the facility staff failed to develop and implement a care plan with specific interventions and approaches to manage the resident's legal blindness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/1/2024 at 1:36 PM, an interview was conducted with the B-Wing Unit Manager (UM #4). The surveyor reviewed Resident #35's care plan with UM #4 who verified and confirmed that the care plan was not comprehensive, and resident centered as it failed to capture the resident's diagnosis of legal blindness. UM #4 stated he was going to revise the resident's care plan. On 8/8/2024 at 10:45 AM, surveyor informed the Director of nursing (DON) and Administrator of the concern regarding failure to develop a care plan for the diagnosis of legal blindness. 48168 2) On 7/24/24 at 9:25 AM a record review of Resident #30's records revealed a document dated 10/10/22 that attested the resident had schizophrenia. A review of the resident's care plan revealed no problem listed for schizophrenia. On 7/24/24 at 2:37 PM an interview with the Director of Nursing (DON) was conducted. He confirmed that Resident #30 had a diagnosis of schizophrenia. During a joint review of the resident's care plan the DON stated that there was no problem listed for the resident's psychiatric disorder of schizophrenia and there should have been. He further stated that the unit managers were responsible to ensure resident care plans were comprehensive, and that MDS nurses and staff nurses also had the ability to update care plans and this was typically done during care plan meetings. On 8/08/24 at 9:10 AM an interview with the Nursing Home Administrator was conducted to review the care plan concern for Resident #30. She acknowledged that she was aware of the concern and that it was being addressed. 47200 3) On 7/26/24 at 10:29AM the surveyor reviewed the medical record for Rresident #92 and observed the following diagnosis present in the medical record: displaced fracture of the left femur neck. On 7/26/24 at 11:26AM the surveyor reviewed the medical record for Resident #92 which revealed no mention of the resident's fracture or care interventions for the fracture. On 7/26/24 at 11:39AM the surveyor shared the concern with the facility's Infection Preventionist Registered Nurse (RN) #30 who acknowledged understanding of the surveyor's concern. On 7/26/24 at 12:31PM the surveyor conducted an interview with the Director of Nursing (DON) who reported that universal hip precautions were used for the resident, however, there was no care plan information addressing the fracture and care of it on the care plan. During the interview, the DON stated to the surveyor that their expectation was for the fracture and care of the fracture to be present on the resident's care plan. The surveyor shared their concern with the DON who acknowledged and confirmed the concern. On 7/29/24 at 1:32PM the surveyor conducted an interview with RN #30 who confirmed that the care of Resident #92's fracture was not on their care plan and that it didn't get put in. 49409 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 07/29/24 at 08:36 AM, a record review revealed that the resident has an active physician's order from 04/18/2024 to the current date, receiving Methadone HCL oral concentrate 10mg/ml; given 6ml by mouth one time a day for opioid usage. Methadone is a synthetic analgesic drug that is used in the treatment of narcotic addiction and has multiple side effects. The facility failed to develop a comprehensive care plan, including a care plan for Methadone usage for addiction and monitoring for possible side effects. An interview with the unit manager (Staff # 23) on 07/28/24 at 1:44 PM revealed that he/she is responsible for updating the care plans, and the facility does not develop a dedicated care plan for Methadone usage. During an Interview with DON (Director of Nursing) on 07/29/24 at 10:01 AM, it was verified that a care plan should be developed for Methadone usage, with a goal and interventions to monitor for side effects. 31145 5) On 7/30/24 at12:30 PM review of complaint MD00186837 revealed a concern that Resident #247 entered the facility at a much higher weight and that the facility failed to monitor the resident's nutritional needs. Review of the weight section of Resident #247's medical record revealed on 11/6/22 Resident #247's weight was documented at 137.0 lbs. On 11/7/22 the recorded weight was 137 lbs. On 11/14/22 the weight was documented as 128.4 lbs. and on 11/21/22 the weight was documented as 132.4 lbs. Review of the admission dietary assessment dated [DATE] documented, Most recent wt.128.4# (11/14/22) show wt. loss 8.6# compared to wt. 137# on 11/6/22 and 11/7/22. Weight on 11/6 and 11/7 questionable. Resident on weekly wts. x 4 weeks to monitor wt. trend. Review of Resident #247's care plan, resident with potential for altered nutrition that was initiated on 11/21/22, had the interventions, notify medical provider and resident representative of unplanned weight changes and obtain weekly weights if unplanned weight loss is identified. There was no documentation that Resident #247's responsible party was notified of the weight loss. The care plan was not implemented. 6) On 7/31/24 at 11:03 AM a review of complaint MD00185198 revealed a concern that Resident #125, who was on a feeding tube (gastrostomy) was extremely malnourished. A G-tube (gastrostomy) is a small, soft tube that is surgically inserted through the abdomen and into the stomach to provide direct access for feeding, hydration, or medicine. Review of the weight section of the electronic medical record documented on 10/25/22 there were (2) weights; (1) was 82.28 lbs. and (1) was 82.6 lbs. On 11/7/22 the weight was 68.8 lbs. and on 11/10/22 the weight was 69.0 lbs. There was no weight obtained on 11/1/22. (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 the admission nutritional assessment on 11/8/24 documented, weight trend since admission show weight loss of -16.7%/-13.8# compared to 82.6# on 10/25/22. The dietician documented, Requests reweigh; BMI classification underweight; Most current wt. show sig wt. loss. Change in wt. discussed with nursing and reweigh requested. Review of a 11/9/22 skilled note documented, weight loss of > 10 lbs. On 8/1/24 at 9:17 AM an interview was conducted with the RD about Resident #125's weight. When asked about physician notification the RD stated that the weights were discussed in risk meetings which are held once a week on Wednesdays but not documented in the medical record. The RD was asked what happened if a weight was noticed out of parameters on a Thursday and the risk meeting was not held until the following Wednesday. The RD stated that she would talk to the nurses but not the physician and the physician would not be made aware until the following Wednesday, therefore if the nurses don't notify the physician, then there is a delay. Review of Resident #125's care plan, Resident with potential for altered nutrition status r/t dysphagia AEB (as evidenced by) need for enteral nutrition to meet 100% estimated needs had the intervention, Notify medical provider and resident representative of unplanned weight changes and obtain weekly weights if unplanned weight loss is identified. Further review of the medical record failed to have documentation that the physician and responsible party were made aware of the documented weight loss. The care plan was not implemented. On 8/1/24 at 10:05 AM discussed the weights and process issues with the DON who confirmed the findings. On 8/6/24 at 2:15 PM the Nursing Home Administrator was informed of the findings. 