STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 50502 Based on the interview and record review, it was determined that the facility failed to inform the resident of the changes to his/ her treatment plan. This was evident for 1(Resident #21) of 6 residents reviewed for residents' care during the survey. The findings include: Hepatitis C is an inflammation of the liver caused by the hepatitis C virus. The virus can cause both acute and chronic hepatitis, ranging in severity from a mild illness to a serious, lifelong illness including liver cirrhosis and cancer. Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities. On 7/22/24 at 10:04 AM, in an interview with Resident #21, he/she expressed concern that the facility staff didn't notify him/her of the results every time he underwent laboratory tests. Resident #21 added that one of his/her medications was stopped without notice. On 7/23/24 at 3:09 PM, further review of the medical record indicated that Resident #21's BIMS assessed on 4/29/24 scored 14 of 15, cognitively intact. On 7/24/24 at 2:57 PM, a review of the progress notes dated 5/28/24 written by Nurse Practitioner (NP #7) revealed that she ordered Resident #21 a new medication, [specific medication name] for hepatitis C that would be given for 12 weeks. Further review of the nurse's notes dated 6/03/2024 indicated, Medication not available, awaiting prior authorization, NP aware. Another nurse note on 7/18/2024 revealed, medication on hold not available NP and doctor aware. However, the notes indicated that the resident needed to be notified of the changes. On 7/25/24 at 8:35 AM, a review of the MAR (Medication Administration Record) revealed that the [name of Hepatitis C medication] was ordered to start on May 28, 2024, but has never been administered and was put on hold for May, June, and July. On 7/25/24 at 9:32 AM, in an interview with the Registered Nurse (RN #8), he stated that if resident orders were changed, the assigned nurse notified the physician or Nurse practitioner and updated the resident or the family members. The notification was then documented in the progress notes. However, none of the nurses documented that the resident was informed of the changes. (continued on next page)

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

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	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 1:35 PM, in an interview with NP #7, she stated that she wrote an order for Resident #21 to start [name of Hepatitis C medication] on May 28, 2024, for 12 weeks. She added that the medication required a pre-authorization from the insurance company due to its high cost. NP # 7 stated that she also called the pharmacy. The insurance company informed NP #7 that they would not give the authorization until a blood test and an infectious disease consult had been completed. NP #7 insisted that she coordinated to obtain the authorization. The surveyor reviewed Resident #21's progress note and MAR regarding Hepatitis C medication: it was never administered, and no documentation was present. NP #7 agreed that she did not inform Resident #21 about his/her medication. On 7/26/24 at 8:29 AM, in an interview with the appointment scheduler (Staff #9), she said, I had reached out to three Infectious Disease specialists, but all of them don't take new patients. So far, no consultation was arranged. Staff #9 was asked about the documentation for the infectious disease consultant. Staff #9 verified that there were no records about the consultant in Resident #21's medical records. On 7/30/24 at 10:38 AM, in an Interview with the DON, he was informed that there was an issue with Resident #21's medication, that the medication was held without the resident's knowledge, and that the resident felt he/she was never involved in the decision-making. The DON stated that there was an insurance issue and a pending Infectious disease consult. The DON was also notified that NP #7 failed to inform the resident and document the plan in the medical record.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on record review and interview it was determined the facility failed to ensure that resident/resident's representative was offered the opportunity to develop advance directives and/or provided information regarding advance directives. This was evident for 2 (Resident #14, #15) of 4 residents reviewed for advance directives. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. 1) On [DATE] at 10:AM a review of Resident #14's electronic medical record revealed no evidence that the resident had an advance directive or that one had been offered to the resident and/or resident's representative (RP). A review of Resident #14's paper chart revealed a Maryland Order for Life Sustaining Treatment (MOLST) dated [DATE] which indicated Attempt CPR (cardiopulmonary resuscitation). However, there was no advance directive found in the paper chart and no documented evidence and/or information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident's representative (RP). On [DATE] at 2:18 PM in an interview with the social services designee (Staff #5) and in the presence of the Regional Director of Social Work (Staff #6), Staff #5 stated that advance directive information should be in each resident's paper chart and may also be scanned into the electronic record. She further stated that most of the residents already have advanced directives upon admission to the facility and the family asked to bring a copy to the facility. Surveyor requested a copy of Resident 14's advanced directives and/or information that the resident/RP were given the information/opportunity to formulate one. The Regional Director of Social Work (Staff #6) responded that they have identified that advance directives were not being addressed. Staff #6 stated that she has re-educated the social work designee (Staff #5) to make sure advanced directives were addressed with every resident that was admitted in the facility and documentation placed in the residents' records. They (Staff #5 and Staff #6) verified and confirmed that Resident #14 did not have an advance directive in his/her records and were unable to provide documentation that the resident/RP were given the opportunity to formulate one. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:40 AM, in an interview with the Director of Nursing (DON) and the Nursing Home Administrator, they were informed that Resident #14 did not have Advanced Directives in their charts and/or documentation that they were given an opportunity to formulate one. No further documentation was provided. 50502 2) On [DATE] at 11:22 AM, a review of Resident #15's medical record revealed the resident was admitted to the facility in July of 2023. However, there was no evidence of an advance directive in the paper chart. Further review of Resident #15's medical record on [DATE] at 11:30 AM revealed that the resident's capacity form had 2 physicians' signatures dated [DATE] and [DATE], which indicated that the resident lacked adequate decision-making capacity. On [DATE] at 12:52 PM, a review of electronic medical records also did not show an advance directive on file and there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. On [DATE] at 10:41 AM, the Director of Nursing (DON) was informed that there was no evidence of an advance directive in the paper chart and in the electronic medical record. The surveyor also shared with the DON that on [DATE] at 2:18 PM, during an interview by another surveyor, the social services department had identified the issue.