43096 7) When investigating complaints on 8/06/24 at 9:22 AM, one of the complaints claimed that Resident #113 did not receive Activities of Daily Living (ADL) care such as showers, nail trims, and shaving. On 8/04/24 at 9:30 AM, the surveyor reviewed Resident #113's MDS (Minimum Data Set: a federally mandated process that assesses the clinical needs and functional capabilities of residents in nursing homes that are certified by Medicare or Medicaid) dated 5/09/23. The MDS was coded that the resident was able to conduct ADL care independently or with supervision. Further review of Resident #113's Documentation Survey Report (also known as GNA task: documentation for the resident's task records with their performance and support provided for each care area such as independent, supervision, limited assistance, extensive assistance, and total dependence) for May-June 2023 revealed that the resident performance level was him/herself or set up required, but the support provided recorded as 'ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.' Additionally, a review of Resident #113's progress note on 8/04/24 at 10:00 AM revealed that a nursing staff member documented 'refused scheduled shower/bath, offered alternative but patient stiff refused' on 6/22/23 and 'resident has been denying showers and being cleaned up at all' on 6/28/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, no care plan was developed for Resident #113 for the ADL refusal. During an interview with the Director of Nursing (DON) on 8/06/24 at 2:56 PM, the DON stated that if residents refused ADL care, the facility staff expected to be approached by other staff, notify family members and providers, be documented on their medical records, and initiate care plan for that. The surveyor reviewed Resident #113's care plan with the DON. The DON verified that care plan of Resident #113's ADL care refusal had been developed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on complaints, observation, record review, and interview, it was determined that the facility staff: 1) failed to hold care plan meetings for residents and/or their representatives (Resident #38, #35, #14, and #15) and 2) failed to revise and update resident's comprehensive care plan (Resident #14, #15, #72) . This was evident for 5 of 87 residents reviewed during a recertification/complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident ' s care. The Minimum Data Set (MDS is a complete assessment of the resident, which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and modify the care plan based on the resident's status. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 7/23/2024 at 9:27 AM, in an interview with Resident #38, the resident told the surveyor that s/he has not seen a social worker for a long time. On 7/23/2024 at 2:03 PM, a review of social services progress notes for Resident #38 did not reveal any care plan meetings were held in 2024. The last documentation by social services was on 11/10/2023 at 08:08 (8:08 AM) that noted: CP (care plan) Review: CP up to date. Resident Current MOLST with date 03/19/2023 and 2 Physician Certificates are both located in resident's chart. On 7/24/2024 at 1:58 PM, in an interview with the Social Services Designee (Staff #5) in the presence of the Regional Director of Social work (Staff #6), Staff #5 stated that she talks with Resident #38 every day when she makes floor rounds. When asked what they talked about, she stated that she just stops by and say hello when she walks the hallways. Surveyor asked Staff #5 when she last had a care plan meeting with the resident and/or the resident representative (RP). Staff #5 confirmed that she was behind with the care plan meetings and that she had not written any notes in Resident #38's chart since 11/10/2023 and prior to 7/23/2024. 2) On 7/22/2024 at 10:24 AM, during initial pool screening, Resident #35 stated s/he had not seen the social worker and/or remember having any care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/2024 at 2:15 PM, an interview was conducted with the Social Services Designee (Staff #5) in the presence of the Regional Director of Social work (Staff #6). Staff #5 stated that she met with Resident #35 on 1/5/2024. When asked when they last had a care plan meeting with the resident and/or their representative (RP), Staff #5 stated that she was behind with the care plan meetings. Staff #5 confirmed that she was behind with scheduling of Care plan meetings and had not had a meeting with the resident and/or their RP in 2024. However, Staff #5 acknowledged that Care plan meetings were supposed to be held on admission, 48 hours after admission, quarterly, and when there was a change in condition. She further stated that they have a plan in place moving forward to make sure care plan meetings were held regularly. On 7/24/2024 at 3:27 PM, a review of social services progress notes for Resident #35 did not reveal any care plan meetings were held in 2024. The last documentation by social services was on 4/5/2024 at 13:06 (1:06 PM) that noted: Faxed Resident Consent for Dental procedure. 3) On 8/5/2024 at 10:00 AM, a review of complaint #MD00198646 and complaint #MDOO188226 was completed. The complainant reported that s/he used to participate in care plan meetings, but the facility does not include her/him anymore. The complainant further reported that s/he was not notified of changes and would like to see the patient [resident #14] in physical therapy but was not sure if the resident could walk. On 8/5/2024 at 10:08 AM, a review of Resident #14's clinical records revealed the resident was originally admitted to the facility on [DATE] with medical diagnoses that included but not limited to muscle wasting and atrophy right/left thigh, difficulty walking, type 2 diabetes, bipolar disorder, dementia. On 8/5/2024 at 12:19 PM, a review of social services progress notes for Resident #14 did not reveal any care plan meetings were held in 2024. The last documentation by social services was on 12/26/2023. On 8/5/2024 at 12:40 PM: In an interview with the Social Services Designee (Staff #5), she confirmed that she has not had any care plan meetings with the resident's representative, [name], this year (2024). However, Staff #5 stated that she was in the process of uploading invites that she was sending out for care plan meetings. On 8/6/2024 at 12:30 PM, an interview was conducted with the Area Manager for Therapy (Staff #35): She stated that Resident #14 has not been on PT (physical therapy)/OT (occupational therapy) case load recently. Staff #35 stated that the resident refused OT evaluation in December 2023 and has not been seen since. She added that Resident #14 was last seen by PT on 11/10/2023. Staff #35 confirmed that the resident was not seen by PT and/or OT for the whole of 2024 because s/he was refusing to be screened. When asked if the resident ' s care plan reflected that s/he was refusing PT/OT services and/or any written progress notes by therapy for the refusals, Staff #35 stated she did not know but will investigate. Staff #35 then reviewed Resident #14's records and stated that she could not find any notes from therapy that indicated that the resident refused PT/OT in 2024. On 8/6/2024 at 12:40 PM, a review of Resident #14's care plan revealed the care plan was not revised to reflect that the resident was refusing to participate in therapy (PT/OT). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/2024 at 10:40 AM, in an interview with the Director of Nursing (DON) and Administrator, they were informed of surveyor's concerns regarding no care plan meetings, resident's family not updated that the resident was not receiving therapy anymore because of their refusal to participate, and care plan not revised to address resident ' s refusals of PT/OT. Administrator stated that she was aware of surveyor's findings. 49409 4) A record review on 07/26/24 at 10:53 AM revealed that Resident # 72 has been in the facility receiving long-term care for more than a year. The most recent quarterly MDS was completed on 05/28/24. No documentation was found to indicate that the IDT held a care plan meeting. The care plan for skin impairment was revised on 04/19/24 and reflected that the resident had stage II and III pressure ulcers. On 07/26/24 at 10:55 AM, the Surveyor observed resident that the resident didn't have any open areas. An interview with the resident on 07/26/24 at 10:55 AM revealed that he/she doesn't have any open areas now but had open areas before, and they were healed. He/she does not remember when they were healed. On 07/26/24 at 11:30 AM, an Interview with a Registered Nurse (Staff #30) regarding the process of care plan updates, he/she stated that unit managers update the care plans in the Nursing department; other departments do their own updates. On 07/26/24 at 01:19 PM, an Interview with the Unit manager (Staff #23) revealed that resident #72 has open areas. He/she attends wound rounds when the treatment Nurse is not available. The treatment nurse does wound rounds along with healing partner consultants on Mondays and Thursdays and also completes the care plan updates. The unit manager also added that the Licensed Nurses, Unit managers, the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) update the care plans when there is a change. On 07/29/24 at 10:19 AM Interview with DON and ADON revealed that wound documentation begins at admission, and ongoing measurements of the wound documentation are done weekly. The care plan is initiated with a baseline care plan, comprehensive, followed by quarterly and significant changes in the resident's condition. DON confirmed that the Unit managers update care plans quarterly, and each time there is a change. After managers update, MDS does the final review. The surveyor reviewed with DON and ADON that the care plan for pressure ulcers were inaccurate. 50502 5) On 7/30/24 at 9:53 AM, a review of Resident #15's medical record dated 6/05/24 revealed a BIMS score of 4 out of 15. Brief Interview for Mental Status (BIMS) is a screening tool used to assess basic cognitive function in patients in long-term care facilities. A score of 0-7 indicates that a patient has severe cognitive abilities. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 11:20 AM, further review of the medical record revealed that Resident #15 had a diagnosis of but not limited to Unspecified Dementia, unspecified severity without behavioral disturbance and Delusional disorders. On 7/30/24 at 11:23 AM, a review of care plans documented for Resident #15 revealed care plans were in place: The resident has impaired cognitive function r/t dementia. which was initiated on 9/15/2023 and revised on 12/03/2023. Resident has a mood problem r/t depression., initiated on 9/15/2023 and revised on 9/15/2023. The resident has a behavior problem r/t Psychosocial issues. Refuses to cover the feet with socks or a cover. Chooses to have bare feet exposed. Refusing medication, increased confusion, increased delusions, verbal aggression, physical aggression. This was initiated on 10/12/2023 and revised on 5/24/2024. However, there was no evidence in the medical record that the care plan was evaluated to reflect behavior monitoring. On 7/31/24 at 10:42 AM, a review of Resident #15's medical record showed that admission/discharge care plan meeting notes were completed on 8/08/23 and 6/06/24. However, further review of the records revealed no evidence indicating that Quarterly and Significant Change Care plan meetings were scheduled and held with the interdisciplinary team. On 8/01/24 at 10:13 AM, during an interview with the Director of Nursing (DON), he stated that he occasionally attended care plan meetings, and the Social worker documented the minutes in the electronic medical record under progress notes. The DON was notified of a concern regarding care plan meeting documentation and scheduling. The surveyor shared the social worker's (Staff #5) statement on 7/24/24 at 1:58 PM with the DON: the facility's care plan meeting. Staff #5 confirmed they were behind with the scheduling of care plan meetings. The DON stated, I am well aware of it; we recognized the issue a month ago and did a 100% audit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide medication and treatment in accordance with professional standards of practice (Resident #110, #120 and #134) and 2) failed to have an order for the management of oxygen for a resident on oxygen therapy (Resident #133). This was evident during a recertification/complaint survey. The findings include: 1) The facility staff failed to monitor Resident #110's blood sugars per hospital's nursing report. Review of Resident #110's medical record on 7/30/24 revealed the Resident was admitted to the facility on [DATE] from the hospital with a diagnosis to include uncontrolled diabetes. Diabetes is a long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels. Review of Resident #110's May 2023 Medication Administration Record (MAR) revealed the facility staff was monitoring the Resident's blood sugar before meals and at bedtime prior to the administration of insulin, 4 times a day from 5/9/23 until 5/15/23. Further review of the Resident's medical record revealed on 5/15/23 the Resident was sent to the hospital for a diagnosis to include hyperglycemia. Hyperglycemia is a condition in which the level of glucose in the blood is higher than normal. The Resident returned to the facility on [DATE]. Review of the Nurse to Nurse Report from the hospital on 5/23/23 stated blood sugar checks before meals and at bedtime. Review of Resident #110's May and June 2023 MARs revealed the facility staff were routinely monitoring the Resident's blood sugar at 12:00 PM and 4:30 PM, 2 times a day. Further review of the Resident's medical record revealed on 6/4/23 at 11:50 AM the Resident's blood sugar was 499. The last blood sugar documented for the Resident was on 6/3/23 at 4:12 PM was 310. A nurse's note on 6/4/23 at 3:07 PM stated, Patient's blood sugar is consistently high above 500. MD advised to transfer him/her out to hospital for further evaluation. Interview with the Director of Nursing (DON) on 8/1/24 at 8:55 AM confirmed the facility staff failed to monitor Resident #110's blood sugar before meals and at bedtime in May and June 2023. 2) The facility staff failed to administer medications as ordered by the physician for Resident #120. Review of Resident #120's medical record on 8/2/24 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include convulsions (seizures). Review of the hospital discharge summary revealed the Resident was ordered to receive Dexamethasone 1 mg on 1/5/23 at 11:00 PM and on 1/6/23 at 8:00 AM then to discontinue. The Resident was also ordered to receive Levetiracetam 1500 mg two times a day to start on the evening of 1/5/23. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Laurelwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Laurel Drive Elkton, MD 21921	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #120's January 2023 MAR revealed the facility staff failed to administer Dexamethasone on 1/5/23 and 1/6/23 and also failed to administer Levetiracetam on 1/5/23 and 1/6/23 per the physician orders. Review of the facility's Medication inventory list revealed the facility has Levetiracetam 500 mg listed in the facility's inventory stock. Interview with the DON and Infection Preventionist on 8/5/24 at 11:42 AM confirmed the facility staff failed to administer Dexamethasone and Levetiracetam to Resident #120 per the physician orders on 1/5/23 and 1/6/23. 3) The facility staff failed to administer medications as ordered by the physician for Resident #134. Review of Resident #134's medical record on 8/5/24 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include cerebral infarction (stroke). On 2/9/24 the physician ordered Eliquis 5 mg two times a day to start on 2/9/24 for stroke prophylaxis. Review of Resident February 2024 MAR revealed the Resident did not receive Eliquis 5 mg on 2/9/24. Review of the facility's Medication inventory list revealed the facility has Eliquis 5 mg listed in the facility's inventory stock. Interview with the Infection Preventionist on 8/6/24 at 11:46 AM confirmed the facility staff failed to administer Eliquis to Resident #134 as ordered on 2/9/24. 44441 4) On 8/1/24 at 11:00 AM a review of a complaint intake #MD00183575, revealed that Resident #133 was admitted on [DATE] and was sent out to the hospital on 5/30/22 for a medical condition. Review of the Hospital discharge summary dated 5/25/22, the admissions note, vital signs log, and the initial assessment forms, had that this resident was on oxygen therapy at 3 Liters via nasal cannula (a flexible tube that delivers oxygen into the nose) and was using oxygen at while at home. However, further review of the Physician's order and the May 2022 Treatment Administration Records (TAR) did not reveal an order for the oxygen or for the care and management of the oxygen. On 8/1/24 at 12:54 PM the Director of Nursing (DON) was asked about the process for taking off orders when a resident was newly admitted . He stated that the admission nurse would take off orders and notify the physicians. The physicians can add new orders or choose to not continue an order. The unit managers double check the orders afterward. The DON was made aware that the resident came in with an order for oxygen, but the order was missed and not transcribed, it was not reflected on the TAR. The DON confirmed that there were no care and management orders for the oxygen therapy and was made aware that this was a concern.