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47200 Based on record review and interview it was determined the facility failed to ensure advance written notification to residents was issued when the facility determined that residents no longer qualified for Medicare part A skilled services. This was evident for 3 out of 3 residents (#46, #25, and #248) reviewed during the surveyor's beneficiary protection notification review during the facility's recertification survey. The findings include: On 7/26/24 at 2:55PM the surveyor provided three Skilled Nursing Facility Beneficiary Protection Notification Review forms and requested them to be completed for Residents #248, #46, and #25 to Registered Nurse #30. On 7/29/24 at 9:08AM the surveyor requested to the facility's Director of Nursing, that the forms be completed and returned to the surveyor. On 7/29/24 at 9:15AM the surveyor notified the facility Administrator that the forms had not been completed or returned. At this time, the surveyor conducted an interview with the facility Administrator who provided the following response regarding notices issued to residents: We don't have them. At this time, the surveyor requested the forms be completed and returned to the surveyor. On 7/29/24 at 10:22AM the surveyor conducted an interview with the facility's Social Services Designee (SSD) #5 who reported they had been taught that the advanced beneficiary notice was given when residents exhausted medicare benefits. SSD #5 acknowledged and confirmed during the interview that the advanced beneficiary notices of non-coverage hadn't been issued to residents. SSD #5 further reported to the surveyor that now, they will be giving the advanced beneficiary notices with the notice of medicare-non coverage forms when residents have exhausted medicare and will be staying in the facility. On 7/29/24 at 11:14AM the surveyor reviewed the completed form for Resident #25 which stated their last covered day of Part A service was 4/5/24 and benefit days were not exhausted and notated that the facility did not issue the advanced beneficiary notice of non-coverage and the resident remained in the facility. On 7/29/24 at 11:17AM the surveyor reviewed the completed form for Resident #248 which stated their last covered day of Part A service was 6/24/24 and benefit days were not exhausted and notated that the facility did not issue the advanced beneficiary notice of non-coverage. Upon further review of attached documentation, a phone call was made to the resident's family by the facility on 6/21/24, however, no written notice was sent until it was mailed out on 6/24/24, the day the coverage was ending. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 11:34AM the surveyor reviewed the completed form for Resident #46 which stated their last covered day of Part A service was 6/20/24 and benefit days were not exhausted and the facility did not issue the advanced beneficiary notice of non-coverage, and the resident remained in the facility. On 7/29/24 at 11:51AM the surveyor shared concerns with the facility's Administrator who acknowledged and confirmed the concerns and stated the following information to the surveyor: The advanced beneficiary notices should have been given.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47200 Based on observation, record review, and interview it was determined the facility failed to ensure secure storage of resident records and personal information. This was evident during the surveyor's exterior environment tour of the facility's grounds during the facility's recertification survey. The findings include: On 7/30/24 at approximately 11:20AM the surveyor conducted an exterior environmental tour of the facility's grounds and observed two exterior doors to the facility which were ajar, unlocked, and able to be opened. One out of two openly accessible areas was found to be a storage area with therapy related medical equipment in disarray, with a two drawer metal filing cabinet present, and two oversized cardboard banker boxes stacked on top, observed to be completely filled with various medical documents with resident personal information present. The surveyor observed and noted the following was present: bad medicare debt documents, resident information including names, admitted s, and lists with social security numbers present, room numbers, letters from the facility to residents, audit documents, and financial documents related to resident insurance information among various other documents. The surveyor noted this storage area was completely accessible from the outside environment. On 7/30/24 at 11:27AM a dual surveyor observation was conducted to observe the concern. On 7/30/24 at 11:37AM dual surveyors notified the facility's Administrator, shared the concern, and accompanied them to observe the concern, at which time the Administrator was interviewed. The facility Administrator observed, acknowledged, and confirmed the concern, then was observed contacting the Director of Maintenance #12, via phone asking them to bring a cart outside to remove the documents. On 7/30/24 at 11:45AM, Director of Maintenance #12 was observed removing the filing cabinet and boxes of documents from the storage area, and at this time an interview was conducted by the surveyors. Director of Maintenance #12 confirmed during the interview that the door to the storage where the documents were located does not close and attempted closure of the door, which was unable to be closed. When the surveyor inquired as to how long the documents had been there, the Director of Maintenance #12 reported they were unsure how the documents became located there and did not know how long they had been there. Director of Maintenance #12 further reported they had not personally utilized that storage area in awhile, but the documents may have been there the last time they had utilized the storage area.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation and interview it was determined the facility failed to ensure a homelike environment. This was evident throughout the facility during the surveyor's environmental tour. The findings include: On 7/30/24 at 9:02AM the surveyor observed room [ROOM NUMBER] and observed an area of unpainted spackling felt to be soft and movable on the wall approximately 4.5ft long by 1.5ft tall adjacent to the resident's window. The resident's television was observed to only have one working tv channel with a fuzzy appearance to the screen. The dresser furniture was observed to have a broken drawer handle on the top drawer which was dangling. Upon observation of the shared bathroom, the surveyor noted the following: one ceiling tile containing a plastic air vent with a bowed appearance and 0.5in separation present, approximately a 1ft long by 3in tall brown stain on the ceiling tile containing the light fixture, one missing ceramic wall tile below the toilet paper dispenser with exposed wall board, one broken ceramic wall tile in which the toilet paper dispenser was affixed to, various chipped paint and scraping present on the wooden trim molding and bathroom door, a 4in x 4in circular area of cracked, unpainted spackling on the wall across from the toilet. On 7/30/24 at 9:13AM the surveyor conducted an interview with Resident #73 who conveyed to the surveyor that seeing the room in disrepair made them feel put down. On 7/30/24 at 9:14AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: one ceiling tile above the window with 2 brown stains present, and a 5in section of window blind was missing. On 07/30/24 at 9:16AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: a 2ft long x 3in tall area of unpainted spackling behind the window bed, another area of unpainted wall spackling 6in long x 1ft tall adjacent to the window with cracked areas and peeling paint, a cracked open area in the drywall approximately 0.5in long x 4in tall adjacent to the left side of the window, one ceiling tile above the window with 3 brown stains present, black scrape marks present on an interior bathroom door, and worn off paint on the toilet seat. On 7/30/24 at 9:22AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: a 5in section of window blind was missing, a 5in section of blind was broken backwards, a broken wooden window sill with approximately a 1.5ft long diagonal appearance, a bathroom ceiling light fixture with no cover and observable wiring and bulb, chipping paint on the wooden trim molding surrounding the bathroom flooring, On 7/30/24 at 9:29AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: approximately a 2ft long section of missing bathroom trim molding, and the nightstand furniture for the bedroom closest to the entry door to the room was observed to have the stain worn off in several areas. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 9:35AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: a strong, foul odor present in the bathroom, 3 out of 6 bathroom ceiling tiles with brown staining present, a cracked wooden window sill, no door stopping mechanism present on the room's entry door, and a cracked, damaged area on the bathroom door approximately 5in long x by 4in tall where the door handle from the entry room door made contact with the bathroom door, unpainted trim molding in the bathroom, sitting, non draining water was observed in the sink inside the room, dark areas of wood were exposed on the trim molding below the sink with worn off paint, cracked and peeling paint was observed behind the bed area and in various areas throughout the room. On 7/30/24 at 9:43AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: a two foot long piece of wooden wall molding missing with splintery edges behind the bed area on the molding that remained, a 2in long x 3in tall area of missing paint with exposed wall board to the left of the door bed, an in room sink with sitting, undrained, pink water with no drain plug/stopper present, the door handle to the bathroom was loose upon entry, no cylinder type part was present to hold the toilet paper roll on the holder, and a cracked area was present in the bathroom door where the room entry door handle was able to make contact with the bathroom door. On 7/30/24 at 9:56AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: a 1ft long x 2in tall cracked area of spackling with exposed mesh pieces on the bathroom door where the room entry door handle was able to make contact with the bathroom door, mismatched pieces of cut flooring were in disarray with a portion which was unattached and surrounding the commode with several of the mismatched pieces supporting the base of the commode, bathroom trim molding paint was observed to be worn and chipped with exposed wood surface, and the wall corner situated in between the in-room sink and the bathroom was observed to be dented with chipped paint and gray markings present. On 7/30/24 at 9:58AM the surveyor conducted an interview and shared concerns with Director of Maintenance #12 who acknowledged understanding of the concerns and reported that room [ROOM NUMBER] and room [ROOM NUMBER] shared plumbing. Director of Maintenance #12 reported the following information to the surveyor: It backs up and I have to snake it, it's on my list. On 7/30/24 at 10:02AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: there was no door stopper present for the entry door to the room, a spackled cracked area on the bathroom door was present in the area where the entry room door handle was able to make contact with the bathroom door, one bathroom ceiling tile was missing with observable exposed insulation present and cobwebs, caulking around the base of the commode was observed to be in disarray with brown debris present, and black debris was observed in the air duct above the entry door to the room. At this time, the surveyor conducted an interview with the Environmental Services Director #47 who confirmed with the surveyor that the bathroom was currently being utilized and was shared with the adjoining room, #217. On 7/30/24 at 10:08AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: areas of wall paint were unfinished in between the resident beds, and a resident's personal clothing was observed in a bag on the floor without closet space necessary to accommodate hanging them. On 7/30/24 at 10:14AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: approximately a 3ft long x 1ft tall area on the wall below the bathroom sink with exposed wall board and peeling paint with black debris present, and orange colored staining on the bathroom sink drain with no drain plug/stopper present. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 10:23AM the surveyor observed the light fixture behind the resident's bed in room [ROOM NUMBER], with a cord that was not in reach of the resident. At this time, the resident reported they could not reach the cord for the light and needed it to be extended. The surveyor shared and observed this concern on 7/30/24 at 10:32AM with Corporate Nurse #36 who acknowledged the concern and confirmed with the resident that this issue would be fixed. Upon observation of the bathroom, the surveyor noted areas of unpainted spackle on the wall adjacent to the commode. On 7/30/24 at 10:32AM the surveyor observed room [ROOM NUMBER] with various areas of brown staining on the ceiling tiles and peeling paint present on the wall behind the bed along the wall molding, a missing section of wooden wall molding and a broken area of wooden wall molding with exposed edges. On 7/30/24 at 10:37AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: unpainted areas of wall spackling, one ceiling light fixture cover in the bathroom with tape present across it, and one paper towel dispenser with a crooked appearance which was movable, loosely attached to the bathroom wall by one screw which was protruding. On 7/30/24 at 10:42AM the surveyor observed room [ROOM NUMBER] and noted two out of two electrical sockets with no plate cover present, each with an additional plug attached to it providing 6 additional outlets to each. On 7/30/24 at 10:44AM the surveyor observed room [ROOM NUMBER] and noted the following areas of concern: an area of missing trim molding with exposed cracked drywall and unpainted spackle, peeling and chipped wall and trim molding paint, and an area with no mirror present on the wall below the light fixture above the in-room sink, with areas on the wall which appeared to have held a mirror previously. On 7/30/24 at 10:48AM the surveyor observed room [ROOM NUMBER] with damaged areas present to the wall area between the dresser and the closet, and unpainted areas of paint on the walls including the bathroom. On 7/30/24 at 10:53AM the surveyor observed room [ROOM NUMBER] with unpainted areas and missing molding trim along the wall behind the resident bed. On 7/30/24 at 10:58AM the surveyor observed room [ROOM NUMBER] with one ceiling tile in bathroom which had a bowed appearance with approximately a 0.5in opening present. On 7/30/24 at 11:01AM the surveyor observed the facility's courtyard which was observable from several resident rooms and community areas. The courtyard was observed by multiple surveyors to have an unkempt appearance with overgrown weeds in the middle of a fenced section, and with dark stained broken concrete areas and rocky debris, several planter pots were observed to be present with no plants. On 7/30/24 at 11:03AM the surveyor conducted an interview with District Manager #52 who reported to the surveyor that the courtyard can be used by residents, and they had observed residents and others utilizing the courtyard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 11:05AM the surveyor observed room [ROOM NUMBER] and noted the following concerns: one missing ceiling light cover in the bathroom with one of two bulbs observed to be lit with the bulbs and wiring exposed, unpainted spackling on the wall across from the commode, and missing areas of caulk around the base of one side of the commode along the floor. On 7/30/24 at 11:10AM the surveyor observed room [ROOM NUMBER] with a loose vent cover and ceiling tile in the bathroom. On 7/30/24 at 11:12AM the surveyor observed room [ROOM NUMBER] with one electrical socket with no cover plate with a second plug attached which provided six additional sockets. On 7/30/24 at 11:14AM the surveyor observed room [ROOM NUMBER] with a loose light fixture present on the wall above the resident who was in bed nearest to the entry door to the room. On 7/30/24 at 11:25AM the surveyor observed the housekeeping room with seven damaged wall tiles. On 7/30/24 at 1:23PM the surveyor conducted interviews with multiple resident council members who reported residents of the facility utilize the courtyard. On 8/5/24 at 2:59PM the facility Director of Maintenance #12 participated in an interview and dual observation of the surveyor's concerns and acknowledged and confirmed understanding of the concerns. During an interview on 8/8/24 at 9:10AM the surveyor's concerns were shared with the facility's Administrator, who acknowledged understanding of the concerns.