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31145

Based on observation, review of the facility investigation, record review, and interview. It was determined that the facility failed to provide a safe environment to prevent a fall with injury causing actual harm (Resident #102), and failed to provide supervision to prevent an elopement (Resident #18 and #106). This was evident in 3 of 3 residents reviewed for accidents during a recertification/complaint survey.

The findings include:

1) On 7/31/24 at 8:38 AM a review of complaint MD00204146, that was received by the State Survey Agency (SA), alleged that Resident #102 was unable to walk or move out of bed. The complaint alleged that staff were changing Resident #102 and apparently dropped Resident #102 resulting in a broken hip.

On 7/31/24 at 8:38 AM a review of Resident #102's medical record was conducted and revealed Resident #102 was admitted to the facility in August 2022 with diagnoses that included heart disease, chronic obstructive pulmonary disease (COPD), and chronic pain. The medical record further revealed that Resident #102 was admitted to hospice care in March 2023 due to heart disease.

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.

Review of Resident #102's 3/25/24 return anticipated MDS, section GG, Functional Abilities and Goals, documented A: roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back on the bed as a (1) which was Dependent - helper does all of the effort. Resident does none of the effort to complete the activity; or the assistance of 2 or more helpers is required for the resident to complete the activity. The resident was also coded a (1) Dependent for personal hygiene, upper and lower body dressing and toileting hygiene.

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.

Review of Resident #102's activities of daily living care plan (ADL), that was created on 2/28/23 documented, Resident requires Mod (moderate) to Max (maximum) assistance with bed mobility.

Review of a physician's progress note dated 3/25/24 revealed the physician saw Resident #102 for an acute visit. The physician documented, seen today for left leg and hip pain. Patient was seen at the bedside; said [he/she] fell yesterday while being turned in bed. Patient was in severe pain at 8/10, was unable to move [his/her] left hip and leg and did not want provider to move them either. Tramadol was given to patient for [his/her] pain; continue to monitor pain. Stat Xray to be ordered to rule out fracture.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the results of the x-ray that was taken on 3/25/24 documented, Acute intertrochanteric femoral fracture with mild displacement with varus angulation. Review of the nursing progress notes dated 3/25/24 at 8:00 PM documented, hospice here to see resident - agrees with plans to transfer to hospital for further evaluation of left hip fracture - resident would like to transfer to hospital to discuss [his/her] options as [he/she] is experiencing pain to [his/her] left hip. Review of the ED (Emergency Department) physician record dated 3/25/24 at 20:29 (8:29 PM) documented, fell out of bed yesterday at [his/her] skilled nursing facility when [he/she] was being repositioned. Has left hip and upper femur pain. Apparently had an x-ray done which showed a left hip fracture. [He/She] is bedbound and does not ambulate. The physician ' s assessment and plan documented, Fall out of bed with left hip pain. Will do x-ray of left femur and hip to look for any fracture. Start pain control with Percocet. [He/She] will require admission to get [his/her] pain under control. On 7/31/24 at 10:15 AM an interview was conducted with Registered Nurse (RN) #4 who was the unit manager. RN #4 stated he had been the unit manager for 1 year. When asked about Resident #102's fall, RN #4 stated he could not remember how Resident #102 had the fall. RN #4 stated that Resident #102 was totally dependent on staff. When asked further about Resident #102, RN #4 stated that he remember that an agency aide (Staff #24) took care of the resident the night the resident fell . RN #4 stated he could not remember anything else. On 7/31/24 at 11:36 AM an interview was conducted with the Director of Nursing (DON). The DON was asked about Resident #102's fall. The DON stated the resident complained of hip pain and that he/she had fallen. When asked about the fall, the DON stated an agency aide assisted one of the facility ' s geriatric nursing assistants (GNA) with the resident. The DON stated, the resident was found on the floor wrapped in blankets. When asked when the fall happened, the DON stated that the resident would have fallen on 3/21/24, however the nurse was not aware of the fall, therefore it was not documented. The DON stated the agency GNA #24 was responsible for the resident that night and that GNA #25 helped agency GNA #24 pick the resident up off the floor and put the resident back to bed. The DON confirmed that the nurse and nursing administration were not aware of the fall until 3/25/24. After nursing administration became aware of the fall, the agency was notified that GNA #24 was to be a DNR (Do Not Return) to the facility. On 7/31/24 at 12:15 PM a review was conducted of the fall investigation given to the surveyor by the DON. The investigation consisted of a word document that stated, Resident presented with pain to hip to nursing staff, nursing staff reports resident had fallen 3 days prior. The document stated pain evaluation and x-rays were done, family was notified, resident discharged to ER (emergency room) and then to another facility from the ER. In the investigation there were only 3 witness statements, from RN #19 and GNA #25. There was a document that stated, multiple attempts made, and agency called several times. Would not locate GNA. Also included was a copy of the 3/25/24 nursing schedule. The DON was asked if there was any other information related to the fall and the response was, that ' s all I have. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/31/24 at 12:40 PM RN #19 was interviewed. RN #19 stated that she was the nurse assigned to Resident #102 on 3/21/24. RN #19 stated that she was not aware of the fall on 3/21/24. RN #19 stated that she did not know how the resident fell . RN #19 stated, one of the mornings the unit manager came to me and asked me if he/she had a fall, and I said I didn ' t know he/she had a fall. RN #19 stated Resident #102 was not able to get out of bed by him/herself. RN #19 stated that Resident #102 did have pain in the leg. RN #19 stated that she worked and was assigned to the resident on 3/25/24 and that the doctor saw the resident and wanted an x-ray. It was confirmed that the resident had a fracture. RN #19 stated, If I had known about the fall on 3/21/24 I would have called the doctor immediately. On 7/31/24 at 12:54 PM an interview was conducted with GNA #25. GNA #25 stated that Resident #102 was total care and that sometimes the resident could turn on her own but most of the time was a 2 person assist. GNA #25 stated that she only worked one half of a shift on 3/21/24 and came in at 7:00 PM. GNA #25 stated that she went on break around 9:00 PM and last rounds were between 9:30 PM and 10:00 PM. GNA #25 stated, I did not have a group because I came in late. There was no one in the hall. I went into the nurse ' s station to put my stuff down. GNA #24 came around to the station and she peaked around the corner and asked if I could help get (Resident #102) off the floor. RN #19 was up at the other end of hall. The resident was laying on his/her back on the floor beside the bed. I asked GNA #24 what happened, and she said she was changing Resident #102 and [he/she fell]. I helped get [him/her] up and back in the bed. GNA #24 told GNA #25 that she told RN #19 that the resident fell . Once Resident #102 was back in bed I left the room. The DON said I should have made sure it had been reported to the nurse before I helped get [him/her] up. I should not have assumed anything regarding the situation. I should have got the OK from the nurse. On 8/1/24 at 10:24 AM an interview was conducted with the facility's Corporate Nurse (Staff #36) who confirmed that the fall was not reported for 4 days, and that facility wide education was not done after the incident and that the incident was not reported to the Office of Health Care Quality (OHCQ). Staff #36 confirmed that the fall's investigation was incomplete. On 8/1/24 at 10:52 AM an interview was conducted with GNA #24 (agency GNA). She was asked about the evening of 3/21/24. GNA #24 stated, ' when they called me, I was baffled about the situation because I had no recollection of the incident. GNA #24 denied that anyone had a fall and that she did not help anyone pick up a resident from the floor. GNA #24 repeated several times to the surveyor that she could not recall that evening. Review of Resident #102's March 2024 Medication Administration Record (MAR) documented the medication Tramadol 50 mg. was ordered on 11/2/23 prn (when necessary) every 6 hours as needed for pain. Tramadol is an opioid that is used to relieve moderate to severe pain. Prior to 3/21/24, the Tramadol was only administered 1 time in March 2024, which was on 3/11/24. From 3/21/24 to 3/25/24, the Tramadol was administered daily for pain levels of 8 out of 10. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/21/24 Tramadol 50 mg. was administered at 11:04 PM. On 3/22/24 Tramadol 50 mg. was administered at 3:12 PM. On 3/23/24 the Tramadol was administered twice, at 1:45 PM and 8:00 PM for left leg pain. Also, a dose of Tylenol (Acetaminophen) 650 mg. was administered on 3/23/24 at 10:14 PM after it was documented that the pain level was a 6 after the administration of the Tramadol. On 3/24/24 Tramadol was administered at 12:33 PM. There was also a prn order for Morphine (ordered on 3/23/23 when the resident was admitted to Hospice) that was given on 3/24/24 at 4:35 PM for a pain level of 6 (which was 4 hours after the Tramadol was administered). On 3/25/24 at 10:13 AM Tramadol was administered. Further review of the medical record revealed no additional documentation of any investigations as to why the resident was in pain every day from 3/21/24 to 3/25/24. On the March MAR there were places for day, evening, and night shift to document monitor for pain every shift that had nurse ' s initials and check marks, however there was no description of the pain and no other documentation as to why or what was done. On 8/1/24 at 1:17 PM an interview was conducted with the DON related to pain assessments. The DON stated that when Resident #102 already had an order for pain medication and the pain medication was administered a couple of days in a row, he would assume it was from the arthritis and not expect a total pain assessment in the assessments section of the medical record. The DON stated he would expect the number of severity, which was documented on the MAR. The DON stated, We weren't aware of the fall so therefore did not associate the pain with that. On 8/5/24 at 2:12 PM an interview was conducted with RN #37. RN #37 was asked about the care she provided to Resident #102 on 3/23/24 and 3/24/24 and the pain the resident was experiencing. RN #37 stated she did not really remember the resident and that she had just started at the facility a month prior. RN #37 was asked if the resident had a prn for pain medication but had not received any medication until all of a sudden received it 5 days in a row, would that trigger her to see what is going on with the resident. RN #37 said yes. When asked when she would fill out a pain assessment, RN #37 said, if it was new and acute or if it was a quarterly pain assessment required by the facility, I would fill it out. RN #37 was asked if the facility had asked her if the resident had a fall. RN #37 stated that no one had told or asked her about a fall. RN #37 stated, if the resident had a fall and was in pain then the resident should have been sent to the hospital. 50502 2) On 7/22/24 at 9:50 AM, Resident # 18 was observed in bed with eyes closed. One fall mat was noted on the right side of the bed. The resident did not respond when surveyors greeted him/ her. On 7/23/24 at 10:14 AM, surveyors reviewed Facility Self-Reported incident MD 00188036. The review revealed Resident #18 had an elopement incident on 1/20/23 around 5:45 PM. Two family members coming into the building to visit another resident found Resident #18 outside in the facility's parking lot. The resident allegedly exited the building without the knowledge of the facility staff. The facility staff assisted the resident back to the building and assessed for any injuries. On 7/23/24 at 10:42 AM, a review of the staff statement regarding Resident #18's elopement incident indicated that Resident #18 was initially seen at the nurse's station around 5:25 PM. Also, a statement from the family members stated that they found Resident #18 outside the south end of the building, wearing a hospital gown and carrying a bag. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 11:03 AM, a review of Resident #18's medical record revealed as A BIMS score was 5 of 15: Brief Interview for Mental Status (BIMS) is a screening tool used to assess basic cognitive function in patients in long-term care facilities. A score of 0-7 indicates that a patient has severe cognitive abilities. The resident was found going inside the Physician's room on 1/18/13 and to another resident's room on 3/18/23 by accident. But Resident #18 had no other wandering, exit seeking and/or elopement incidents. On 7/24/24 at 10:18 AM, in an interview with the Director of Nursing (DON), he stated that the facility staff assumed that Resident #18 did not use the front door to go out but used the kitchen exit door. He stated that the facility had no video footage verifying the resident's exit. The DON confirmed that they presumed the resident followed a kitchen staff to go out and indicated that the door leading to the dumpster was the only door not secured before the elopement incident. He also verified that the kitchen staff didn't lock the kitchen door and that the kitchen staff only locked the door when they were finished with the shift when the elopement occurred. The DON stated that Resident #18 had no wandering issues in the past and had no exit-seeking behavior. The DON added that the wanderguard was ordered after the incident, and discontinued on 8/14/23 because the resident can no longer ambulate and bear weight. On 7/25/24 at 11:02 AM, in an interview with Staff #10 (Cook), he stated that the staff could access the main door to the kitchen and usually went inside the kitchen to get ice. He added that before the incident, the kitchen staff would push the door to go out towards the dumpster and use a keypad with a code to enter back to the kitchen. He stated that the kitchen exit door lock was replaced after the incident and that a key was now used instead of a keypad. Staff #10 showed the surveyors how to exit using the kitchen door towards the dumpster. He unlocked the door using a key that was kept inside a drawer. On 07/25/24 at 1:08 PM, in an interview with Staff #12 (Maintenance director), he revealed that before the incident, the kitchen staff used a numerical lock/ keypad system located outside the kitchen back door. The staff had to push the door to go outside and use the keypad to go inside. He/she added that the keypad was removed and changed right away after the incident. On 8/08/24 at 09:35 AM, during an interview with the DON and Administrator, the surveyor shared concerns that the facility failed to prevent the elopement incident by ensuring that all exit doors were locked, especially the back kitchen door. 34484 3) Review of Resident #106's medical record on 7/29/24 revealed the Resident was admitted to the facility on [DATE] with diagnosis to include Alzheimer's disease. Alzheimer's disease is a progressive disease that destroys memory and other important mental functions. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	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. Further review of Resident #106's medical record revealed the facility staff assessed the Resident's behaviors in Quarterly MDS on 1/26/21 and 5/13/21. The facility staff coded the Resident as a 0 for Behavior not exhibited in Section E Behavior E0900 Wandering: Presence and Frequency. Review of an anonymous concern in June 2021 that Resident #106 was found outside the building by the facility staff, the Surveyor asked on 7/29/24 for the investigation of the incident. Review of the facility investigation revealed it was reported to the Office of Health Care Quality that Resident #106 was found in the facility's adjacent parking lot on 6/5/21 by facility staff and escorted back to the building unharmed. During interview with Staff #38 on 7/30/24 at 2:34 PM, Staff #38 stated on 6/5/21 she was leaving the facility when she saw Resident #106 in the adjacent parking lot to the facility. At that time she escorted the Resident back to the facility and notified the nurse. Staff #38 was asked how she believed the Resident was able to get out, she stated the front door is always locked so I believe the Resident followed visitors out and the Receptionist didn't notice the Resident leave with the visitors. Staff #38 stated she has worked at the facility full time for 7 years and stated this is the only time I am aware the Resident had eloped from the facility. Interview with the Director of Nursing on 8/1/24 at 9:58 AM confirmed the facility staff failed to provide supervision for Resident #106 to prevent an elopement on 6/5/21.