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 2 (#38, #4) of 4 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: 1) During an initial screen of Resident #38 on 7/23/2024 at 9:37 AM, the resident stated that s/he was sent out to the hospital on 6/28/2024. On 7/23/2024 at 1:48 PM a review of nurses' progress notes and change in condition documentation revealed Resident #38 was sent to the ED (emergency department) on 6/28/2024 at 2206H (10:26 PM) via 911. On 7/24/2024 at 12:17 PM an interview was conducted with Licensed Practical Nurse (LPN #3). Regarding written notification of reason for transfer to the hospital, LPN #3 stated that s/he was not aware that they had to give the resident and/or family written notification of reason for transfer to the hospital. LPN #3 added that the residents and/or their families were told verbally why the residents were transferred to the hospital. S/he further stated that the reason for transfer was written in the change in condition form and nurses' progress notes in the resident's chart. On 7/24/2024 at 12:25 PM, an interview was completed with B-Wing Unit Manager (UM #4). UM #4 confirmed that s/he has never given residents/their RPs in writing the reason for transfer to the hospital. S/he stated that the resident and their RP were told verbally the reason why the resident was transferred (in person if RP was in the facility and/or phone call if not in facility). UM #4 added that the reason for transfer was documented in the transfer form that was included in the paperwork (transfer packet) sent with the resident to the hospital. S/he confirmed that Resident #38 and/or their RP were not notified in writing reason for transfer/discharge to hospital. On 8/8/2024 at 10:45 AM, in an interview with the Director of Nursing (DON) and the Nursing Home Administrator, surveyor shared concerns regarding written notification of resident and/or their RP of reason for transfer/discharge to the hospital. They did not provide any documentation that Resident #38 and/or their RP was notified in writing the reason for the transfer to the hospital on 6/28/2024. 49409 2) Resident #4 is [AGE] years old, has been at the facility for less than 6 months, and diagnosed with colon Cancer, Post resection and chemotherapy, acute kidney failure, Diabetes Mallitus, Hypertension, Obstructive sleep apnea, morbid obesity, GERD. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review conducted on 07/30/24 at 12:22 PM revealed that the resident was transferred to the Hospital, documentation does not reflect that the resident or the resident's family were notified regarding the reason why the resident was transferred to the Hospital. On 07/30/24 at 03:18 PM, an Interview with LPN Staff # 23 revealed that he/she assisted with sending documents to the Hospital but did not communicate with the resident or family regarding the reason why the resident was going to the hospital. Surveyor reviewed with both Staff # 23 and the DON (Director of Nursing) regarding the failure to communicate with the resident about the reason why he/she is being transferred to the hospital, and they agreed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49409 Based on record review, resident interview, and staff interviews, it was determined that the facility failed to offer a Bed-hold notice to the resident or resident's representative before the facility transferred a resident to the hospital. This was evident for 1 (Resident #72) of 4 resident records reviewed for hospitalization during a recertification/complaint survey. The findings include: Bed hold notice includes providing written information to the resident and bed charges, including the duration of the bed hold until the resident is permitted to return to the nursing facility. On 07/23/24 at 10:44 AM, an interview with (resident #72) revealed that he/she went to the Hospital unplanned, recently in January and April of 2024. The resident further confirmed that no one at the facility informed him/her about the bed hold policy. On 07/26/24 at 11:16 AM, medical record review of the INTERACT transfer assessment and the resident's progress notes revealed that the behold policy was not discussed with the resident or given a copy, prior to sending the resident to the hospital. 07/29/24 12:22 PM Interview with LPN Staff # 23 revealed that the facility will not hold the bed for the resident to return. Another department will send the bed hold notification to the family. Sometimes, Nurses may read the policy to the resident, and the social worker calls or faxes the bedhold policy to an emergency room at the hospital, and a copy is kept in the social work department. An interview with the Social worker designee, staff # 5, and the DON (Director of Nursing) on 07/29/24 at 12:56 PM, revealed that the Nurses communicate with families regarding acute transfer to the hospital and the bed hold policy when the social worker is not available. If the resident is still at the hospital, a bed hold authorization letter is mailed to the family, if a resident is back at the facility, a copy of bed hold authorization is given to the resident. Medicaid does not pay for bed hold, but private pay resident's bed will be held. Reviewed with the social work designee, Staff #23, and the DON that the bed hold policy process does not meet the required regulation of the bed hold policy, and they agreed.

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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. (continued on next page)

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48168 Based on record review and interview it was determined that the facility to refer residents to the appropriate state-designated authority for Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination. This was evident for 1 resident (Resident #30) of 2 residents reviewed for PASSAR during the annual survey. The findings include: Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. On 7/24/24 at 9:02 AM a review of Resident #30's records revealed a PASSAR Level I screening form dated 3/10/22 which indicated that the resident should have been referred for a Level II evaluation. No Level II PASSAR documentation found in the resident's records. On 7/24/24 at 9:28 AM an interview with the Director of Nursing (DON) was conducted. The Level I PASSAR was reviewed which indicated that a Level II referral was required. The DON was asked to provide evidence that a PASSAR II referral was done for Resident #30. On 7/24/24 at 10:04 AM the Infection Prevention Nurse (Staff #30) informed the surveyor that there was no referral for PASSAR Level II for Resident #30. On 8/08/24 at 9:10 AM an interview with the Nursing Home Administrator (NHA) was informed that Resident #30 did not have a required referral for PASSAR Level II. She said she was aware of the deficiency and that it was being addressed.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42507 Based on observation, record review, and interview it was determined the facility failed to meet professional standards of practice by failing to ensure staff followed physician orders for administration of medications and documentation. This was evident for 2 (Resident #41, #66) of 4 residents observed for medication administration during a recertification/complaint survey. The findings include: On 7/31/2024 at 9:48 AM, surveyors met the nurse, Registered Nurse, RN #8, at a medication cart on the A-Wing Unit. RN #8 reported he was preparing medications for Resident #41. Surveyors observed RN #8 remove from the medication cart and give Resident #41 their morning meds including the following: 1 tab Senna Plus and 1 Acidophilus (probiotic). On 7/31/2024 at 10:55 AM, surveyors observed RN #8 pulled administer Resident #66 their morning meds including the following: 1 tab Metformin 500 mg. The medication Topiramate 25 mg was not available. RN #8 informed Resident #66 that they were going to follow up with the doctor. He stated that the medication was re-ordered but not delivered by pharmacy. On 7/31/2024 at 1:30 PM, a review of Resident #41's active orders and Medication Administration Record (MAR) revealed the following orders: - Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth two times a day for constipation Pharmacy Active 3/28/2023 17:00 3/28/2023, and - Probiotic Capsule 250 MG (Saccharomyces boulardii) Give 1 capsule by mouth every morning and at bedtime for supplement Pharmacy Active 3/27/2023 21:00 3/28/2023 However, RN #8 had given Senna Plus instead of Sennosides 8.6 mg tablet and Acidophilus probiotic instead of Probiotic Capsule 250 mg (Saccharomyces boulardii) to Resident #41. On 7/31/2024 at 1:37 PM, a review of Resident #66's active orders and MAR revealed the following orders: - Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl) Give 2 tablet by mouth in the morning for diabetes Pharmacy Active 4/4/2024 07:00 4/3/2024, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Topiramate Oral Tablet 25 MG (Topiramate) Give 1 tablet by mouth every morning and at bedtime for Seizures Pharmacy Active 8/24/2023 21:00 6/11/2024 However, RN #8 had given 1 tab of Metformin 500 mg instead of 2 tabs as ordered. Topiramate was not given because it was not available. Review of the MAR at 1:37 PM on 7/31/2024 revealed the Topiramate was not signed off by the nurse as not given (the slot was left blank). On 7/31/2024 at 2:57 PM, surveyors reviewed Resident #66's medications with RN #8. RN #8 confirmed that he had given 1 tab of Metformin instead of 2 tabs as ordered. He removed the medication blister packs from the med cart and counted 15 remaining tabs. There should have been 14 tabs remaining had he given 2 tabs instead of 1. RN #8 stated that it was an error and reiterated that he was new to the facility (2 weeks) and still in training. Regarding Resident #66's missed dose of Topiramate, RN #8 stated that the medication was still not available. On 8/1/2024 at 8:55 AM, a review of the facility's policies and procedures for Medication Administration was completed: Under Procedure: I: General Procedures: a) Administer medication only as prescribed by the provider. f) Observe the five rights in giving each medication: i. the right resident, ii. the right time, iii. the right medicine, iv. the right dose, and v. the right route. l) Read medication label three times before administering medication: i. First, when pulling the medication from the drawer, ii. Second, when comparing label to MAR, and iii. Third, when preparing to administer the medication. x) Report medications errors gg) Medications that are refused or withheld or not given will be documented. On 8/1/2024 9:30 AM, in an interview with A-Wing Unit Manager (UM #23), Surveyors reviewed their findings during medication pass observation conducted on 7/31/2024. UM #23 stated that RN #8 had informed her about Resident #41 getting the wrong medications and Resident #66 getting 1 tab of Metformin instead of 2. Regarding Resident #66's Topiramate 25 mg, UM #23 stated that the medication was delivered last evening by the pharmacy and the resident got their evening dose. On 8/1/2024 at 1:06 PM, surveyor shared concerns regarding the observations during medication pass by RN #8 on 7/31/2024 with the Director of Nursing (DON). DON was informed that the med error rate was greater than 5%. The total medication error rate for the four medication pass observations was 13.79 % (over 5%). This was reviewed with the Administrator and DON prior to survey exit on 8/8/2024 at 10:40 AM.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on observation, interview, and medical record review, it was determined the facility failed to implement an ongoing program of activities based on the abilities, interests and treatment needs of a resident that resided in the facility. This was evident for 1 (#38) of 82 residents reviewed during a recertification/complaint survey. The findings include: Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care On 7/22/2024 at 10:00 AM and 2:00 PM respectively, surveyor observed Resident #38 lying in bed with eyes closed. There were no forms of activity being provided in his/her room. The TV on the wall across the foot of the bed was off. On 7/23/2024 at 9:25 AM, a subsequent observation of Resident #38 revealed the resident awake and lying in bed. There was no other resident (roommate) in the room. The television was not on, and resident had no activities. In an interview with Resident #38, when asked about activities, the resident stated that They haven't asked me to participate in any activities. 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 dementia, mild cognitive impairment, insomnia. Review of quarterly MDS with assessment reference date (ARD) of 7/5/2024 noted the Resident had a BIMS (Brief Interview of Mental Status) score of 9. A score of 8-12 points indicates moderately impaired cognition. On 7/23/2024 at 1:15 PM, a review of physician orders revealed the following active orders dated 7/3/2024: May participate in group & individual activities of choice as tolerated including those involving foods as per current diet order. No directions specified for order. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/2024 at 1:44 PM, a review of Resident #38's care plan revealed an activity care plan focus The resident has little or no activity involvement Disease Process with interventions Assure that the activities are compatible with resident's physical and cognitive capabilities; Encourage resident to participate in music and memory programs; Interview and determine resident activity preferences; Invite resident to scheduled activities; 1:1 in room visits if unable to attend out of room events. The care plan was not followed as there were no music and/or memory programs and no 1:1 in room visits observed. On 7/23/2024 at 2:10 PM, a review of Activities progress notes was completed: Last note was documented on 5/16/2022 at 11:08: Activities Progress Note Note Text: Resident likes listening to R&B Jazz music. My goal is to try to get [resident] more involved in other activities that we offer. On 7/24/2024 at 9:01 AM, an interview was conducted with the Activities Director (Staff #2). Regarding Resident #38's activities, Staff #2 stated that the resident did not like to participate in group activities but likes conversation. She stated that sometimes the resident will come out but not very often. Staff #2 stated that the Activity Aide goes into the resident's room and talk with him/her one on one for 15-to 20 minutes. When asked where staff documented their visits/activities, Staff #2 stated that activities were documented in POC (electronic record) and added that they had an activities book that the Activity Aide documents in when she meets with residents. Surveyor reviewed the activities book with Staff #2: Resident #38 was seen on 4/17/2024 and 6/24/2024 for activities (conversation/check on). Surveyor requested from Staff #2 documentation that Resident #38 had any other activities and/or one-on-one with activities staff from January 2024 through July 2024. Staff #2 was unable to provide that documentation. She stated that she had been in the position for 1 year and that the Activities Aide was also new. Staff #2 confirmed that they were not seeing the residents that needed one-on-one activities as often as they should. On 8/8/2024 at 10:40 AM, the Director of Nursing and Administrator were informed of the concern regarding failure to provide activities for Resident #38 prior to survey exit. No further documentation of any activities that the resident was involved in and/or documentation provided to indicate the resident was offered or declined a group activity.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