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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 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42507

Based on observation, medical record review, and interview, it was determined the facility staff failed to change a resident's urinary catheter and drainage bag and failed to follow discharge orders from an acute care facility to arrange for a resident with a foley catheter to be seen by an outpatient urologist (Resident #48), and 2) failed to monitor and empty a urinary drainage bag as ordered (Resident #70). This was evident for 2 of 2 residents reviewed for urinary catheter during a recertification/complaint survey.

The findings include:

A urologist is a doctor that specializes in the study or treatment of the function and disorder of the urinary system.

A urinary (foley) catheter is a flexible tube that is inserted into the bladder to drain urine.

1) On 7/22/2024 at 1:49 PM, Resident #48 was observed in bed with a urinary catheter bag hanging on the right side of their bedframe. In an interview with the resident s/he stated that the urinary catheter was placed a long time ago and has not been changed by staff. However, Resident #48 further stated that the catheter was supposed to be changed every three (3) months by a urologist but has not been touched since it was changed in the ER (emergency room) a couple of months ago.

On 7/25/2024 at 12:12 PM, a review of physician orders did not reveal an active order for a urologist follow up. However, the following order dated 3/11/2024 at 9:15 AM was noted:

- Change indwelling catheter every 3 months and drainage bag every 30 days as needed for catheter care.

On 7/25/2024 at 12:40 PM, a review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the months of April, May, June, and July 2024 revealed Foley catheter care was provided every shift and output documented. However, there was no notation/documentation of when the Foley catheter and/or drainage bag was changed.

On 7/30/2024 at 9:54 AM, a review of nurses' progress notes dated 3/9/2024 revealed the following documentation: Resident came back from hospital with new catheter 16 Fr Per Dr. order resident needs a F/U apt with the urologist and the catheter needs to be replace q 3 months on 5/1/2024.

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NAME OF PROVIDER OR SUPPLIER Laurelwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Laurel Drive Elkton, MD 21921	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/2024 at 11:07 AM, in an interview with B-Wing Unit Manager (UM #4), he confirmed that Resident #48 had the urinary catheter changed in the hospital on 3/9/2024. He further stated that they had orders to change the drainage bag every 30 days and catheter every 3 months and PRN (as needed). When asked if the catheter and/or drainage bag had been changed since the resident returned to the facility in March 2024, UM #4 reviewed Resident #48's records but could not find staff documentation that the resident's catheter and/or drainage bag had been changed since returning to the facility in March 2024. Regarding Resident #48's follow up urologist appointment, UM #4 stated the appointment was scheduled but the resident refused to go. Surveyor requested from UM #4 documentation to show proof of the scheduled appointment and/or resident's refusal. He was unable to provide any documentation. On 7/30/2024 at 11:47 AM, a review of the hospital discharge summary dated 3/9/24 revealed the following documentation: You were seen in the [name] Emergency Department for a dislodged catheter. We replaced the Foley catheter Since you are chronically maintaining a Foley, you need to be set up with a urologist and your abnormal anatomy-your catheter needs to be replaced every 3 months (around 5/1/2024) On 7/30/2024 at 1:03 PM, in an interview with Registered Nurse (RN #30), she stated that she could not find any documentation in both Resident #48's paper chart and PCC (electronic record) regarding a urologist follow up appointment. However, RN #30 stated that she was waiting for the appointment scheduler to investigate if an appointment was scheduled. On 7/30/2024 at 2:07 PM, in a follow up interview with RN #30, she confirmed that there was no scheduled urologist appointment made for Resident #48 since returning to the facility in March 2024. On 7/30/2024 at 2:36 PM, an interview was conducted with the Appointment Scheduler (Staff #9). Regarding Resident #48's follow up urologist appointment, Staff #9 stated that she could not recall off hand if the resident had a urologist consult this year (2024). On 7/30/2024 at 2:51 PM, in a follow up interview with Staff #9, she confirmed that a urologist appointment was never scheduled for Resident #48 and that the resident never went for a follow-up urology visit. On 8/8/2024 at 10:40 AM in an interview with the Director of Nursing (DON) and Administrator, surveyor shared concerns regarding the outpatient follow-up urology visit that the resident missed, and staff failure to change the urinary catheter and drainage bag as per doctor's orders. 44441 2) On 7/23/24 at 11:20 AM during an initial tour of the facility, Resident #70 was observed to have a urinary catheter, a device that drains urine from the bladder. A Review of the Physicians order dated 7/11/24 on 7/30/24 at 1:18PM had an order written as: Montor and record output per shift for catheter care. Review of the May, June and July 2024 Treatment Administration Records (TAR) also had the same order. Further review revealed that on different days in these months, the urinary outputs were not recorded. These days were as follow: 5/13. 5/23, 5/29 evening shift. 6/2, 6/15-night shift, 6/16 evening shift, 6/29 evening/night shift, 7/16, 7/20-night shift, 7/23, 7/26-day shift, and 7/27 evening shift. (continued on next page)

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	215111	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelwood Healthcare Center	100 Laurel Drive Elkton, MD 21921