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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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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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50502 Based on a review of employee records and interviews, it was determined that the facility failed to ensure that nursing staff had competency evaluations upon hire. This was evident for 5 (Registered Nurse #50, #51, Geriatric Nursing Assistant #16, #48, and #49) of 5 randomly selected nursing staff reviewed for competencies. The findings include: Nursing competence is defined by the American Nurses Association as an expected level of performance that integrates knowledge, skills, abilities, and judgment. On 7/26/24 at 11:08 AM, a telephone Interview with the staffing coordinator (Staff #13) revealed that the facility had no official educator. Staff #13 explained that training was conducted by the staffing coordinator, Director of Nursing (DON), or Human Resources (HR). Staff #13 stated that an orientation packet, including their skills checklist, was provided to the new hires and then given to the DON once completed. He/she added that after the orientation, competency training is done yearly. On 7/26/24 at 12:50 PM, a review of nursing employee records revealed the following: 1. Registered Nurse (RN) #50 was hired in March 2023. No competency evaluation was found. 2. Registered Nurse (RN) # 51 was hired in January 2023. Competency training is on file but not signed and dated. 3. GNA #16 was hired in January 2022. No competency evaluation was found. 4. GNA #48 was hired in April 2012. No competency evaluation was found. 5. GNA #49 was hired in May 2020. No competency evaluation was found. On 7/29/24 at 01:53 PM, in an interview with the Assistant Director of Nursing (ADON), who also is a staff educator (RN #14), she stated that the competency training for GNAs and nurses was a team effort between the unit managers (UM), infection preventionist (IP) nurse, DON and ADON. RN #14 added that upon hire, the facility provided a skills checklist to the orientee who shadowed the preceptor, and the skills checklist would be signed off by the preceptor and indicated on each skill. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 09:00 AM, during an interview with DON, he stated that the competency training for GNAs and nurses was a collective effort by UM, ADON, and IP nurse. The surveyor asked how the facility verified new nursing staff skills. The DON explained that the facility held classroom training wherein the nursing staff watched videos and were assigned to a specific individual as a preceptor. The staff kept the skills checklist and gave it to the preceptor, and they both went through it. The DON stated that he expected the trainee and the preceptor to sign and date the form. The DON was notified of the concern that out of 5 randomly selected employee records, only one had a skills checklist upon hire but needed to be dated and signed. The DON confirmed that the nurse should have signed and dated the skills checklist.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50502 Based on a review of employee records and interviews, it was determined that the facility staff failed to conduct performance reviews of Geriatric Nursing Assistants (GNAs)at least once every 12 months. This was evident for 3 (GNA #16, #48, and#49) of 3 randomly selected GNAs' records reviewed for annual training requirements during the recertification/complaint survey. The findings: On 7/26/24 at 12:50 PM, a review of randomly selected 3 GNAs' records revealed the following: 1. GNA #16 was hired in January 2022- no annual performance review found. 2. GNA #48 was hired in March 2013. no annual performance review was found. 3. GNA #49 was hired in May 2020- no annual performance review found. On 7/29/24 at 1:53 PM, in an interview with the Assistant Director of Nursing (ADON), who is also a staff educator (RN #14), she stated that the nursing staff are evaluated annually by the Director of Nursing (DON). On 7/30/24 at 10:35 AM, during an interview with the DON, the surveyor shared concerns that the employees' personal files did not contain annual performance reviews. The surveyor requested copies of the annual performance reviews for GNA #16, #48, and #49. On 7/30/24 at 1:04 PM, the Infection Control Preventionist (ICP) entered the conference room and said, The DON confirmed that there was no performance review for GNA #16, #48, and #49. On 7/30/24 at 09:00, the DON was made aware of the concern regarding GNAs' annual performance review.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42507 Based on observation, medical record review, and interview, it was determined the facility failed to ensure that its medication error rates are not 5 percent or greater. This was found to be evident based on errors identified during medication administration for 2 (Resident #41, #66) of 4 residents observed. The observations were made on two of two nursing units and involved one of three different nurses. The findings include: On 7/31/2024 at 9:48 AM, surveyors met the nurse, Registered Nurse, RN #8, at a medication cart on the A-Wing Unit. RN #8 reported s/he was preparing medications for Resident #41. RN #8 was observed removing the following medications from the medication cart: 1 Acetaminophen 650 mg 1 Senna Plus 1 Eliquis 2.5 mg 1 Amlodipine 5 mg 1 Acidophilus (probiotic) 1 Metoprolol ER 25 mg, and Med Plus 2.0 Vanilla nutritional drink, 120 ml (supplement). RN #8 then gave the medications to resident #41. On 7/31/2024 at 10:55 AM, surveyors observed RN #8 pulled out from the medication cart the following medications and administered them to Resident #66: 1 Carvedilol 12.5 mg, 1 Metformin 500 mg, 1 Glimepiride 2 mg, * Topiramate 25 mg (was not available). RN #8 informed Resident #66 that they were going to follow up with the doctor. S/he stated that the medication was re-ordered but not delivered by pharmacy. On 7/31/2024 at 1:30 PM, a review of Resident #41's active orders and Medication Administration Record (MAR) revealed the following orders: - Senna Oral Tablet 8.6 MG (Sennosides) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 1 tablet by mouth two times a day for constipation Pharmacy Active 3/28/2023 17:00 3/28/2023, and - Probiotic Capsule 250 MG (Saccharomyces boulardii) Give 1 capsule by mouth every morning and at bedtime for supplement Pharmacy Active 3/27/2023 21:00 3/28/2023 However, RN #8 had given Senna Plus instead of Sennosides 8.6 mg tablet and Acidophilus probiotic instead of Probiotic Capsule 250 mg (Saccharomyces boulardii) to Resident #41. On 7/31/2024 at 1:37 PM, a review of Resident #66's active orders and MAR revealed the following orders: - Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl) Give 2 tablet by mouth in the morning for diabetes Pharmacy Active 4/4/2024 07:00 4/3/2024, - Topiramate Oral Tablet 25 MG (Topiramate) Give 1 tablet by mouth every morning and at bedtime for Seizures Pharmacy Active 8/24/2023 21:00 6/11/2024 However, RN #8 had given 1 tab of Metformin 500 mg instead of 2 tabs as ordered. Topiramate was not given because it was not available. Review of the MAR at 1:37 PM revealed the Topiramate was not signed off by the nurse as not given (the slot was left blank). This represented 4 errors out of 29 opportunities for error rate of 13.79 %. On 7/31/2024 at 2:52 PM, in a follow up interview with RN #8, surveyors reviewed Resident #41's active orders and medication pass observation. RN #8 reviewed and confirmed that s/he had given Senna Plus instead of Sennoside and Acidophilus instead of Probiotic capsule 250 mg (Saccharomyces boulardii). RN #8 retrieved the Probiotic capsule from the med cart and affirmed that s/he had given the wrong medication. On 7/31/2024 at 2:57 PM, surveyors reviewed Resident #66's medications with RN #8. RN #8 confirmed that s/he had given 1 tab of Metformin instead of 2 tabs as ordered. S/he removed the medication blister packs from the med cart and counted 15 remaining tabs. There should have been 14 tabs remaining had s/he given 2 tabs instead of 1. RN #8 stated that it was an error and reiterated that s/he was new to the facility (2 weeks) and still in training. Regarding Resident #66's missed dose of Topiramate, RN #8 stated that the medication was still not available. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/2024 at 8:55 AM, a review of the facility's policies and procedures for Medication Administration was completed: Under Procedure: I: General Procedures: a) Administer medication only as prescribed by the provider. f) Observe the five rights in giving each medication: i. the right resident, ii. the right time, iii. the right medicine, iv. the right dose, and v. the right route. l) Read medication label three times before administering medication: i. First, when pulling the medication from the drawer, ii. Second, when comparing label to MAR, and iii. Third, when preparing to administer the medication. x) Report medications errors gg) Medications that are refused or withheld or not given will be documented. On 8/1/2024 9:30 AM, in an interview with A-Wing Unit Manager (UM #23), Surveyors reviewed their findings during medication pass observation conducted on 7/31/2024. UM #23 stated that RN #8 had informed her about Resident #41 getting the wrong medications and Resident #66 getting 1 tab of Metformin instead of 2. Regarding Resident #66's Topiramate 25 mg, UM #23 stated that the medication was delivered last evening by the pharmacy and the resident got their evening dose. On 8/1/2024 at 1:06 PM, surveyor reviewed with the Director of Nursing (DON) the medication pass observations on 7/31/2024 with RN #8. DON was informed that the med error rate was greater than 5%. The total medication error rate for the four medication pass observations was 13.79 % (over 5%). This was reviewed with the Administrator and DON prior to survey exit on 8/8/2024 at 10:40 AM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42507 Based on observation and interview it was determined facility staff failed to remove expired medications and patient supplies. This was evident on 1 of 2 nursing units and a central supply room observed during a recertification/complaint survey. The findings include: On 7/31/2024 at 11:45 AM, A-Wing Unit CMA (Certified Medicine Aide) medication cart was reviewed for medication storage and labeling in the presence of RN #8: Surveyor found in the overflow drawer of the med cart one blister pack of Mirtazapine 15 mg tabs that expired on 7/16/2024 for Resident #49. RN #8 confirmed the findings and showed the expired drugs to the Regional Director of Clinical Operations (Staff #33), who immediately removed them from the med cart. On 8/1/2024 at 10:10 AM, observation was made of the Central Supply room, in the presence of the Central Supplies staff (Staff #9) and A-Wing Unit Manager (UM #23): The following items were found expired: A box of BD vacutainer eclipse blood collection needles expired on 12/06/2017 A Nipro Box of 22 Gauge needles expired on 4/30/2022 A Nipro box of three (3) 20 Gauge needles expired on 12/3/2021 A #22-gauge needle 11/2 x1 expired on 11/09/2018 A Discofix 3-way stopcock expired on 3/1/2021 2 Cap-1 caps expired on 6/1/2023 A box containing multiple 21 G -22 G blood draw needles expired on 3/31/2023, and A vacutainer Red-Top expired in 2022 Central supplies staff (Staff #9) and A-Wing Unit Manager (UM #23), both verified and confirmed that the above listed items were expired and immediately placed them in a sharps' container in the central supply room. On 8/1/2024 at 1:06 PM, the medication storage rooms observations were reviewed with the Director of Nursing (DON). DON stated he was going to follow up. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/2024 at 10:40 AM, surveyor shared concerns regarding the observations on 8/1/2024 with the Nursing Home Administrator (NHA) and DON prior to survey exit. NHA stated she was aware of the above findings.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49409 Based on the surveyor's observation and interview with staff, it was determined that the facility failed to ensure that it had qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services. This was evidenced by the lack of qualified staff and has the potential to affect all residents. The findings include: Full-time means working 35 or more hours a week. Part-time employees typically work fewer hours in a day or during a work week than full-time employees. The U.S. Department of Labor, Bureau of Statistics uses a definition of 34 or fewer hours a week as part-time work. On 07/22/24 at 09:32 AM, an Interview with the Culinary Director (Staff #11) revealed that he/she has been working for the past two years as the Culinary Director and does not have a Certificate in Dietary Management (CDM). He/she enrolled in the CDM course and can provide the registration. Staff #11 also stated that the Registered Dietician (RD) supervises the kitchen and works at the facility four days a week, adding, My understanding is that as long as the Dietician is in the building, we are okay to meet the requirement. On 07/24/24 at 10:40 AM, an Interview with a Registered Dietician (Staff # 17) revealed that he/she had worked at the facility for two years and didn't have a Certified Dietary Manager. While at the Facility, RD assists with tray line temperatures, checks residents' food preferences, and attends risk meetings, but does not attend care plan meetings. The surveyor reviewed with both the RD and the Culinary Director that the Culinary Director's lack of a CDM certificate does not meet the facility's requirement of having qualified staff to carry out food and nutrition services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49409 Based on the surveyor's observation and Interviews with staff, it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards for food safety requirements. This was identified during multiple observations of the kitchen food service operations during the recertification/complaint survey and has the potential to affect all residents. Findings include: The surveyor's kitchen initial observation on 07/22/24 at 09:32 AM revealed ice plaques on plastic freezer curtain strips in the freezer room. Icicles were noted on the black cord connecting the freezer and freezer door. Icicles noted behind condenser connection. Several icy spots were noted on the floor of the freezer room (they appear like black ice, making them hard to notice), and some icy spots were noted on the ceiling of the Freezer room. On 07/22/24 at 09:35 AM, a pile of untilted dessert bowls was noted on the countertop near the dishwashing area. Above the untitled dessert bowls, a non-functional wall-mounted insect light trap was noted. Black dust particles were noted in the top bowl. On 07/24/24, at 10:15 AM, the surveyor observed a pile of dessert bowls on the countertop near the dishwashing area. An Interview with dietary staff # 53 on 07/22/24 at 9:45 AM revealed that the bowls will be used for the dessert tray line. An interview with the Culinary Director (Staff #11) on 07/22/24 at 10 AM revealed that the freezer temperatures are checked once a week, and he/she walks through to inspect the freezer. He/she creates a ticket for environmental service to check if any issues are identified. On 07/24/24 at 10:22 AM, an Interview with the district manager (Staff # 52) revealed that the environmental services staff checks the freezers as part of preventive maintenance schedules and also addresses any issues that are identified by the staff. On 07/24/24 at 10:45 AM, the surveyor reviewed with the Culinary Director and the District Manager that the icicle formation and icy spots identified in the freezer room do not meet the food safety requirements. The surveyor also reviewed the collection of black dust particles in untitled dessert bowls under a wall-mounted insect light trap and next to the dishwashing area, with potential contamination via splash, dust, etc.