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview with Staff #14 a Geriatric Nursing Assistant (GNA) on 7/31/24 at 11:12 AM, she was asked how often the urinary catheters were to be emptied. She stated that she empties the urinary bags whenever she rounds on her residents or noticed that they were almost full. She was asked if she had come across the bags not being emptied by the previous shift and she stated that she has occasionally. She was asked what could happen if the urinary bags were not emptied as ordered. She stated that if urine has nowhere to go the urinary bag will overfill, and if done too many times, can cause infection in the bladder. In another interview with Staff #18 a GNA on 07/31/24 at 11:13 AM, She was asked the frequency for emptying urinary bags. The GNA stated that the urinary bags should be emptied at the beginning and end of each shift. She stated that she had witnessed occasionally, the urinary bags not emptied by the previous shift. The GNA was asked what could happen if the urinary bags were not emptied as ordered. She stated that the old pee will go back into the bladder and cause infection. On 07/31/24 at 3:43 PM The Director of Nursing (DON) was made aware that this was a concern.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on complaint, medical record review and staff interview it was determined the facility failed to have a process in place to address weight loss in a timely manner (Resident #247, #125). and 2) failed to monitor a resident's nutritional status by documenting their eating amount every shift and developing a care plan (Resident #103). This was evident for 3 of 4 residents reviewed for nutrition during a recertification/complaint survey. The findings include: 1) On 7/30/24 at12:30 PM review of complaint MD00186837 revealed a concern that Resident #247 entered the facility at a much higher weight and that the facility failed to monitor the resident's nutritional needs. On 7/30/24 at 12:30 PM Resident #247's medical record was reviewed and revealed the resident was admitted to the facility in November 2022 for rehabilitation following hospitalization . The resident was in the facility for 37 days until discharge home in December 2022. Review of the weight section of Resident #247's medical record revealed on 11/6/22 Resident #247's weight was documented at 137.0 lbs. On 11/7/22 the recorded weight was 137 lbs. On 11/14/22 the weight was documented as 128.4 lbs. and on 11/21/22 the weight was documented as 132.4 lbs. It was noted that the 11/14/22 weight was struck out by the dietician on 12/7/22 and it stated reweighed. Review of the admission dietary assessment dated [DATE] documented, Most recent wt.128.4# (11/14/22) show wt. loss 8.6# compared to wt. 137# on 11/6/22 and 11/7/22. Weight on 11/6/22 and 11/7/22 questionable. Resident on weekly wts. x 4 weeks to monitor wt. trend. Review of the Nutritional assessment that was done in the hospital on 11/1/22 revealed Resident #247's weight was 61.8 kg. which was 136.246 lbs. which was the resident's normal weight. Review of the physician's progress note of 11/20/22 documented, Weight loss. Currently being monitored closely. Multiple contributing factors including cognitive impairment as well as poor appetite and dysphagia. Continue multidisciplinary approach along with dietitian team. There was no further documentation about Resident #247's weight. The physician's note of 11/20/22 stated weight loss, however the dietician struck out the 11/14/22 weight 3 weeks later on 12/7/22 and did not write a note explaining why the weight was struck out. The dietician did not have an up-to-date weight on 12/7/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 1:13 PM the Registered Dietician (RD) was interviewed and the surveyor asked her about the nutritional assessment of 11/20/22. The RD stated, on admission [he/she] was 137.0 pounds, and I like to verify after. The 128.4 lbs. was struck out. Then we weighed on 11/21/22. I don't feel in that short period of time [he/she] lost that much weight. [He/she] had issues with fluid. The surveyor asked if the hospital indicated Lasix (a fluid pill) was used and the dietician said no. It was noted that the resident was not on a diuretic (fluid pill) while in the facility. The RD was asked why she struck out the weight of 11/14/22 of 132.4 lbs. on 12/7/22. The RD said, that is when I probably was doing my review. The RD was asked why 3 weeks later she would strike out the weight and she did not have an answer. When asked if there was a weight taken on 12/7/22 the RD stated there was no weight taken on 12/7/22, therefore she did not know how much the resident weighed. The RD also confirmed that there was no dietary note or assessment written on 12/7/22. On 7/31/24 at 10:13 AM the issue was discussed with the Director of Nursing (DON). The surveyor informed the DON of the concern that the RD would strike out a weight 3 weeks later and not follow-up and that there was no notification, and nothing documented after the 11/14/22 weight of 128.4 lbs. which was an 8.6 lb. weight loss in 1 week. The DON stated they have had issues with the weights and that they were aware. 2) On 7/31/24 at 11:03 AM a review of complaint MD00185198 revealed a concern that Resident #125, who was on a feeding tube (gastrostomy) was extremely malnourished. On 7/31/24 at 11:03 AM a review of Resident #125's medical record revealed the resident was admitted to the facility in October 2022 from an acute care facility with diagnoses that included cerebral palsy and a gastrostomy tube that had malfunctioned. Review of the 10/26/22 dietary progress note documented the resident was s/p (status post) hospitalization with J-tube dysfunction and per the hospital chart, a G-tube was placed on 9/20/22. The dietary note documented Resident #125's weight as 82.6 lbs. and BMI (body mass index) was classified as underweight. A J-tube (jejunostomy) is a soft, plastic tube that is surgically inserted into the small intestine through the abdomen to help with nutrition and hydration. A G-tube (gastrostomy) is a small, soft tube that is surgically inserted through the abdomen and into the stomach to provide direct access for feeding, hydration, or medicine. Review of the weight section of the electronic medical record documented on 10/25/22 there were (2) weights; (1) was 82.28 lbs. and (1) was 82.6 lbs. On 11/7/22 the weight was 68.8 lbs. and on 11/10/22 the weight was 69.0 lbs. Review of the admission nutritional assessment on 11/8/24 documented, weight trend since admission show weight loss of -16.7%/-13.8# compared to 82.6# on 10/25/22. The dietician documented, Requests reweigh; BMI classification underweight; Most current wt. show sig wt. loss. Change in wt. discussed with nursing and reweigh requested. Will adjust enteral nutrition using current wt. 68.8# to provide 41 kcal/day and 1.7 gm pro. Review of a 11/9/22 skilled note documented, weight loss of > 10 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2022 Medication Administration Record (MAR) indicated blank spaces on 11/1/22 and 11/8/22 for weights. Review of the Resident Height and Weight Policy that was given to the surveyor by Staff #30 on 7/31/24 at 8:45 AM revealed, C. On Admission: 1. weigh the resident within 24 hours of admission 2. Obtain weekly weights times for weeks (x4 weeks) for baseline. E. Reporting weights: weight loss concerns are reported to the practitioner and discussed at the weekly clinical meetings. On 8/1/24 at 9:17 AM an interview was conducted with the RD about Resident #125's weight. The RD stated, I requested a reweight. They got the reweight on the 10th and [he/she] was 69 lbs. Sometimes when I see the weight on admission, I feel like it is not accurate. Sometimes even in the hospital I am not sure if that weight is obtained prior to them coming to see us. I look at that weight for a reference. The surveyor brought up that the weight policy for new admissions was weekly weights times 4 weeks. The RD acknowledged that a weight was not obtained on 11/1/22 as evidenced by a blank on the MAR and no documentation in the weight section of the medical record. The RD agreed that it was a process issue. When asked about physician notification the RD stated that the weights were discussed in risk meetings which are held once a week on Wednesdays but not documented in the medical record. The RD was asked what happened if a weight was noticed out of parameters on a Thursday and the risk meeting was not held until the following Wednesday. The RD stated that she would talk to the nurses but not the physician and the physician would not be made aware until the following Wednesday, therefore if the nurses don't notify the physician, then there is a delay. On 8/1/24 at 10:05 AM discussed the weights and process issues with the DON who confirmed the findings. On 8/6/24 at 9:22 AM RN #1, the MDS Coordinator was interviewed and stated that there was no weight loss, only a 5 lb. weight loss because the dietician did not go off the hospital record. RN #1 stated there was a discrepancy with the documentation. RN #1 stated the hospital weight upon admission was 73 lbs. and she just uploaded the hospital documentation in the medical record on 8/1/24 after being informed of the MDS error. However, the admission MDS dated [DATE] documented the weight as 83 lbs. and was completed by RN #1. The Nursing Home Administrator was informed on 8/6/24 at 2:15 PM of the process issues with weights and nutrition. 