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 49409 Based on the surveyor's observation and staff interviews, it was determined that the facility failed to maintain the guidelines and the facility's policy for storing food brought in by family or visitors and distinguishing it from the facility's food. This was evidenced by observations of residents' food storage brought in by family and visitors and has the potential to affect all residents. The findings include: On 07/24/24 at 11 AM, an interview with the unit Manager (Staff # 23) revealed that the refrigerator located in the nourishment room next to the Nurses' station is used for the purpose of saving any supplements, sandwiches for residents, and any food brought by the residents' family or visitors. He/She also stated that the food is always labeled and will be removed after three days. On 07/24/24 at 11:12 AM, the surveyor observed food in the refrigerator at unit A in a paper bag with the resident's name on it but no date. Surveyor also observed an unlabeled container with a smoothie-like drink and an unlabeled open water bottle. The unit manager (Staff # 23) was not able to verify if it was the resident's food or not. On 07/25/24 at 04:43 PM, an Interview with RN staff # 5 stated that he/she was unsure how long the residents' food could be saved in the refrigerator. On 07/25/24 at 04:50 PM, the surveyor observed food in the refrigerator in the nourishment room of unit B. Noted that the refrigerator was full of food packs like pepperoni slices, cheese sticks, etc,. The balanced beef stew pack was labeled with the resident's name but no date when it was placed in the refrigerator. On 07/25/24 at 5:10 PM reviewed with NHA regarding unlabeled food in both refrigerators.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 48168 Based on record review and interview it was determined that the facility failed to ensure that residents understood the arbitration agreement. This was evident for 1 signed agreement (for Resident #14) of 3 signed agreements reviewed during the recertification/complaint survey. The findings include: On 7/22/24 during the entrance conference a request was made for arbitration agreements. On 7/24/24 at 9:08 AM a review of the binding arbitration agreement for Resident #14 revealed that the document was electronically signed by the resident on 9/22/23. On 7/24/24 at 10:41 AM a review of Resident #14's clinical records revealed a certification of capacity form dated 7/24/22 that indicated the resident lacked capacity to make decisions or sign documents due to cognitive impairment. A second capacity form was present in the resident's record that also indicated the resident lacked the ability to make decisions. On 7/24/24 at 12:04 PM an interview with the Admissions Director (Staff #40) regarding arbitration agreements was conducted. Resident #14's arbitration agreement was reviewed and when asked, she confirmed that the resident signed the agreement even though there was documentation that the resident lacked capacity to do so. She said she was uncertain why the arbitration agreement was signed by a resident who lacked capacity to sign documents. On 7/24/24 at 2:52 PM an interview with the Nursing Home Administrator (NHA) was conducted. She reviewed Resident #14's signed arbitration agreement and capacity forms. She was asked to provide any evidence that the resident had capacity to sign the arbitration agreement as of 9/22/23. The NHA said she was informed by Staff #40 of the concern and that she had looked and not found any evidence that the resident had capacity to sign the document on 9/22/23. The NHA acknowledged that this was a deficiency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50458 Based on observation, interview and record review, it was determined that the facility failed to 1) use proper hand hygiene and 2) use proper personal protective equipment, evident for 1 resident (Resident # 73) of 23 residents reviewed for Enhanced Barrier Precaution (EBP). The facility also failed to 3) perform annual revision of Infection Prevention and Control Policies and Procedures, which was evident for 4 of 5 policies and procedures reviewed during the infection control task. The findings include: 1).On 8/05/24 at 10:50 AM an observation of Resident #73's dressing change was conducted. After Wound Nurse (Staff #29) removed the resident's soiled dressing, she removed her dirty gloves and put on clean gloves without performing hand hygiene. On 08/05/24 at 1:03 PM an interview with Staff #29 was conducted. Staff #29 failed to state that handwashing should be performed before and after changing gloves. On 08/06/24 at 10:00 AM an interview with the Director of Nursing (DON) was conducted. He was informed that Staff #29 did not perform hand hygiene before she put on clean gloves during resident #73's dressing change. On 08/06/24 at 11:52 AM an interview was conducted with the Infection Preventionist Nurse (Staff #30). She was informed that Staff #29 removed the resident's soiled dressing, she removed her dirty gloves and put on clean gloves without performing hand hygiene. Staff #30 acknowledged the finding and validated the concern. On 08/08/24 at 9:10 AM an interview was conducted with the Administrator. She was informed that Staff #29 was observed not performing hand hygiene before and after gloving. She acknowledged the finding and validated the concern. 2) Enhanced Barrier Precautions (EBP) are an infection control strategy that uses personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs) between residents in nursing homes. On 08/05/24 at 11:14 AM, a Geriatric Nursing Assistant (GNA #28), was observed to accompany Resident #73 to the shower room. Resident #73 had an order for EBP, specifically that staff must wear a gown and gloves when they assist the resident to shower. There was no supply of gowns or gloves seen in the shower room. On 08/05/24 at 1:24 PM an interview with GNA #28 was conducted. He confirmed that he failed to wear a gown when he assisted Resident #73's shower. He also confirmed that there were no gowns or gloves available in the shower room and that he had to ask a coworker to bring him gloves. On 08/06/24 at 8:31 AM an interview with Unit Manager (Staff #24) was conducted. He was informed that Staff #28 was not wearing a gown when he assisted Resident #73 to shower. Staff #24 acknowledged the finding of concern. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/24 at 10:00 AM an interview with the Director of Nursing (DON) was conducted. He was informed that Staff #28 was not wearing a gown when he assisted Resident #73's shower. He acknowledged the finding and validated the concern On 08/06/24 at 11:52 AM an interview was conducted with the Infection Preventionist Nurse (Staff #30). She was informed that Staff #28 was not wearing a gown when he assisted Resident #73's shower. Staff #30 stated that she had learned about the incident and made sure the shower room was now stocked with PPE supplies and further explained that staff usually brought all needed supplies to the shower room. On 08/08/24 at 9:10 AM an interview was conducted with the Administrator. She was informed that Staff #28 did not wear a gown when he assisted Resident #73's shower. She acknowledged the finding and validated the concern. 3) On 08/01/24 at 10:46 AM a record review of the facility's infection control policies and procedure was conducted and revealed that 4 of the 5 policies and procedures were not updated annually. *Resident Influenza Vaccine- no revisions for 2022, 2023 *Antibiotic Stewardship - no revisions for 2023 *Resident Pneumococcal Vaccines - no revisions for 2020, 2021 *Standard Precautions and Transmission Based Precautions - no revisions for 2020, 2022, 2023 On 08/06/24 at 11:52 AM an interview with Staff #30 was conducted. When she was informed that a review of the Infection Prevention and Control Policies and Procedures revealed that they were not updated annually, she acknowledged the finding and validated the concern. On 08/08/24 at 9:10 AM an interview was conducted with the Administrator. She was informed that the Infection Prevention and Control Policies and Procedures were not updated annually. She acknowledged the finding and validated the concern.