43096 3) When investigating complaints on 8/07/24 at 12:20 PM, a complainant reported that Resident #103 was observed several times his/her food was served without appropriately prepared to eat, like unopened milk and/or not cut for picking up. On 8/07/24 at 12:40 PM, the surveyor reviewed Resident #103's medical record, including body weight. The review revealed that only two body weights were documented: upon admission and 14 days later than the admitted . Further review of Resident #103's care plan showed that the facility initiated a care plan on 9/22/22 for Resident #103 had behavior issues regarding refusing weekly weights. The intervention for this care plan included 'behavioral health consults as needed' and 'notify the medical provider of increased episodes of behavior.' However, no resident-centered, measurable care plan was developed for Resident #103. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 12:31 PM, the surveyor reviewed Resident #103's medical records. The review revealed that the facility dietitian (Staff # 17) completed the resident's nutrition assessment on 9/07/22. The assessment documented that it may be beneficial for staff to assist with cutting up meat for optimal po (oral) intake. The order was placed on 9/10/22. A review of Resident #103's medical record, including the GNA (Geriatric Nurse Assistant) task on 8/07/24 at 2:47 PM, revealed that the form had a section for documenting eaten amounts every shift every day. The resident's percentage of the meals eaten was documented from his/her admission to discharge; Resident #103 had resided in this facility for 63 days. However, 12 days of his/her stay did not document any amount eaten all day, and 26 days partially documented his/her eaten amount. Also, the documentation showed that Resident #103's eating amount was gradually reduced from 51-100% to 26-50%. During an interview with a Geriatric Nurse Assistant (GNA # 39) on 8/07/24 at 3:10 PM, GNA #39 stated that residents' eating amounts should be documented each shift. If they noted that they were reduced continuously, they should report it to nurses. In an interview with Staff #17 (dietitian) on 8/07/24 at 3:20 PM, Staff #17 said, I do an initial assessment and quarterly assessment. Whenever I saw residents and noted concerns, I addressed them with my notes. Staff #17 verified that she had no additional information except the initial nutrition assessment on 9/7/22 for Resident #103. Staff #17 said, No one reported to me. Without my observation or report, I am not able to catch the issues. During an interview with the Director of Nursing (DON) on 8/08/24 at 8:50 AM, DON was asked how the facility staff monitor residents' nutrition status. The DON stated that the facility staff checked residents' body weight; if they refused it, they monitored their eaten amount as a percentage. He also added that if any concern was noted, nursing staff should report it to dietitians and physicians. The surveyor shared Resident #103's documented eating amount with blank columns and reduced amounts, and no appropriate care plan was developed for the resident's refusal of body weight monitor. The DON was informed that there was no documentation to support that Resident #103's nutrition status was being monitored. The DON validated the above concerns.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (#102) of 2 residents reviewed for Hospice care and one facility self report (Resident #131) during a recertification/complaint survey. The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On [DATE] at 8:38 AM a review of Resident #102's medical record was conducted and revealed Resident #102 was admitted to the facility in [DATE] with diagnoses that included heart disease, chronic obstructive pulmonary disease (COPD), and chronic pain. The medical record further revealed that Resident #102 was admitted to hospice care in [DATE] due to heart disease. Review of the electronic record failed to produce any documentation from Hospice such as progress notes and assessments of the resident. Review of the paper medical record failed to produce Hospice notes. On [DATE] at 10:43 AM Staff #30 looked through Resident #102's medical record and stated there were (3) notes dated [DATE], [DATE] and [DATE]. Staff #30 confirmed there were no Hospice notes in the electronic or paper medical record from [DATE] to [DATE]. The Nursing Home Administrator was informed on [DATE] at 2:15 PM. 43096 2) Naloxone (also known as Narcan) reverses an opioid overdose. It should be administered to anyone who presents with signs of opioid overdose or when an opioid overdose is suspected. On [DATE] at 8:13 AM, the surveyor investigated one of the facility's self-report incidents, MD00181930. The report stated that Resident #131 was noted by the facility nursing staff on [DATE] at 11:15 PM to be unresponsive in bed without respiration and pulse. The facility nurses started CPR, and 911 was called. The facility's report stated that they administered Narcan twice. However, further review of Resident #131's medical record on [DATE] at 8:30 AM revealed that there was no documentation for the order of Narcan and administration records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on [DATE] at 8:45 AM, the DON stated that Narcan is expected to chart in the residents' MAR (Medication Administration Record) even though it was an emergency. The surveyor reviewed Resident #131's MAR with the DON. The DON verified that there was no documentation regarding Narcan administration. The surveyor informed the DON of the above concern.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 50502 Based on a review of employee records and an interview, it was determined that the facility failed to provide evidence that nursing staff had received annual education on abuse, neglect, exploitation prevention, and misappropriation of resident property along with dementia management and resident abuse prevention . This was evident for 5 (Registered Nurse #50, #51, Geriatric Nurse Assistant #16, #48, and #49) of 5 randomly selected nursing staff reviewed for annual training requirements during the recertification/complaint survey. The findings include: Relias is an online training provider that offers continuing education (CE) for healthcare, senior care, and disabilities professionals. Relias's CE library covers a wide range of topics and is accredited by many national and state licensing boards. Relias's courses are designed to help healthcare workers improve patient care, grow, and provide high-quality care. 1) On 7/26/24 at 11:08 AM, a telephone Interview with staffing coordinator (Staff #13) revealed that the facility had no assigned staff development personnel. Staff #13 added that the Director of Nursing (DON) trained the nursing staff. Annual training was conducted by either the staffing coordinator or Human Resources (HR). Staff #13 stated that an orientation packet was provided to the new hires then given to the DON once completed. She added that after the orientation, competency training is done yearly. On 7/26/24 at 12:50 PM, a review of randomly selected five nursing employees' records revealed the following: 1. Registered Nurse (RN) #50 was hired in March 2022. Completed abuse training, including preventing, recognizing, and reporting abuse on 9/07/23. However, no other training records were found in 2022. 2. Registered Nurse (RN) #51 was hired in January 2023. Abuse training (preventing, recognizing, and reporting abuse) was completed on 3/11/24. No additional training record of annual Abuse, Neglect, and exploitation was found upon his/her hire. 3. GNA #16 was hired in January 2022. There is no record of abuse training record upon hire and no record of annual Abuse, Neglect, and exploitation training. 4. GNA #48 has worked in this facility for over ten years. Since Relias (an online training program) started in 2017, no record of annual abuse, neglect, and exploitation training was found. 5. GNA #49 was hired in May 2020. Abuse training was completed in October 2020 upon hire; however, there was no record of annual Abuse, Neglect, and exploitation training. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview with the DON on 7/30/24 at 10:35 AM, he stated that annual training was usually in Relias, and the ADON and the HR track the training records. The surveyor reviewed employee training records for RN #50, #51, GNA #16, #48, and #49 with the DON. The DON confirmed that GNA #16 had no Relias transcript, RN #50, RN #51, GNA #48, and GNA #49 did not have evidence to support they received abuse neglect. Also, the DON was made aware that training was inconsistent; some have abuse and neglect, exploitation prevention training upon hire, and annually. 43096 2) The surveyor reviewed the facility's self-reported incidents on 7/25/24 at 1:20 PM. One of the incidents, MD00186359, revealed that Resident #112 reported that a Geriatric Nursing Aide (GNA #16) slapped his/her hand on 11/27/22. Further review of the facility's investigation documentation revealed that GNA #16 was removed from Resident #112's care. The resident was assessed head to toe, an X-ray was taken, and staff education was provided. However, a review of GNA #16's training records on 7/25/24 at 3:09 PM revealed that she did not have abuse training records upon hiring and after this incident. During an interview with the Director of Nursing (DON) on 7/25/24 at 3:28 PM, the surveyor reviewed GNA #16's training records with the DON. The DON verified that GNA #16 was not listed on the abuse training attendant on 11/28/22, and no additional abuse training records were presented.